Our Forgotten Elders: Older People on the Streets and in Hostels

by
Dr Maureen Crane

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Our Forgotten Elders is a report commissioned by St Mungo’s into the plight of elderly people sleeping rough. Anyone reading it will immediately see why we felt we need to have this report written, for it brings to light a problem that has too long been overlooked or ignored.

In essence the report shows that there are all too few services for people aged 50 and over who sleep rough in Britain. Homelessness is a problem that is often associated with young people, yet there are more over-50s than teenagers on our streets. While there are 22 projects exclusively for young people in London, there are none for older rough sleepers.

This is a situation that we cannot allow to continue. The report shows quite clearly that older rough sleepers are frequently the most vulnerable, often suffering severe mental and physical health problems.

St Mungo’s is trying to change this situation. We are a large homelessness organisation with 60 projects housing over 1200 people each night. We run hostels, care homes, supported housing, and resettlement and job-finding programmes. We successfully ran a hostel for two year reserved for homeless people aged 50 and over in London. We are in the process of setting up a replacement. We hope that our example will be followed by others.

My thanks to Maureen Crane for her excellent report, whose conclusions we hope will be acted on.

Charles Fraser

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Dr Maureen Crane is a registered general and mental nurse. She completed her PhD on older homeless people at the University of Sheffield in 1997. She is now a Research Fellow at the Sheffield Institute for Studies on Ageing, University of Sheffield, and is continuing to do research into the problems and needs of older homeless people.
Acknowledgements

I thank particularly the older homeless people with whom I have been in contact over the years. Without their trust, cooperation, and willingness to share sometimes painful memories, our understanding of their plight would still be elementary. Although some have suffered years of hardship while homeless and have passed away before they could benefit from our growing awareness of the types of help that can make a positive difference to their lives, others will be able to take advantage of the knowledge gained from these individuals.

I would also like to thank Charles Fraser, Andy Shields and many of their colleagues at St Mungo’s, who have supported my work over many years and are developing practical solutions to my research findings. Particular thanks are also extended to many other staff of several projects working with homeless people in the UK and the USA who have provided information, support and advice. I am indebted to Virginia Graham and the Trustees of the Henry Smith’s Charity who enthusiastically supported the Lancefield Street Centre and my research. I also thank The King’s Fund for funding the initial year of the Centre’s evaluation, and the Trustees of the Sir Halley Stewart Trust for funding a study of the outcomes of resettlement for clients at the Centre.

Lastly, I send thanks to Tony Warnes at the Sheffield Institute for Studies on Ageing, University of Sheffield, for his continued support and assistance with my work. I am also grateful for his comments and help with the preparation of this report.
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References
This report describes the problems and needs of older homeless people, their contact with services, and how they can best be helped. It discusses some innovative projects that have been set up exclusively for older homeless people by voluntary organisations. Six case studies are presented to demonstrate how dedicated services can make a difference to the lives of people whose plight has been ignored for years.

**The problem of older homelessness**

The extent of homelessness among older people in Britain is more widespread than is documented. Official figures represent only the ‘tip of the iceberg’ and do not include many older homeless people who are on the streets and in hostels. At least 834 people aged 50 years and over slept rough in London at some time between April 1999 and March 2000, and a one-night survey in August 2000 found 700 people of a similar age in London’s direct-access and first-stage hostels.

Homelessness is a problem generally associated with young people, yet the majority of single homeless people are middle-aged and older. A one-night survey in May 2000 estimated that 25% of rough sleepers in London were aged over 50 and just 13% aged under 25. In August 2000, there were more than three times as many residents aged 50 years or more than there were young people (aged under 20 years) in London’s direct-access and first-stage hostels. Likewise, a recorded 224 people aged under 20 years (compared to 834 aged 50+ years) slept rough in London at some time between April 1999 and March 2000.

Compared to young homeless people in hostels, older residents tend to be in large hostels and to remain in hostels for years without being resettled. In August 2000, just 19% of hostel residents aged under 25 years but nearly one-half (45%) aged 50 years and over were in hostels with 100 or more beds. 3% of the residents aged under 20 years, 20% aged 20-29 years, yet 76% aged 60 years or more, had been in their hostel for longer than 12 months.

There has been a rapid growth of services for young homeless people, but services for older homeless people are scarce. In London, 5 day centres and 17 direct-access and first-stage hostels (that accept referrals from street out-reach teams, day centres, and single homeless people’s agencies) target young homeless people (with a maximum age of 21-30 years).

In contrast, there are no day centres or first-stage hostels in London exclusively for older homeless people.

**Older homeless people’s problems and contact with services**

Some older people have been homeless for more than 20 years and have become elderly while homeless. Others have become homeless for the first time in old age, having married, raised a family and worked for most of their life.

Compared to the general elderly population, homeless older people have severe unmet needs yet little or no contact with mainstream housing, health and social services. Many have serious untreated physical and mental health problems. Some do not claim welfare benefits but survive by eating food from litter-bins. Many are isolated and either lack family or have had no contact with relatives for years.

Statutory services assume that people in need are able and will ask for help, or that they have family who will intervene on their behalf. Their staff rarely search on the streets for vulnerable people with unmet needs who do not seek help. The help that many older homeless people currently receive is provided by voluntary sector organisations.

Many older homeless people are reluctant to use services for homeless people of all ages. A few voluntary sector organisations have, therefore, developed innovative projects exclusively for older clients.

These innovative projects are effectively helping both those who have recently become homeless and those who have been homeless for years. They have demonstrated that the circumstances of this client group can be improved, and that many benefit from such help. These services are not, however, widespread.

**The next steps**

Through the government’s recent policy and programme changes and through charitable foundations, there are opportunities for organisations to develop efficient and comprehensive services for older homeless people.

**EXECUTIVE SUMMARY**
Older homeless people require a full spectrum of services that provide a pathway from the streets to permanent housing. Because of their reluctance to use all-age services, projects need to be developed exclusively for this client group.

Services for older homeless people need to be proactive, intensive and individualised. Workers need to actively seek out those in need and persuade them to accept help.

There needs to be further exploration of ways to help older homeless women who sleep rough. A small-scale pilot project should be established in London specifically for this group, which provides out-reach services, easily-accessible temporary accommodation, good links with mental health services, and eventual resettlement.

New approaches to helping older people with both mental health and alcohol problems should be tried. Specialist workers and hostels are needed to target this group and to pilot programmes of care that minimise disturbed behaviour and prevent their unhelpful eviction.

There is a great shortage in London of supported move-on accommodation for older homeless people. Various models of permanent housing and support need to be developed that take into consideration both the clients’ needs and their preferences.

It is essential that statutory agencies and voluntary sector homeless people’s services collaborate, so that older homeless people receive the help that they need.

More work is required (i) to establish the causes of homelessness, (ii) to develop monitoring systems that can detect and anticipate people who are at risk, and (iii) to investigate various approaches to primary prevention.
Homelessness is a long-standing problem in Britain. It is most pronounced in cities and large towns, and affects men and women of all ages and both single people and families. Among the single population, homelessness is often associated with young people and their vulnerability - they tend to be visible on the streets and in shop doorways and to gain the media’s interest. According to records kept by homelessness organisations, however, 834 people aged 50 years and over compared to just 224 people aged under 20 years slept rough in London at some time between April 1999 and March 2000. Moreover, a survey of people sleeping rough during one night in May 2000 estimated that 25% of people were aged over 50 and only 13% aged under 25. The majority of single homeless people are middle-aged and older but they receive less attention from the media, the public, and from politicians and some service-providers. Several reports have been written about the problems and needs of young homeless people, but there are comparatively few about their older counterparts.

This report focuses on older homeless people. Although there is no consensus among service providers as to the age at which a homeless person is ‘older’, often 50 years and over is used. This is because people of that age who have been homeless for years tend to have physical disabilities and health problems comparable to the housed population 10-20 years older (Cohen and Sokolovsky, 1989). This report describes the problems and needs of older homeless people, and looks at effective ways to help them. It describes some innovative projects that have been set up exclusively for this client group, and highlights how these schemes are successfully helping both older people who have been homeless for years as well as those who have recently become homeless. Case studies are presented to demonstrate how dedicated services can make a difference to the lives of people whose circumstances have been neglected for years.

Homeless people fall into two groups: the ‘officially’ homeless and the ‘unofficially’ homeless. The former have been accepted by local authority housing departments as homeless and in priority need, they appear on official housing lists, and include families with children, and single people who are vulnerable because they are elderly, disabled, or mentally or physically ill. There are also many single homeless people who stay in hostels or night-shelters, or sleep rough on the streets or in doorways, parks, cars, and derelict buildings. They are not on local authority housing lists, do not appear in local authority homelessness statistics, and are thus ‘unofficially’ homeless. Some have not made their circumstances known to local authority housing departments, while others have not been accepted by statutory agencies as homeless and in priority need. Older homeless people are found in both the official and unofficial homeless groups. This report concentrates, however, on ways of helping those who are unofficially homeless. This group are particularly isolated and neglected and most are unknown to mainstream elderly service-providers.

Homelessness is a complex issue which is difficult to curtail or resolve. There is a constant flow of people of all ages becoming homeless and being rehoused. Some people are homeless for just a short while, and either find themselves accommodation or are allocated social housing (by local authority housing departments or housing associations). Others are unable to find accommodation, do not apply or qualify for social housing, and remain homeless for years. Many single homeless people have health, psychological and social problems and require services beyond simply the provision of housing. Prolonged homelessness can lead to or exacerbate physical and mental illnesses, depression and demoralisation, and alcohol and drug addiction.

Since the late 1980s, the government has played an increasing and more directive role in the development and funding of services for homeless people. It has been responding both to the increase in the number of rough sleepers in central London and other large cities, particularly of young homeless people, and to strong pressures for action from the media, tourism, retail companies and the general public. During the early 1990s, the Conservative Government invested more than £255 million into services for single homeless people, principally through the Rough Sleepers Initiative (RSI) and the Homeless Mentally Ill Initiative. Since the election of the Labour Government in 1997, the creation of a Social Exclusion Unit heralded the setting up of Rough Sleepers Unit and a Homelessness Action Programme to replace the RSI. A further £194 million has been
invested in services for single homeless people, and a target set to reduce by two-thirds by 2002 the number of people who sleep rough each night (described in chapter 6).

**The report’s sources and structure**

This report has been commissioned by *St Mungo’s*, a voluntary sector organisation that has been working with single homeless people in London since 1969. It draws on the findings of two studies of older homeless people that have been carried out by the author. The first is an intensive 15-month field study in 1994-95 of 225 older homeless people in London, Sheffield, Leeds and Manchester (the Four-City Study) (Crane, 1999). The second is a study of older rough sleepers who were admitted to the *Lancefield Street Centre* in west London during 1997-98. Information was gathered about their progress while at the Centre and once rehoused (Crane and Warnes, 2000a). The Centre was opened for two years as a pilot project, was managed by *St Mungo’s*, and targeted rough sleepers aged 50 years and over (described in Chapter 4).

The report also draws on: (i) the findings of study in 2000 of single homeless people in London of all ages which was commissioned by *Bondway, St Mungo’s and Thames Reach* (Crane and Warnes, 2000b); (ii) other accounts that have been written about older homeless people in Britain, Australia and the USA; and on (iii) the opinions and recommendations of several service-providers in this country and elsewhere who work with the client group (Cohen and Sokolovsky, 1989; Douglass et al., 1988; Iqbal, 1998; Keigher *et al.*, 1989; Warnes and Crane, 2000; Wilson, 1995).

In the next two chapters, the prevalence of homelessness among older people is outlined, followed by a summary of their backgrounds, problems and needs. Chapter 4 focuses on how statutory and voluntary sector agencies are responding to the needs of older homeless people, and describes some innovative projects that have been established by voluntary organisations to work exclusively with this client group. In Chapter 5, case studies are presented which highlight how the *Lancefield Street Centre* has helped six older rough sleepers. The case studies include some people who had been homeless for years and are now successfully rehoused. Chapter 6 discusses the current policy and funding environment for setting up services, while the final chapter highlights the way forward in developing services for older homeless people.
There are no reliable figures of the number of older people who are homeless at any given time in Britain, nor is there information about the number of older people who become homeless and are rehoused over a given period. Assessing the extent of the problem is difficult. Homelessness is not a persistent state – there is a steady flow of people of all ages becoming homeless and being rehoused. Evidence suggests that the population which experiences homelessness over one year is three to five times the number on any one night (Wright and Devine, 1995). This chapter summarises our present knowledge of the extent of homelessness among older people.

‘Officially’ homeless older people

As described in the previous chapter, official statistics only exist for older people who are accepted by local authority housing departments for priority housing on the grounds of old age. According to these statistics, the number of elderly households in England accepted as statutorily homeless has reduced since the early 1990s, from 6,020 households in 1994-95 to 3,740 in 1999-2000 (Table 2.1) (DETR, 2000). These figures, however, offer little indication of the scale of homelessness among older people. They represent the number of households who are accepted as homeless.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Number</th>
<th>Vulnerable due to old age Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991/2</td>
<td>139,630</td>
<td>5,960</td>
<td>4</td>
</tr>
<tr>
<td>1994/5</td>
<td>116,850</td>
<td>6,020</td>
<td>5</td>
</tr>
<tr>
<td>1995/6</td>
<td>116,550</td>
<td>5,820</td>
<td>5</td>
</tr>
<tr>
<td>1996/7</td>
<td>110,810</td>
<td>5,200</td>
<td>5</td>
</tr>
<tr>
<td>1997/8</td>
<td>102,650</td>
<td>4,040</td>
<td>4</td>
</tr>
<tr>
<td>1998/9</td>
<td>106,270</td>
<td>3,870</td>
<td>4</td>
</tr>
<tr>
<td>1999/0</td>
<td>105,520</td>
<td>3,740</td>
<td>4</td>
</tr>
</tbody>
</table>

Notes: 1. DETR, 2000. 2. Percentage of all those accepted as in housing priority need.

Some households may consist of two or more elderly people. Some local authorities accept as vulnerable and homeless men and women aged 60 years and over, while others only include men when they reach the age of 65 years. A study in Scotland estimated that the number of elderly people who present each year as homeless to Scottish local authorities could be twice the number of households reported as homeless in statistics (Wilson, 1995).

‘Unofficially’ homeless older people

Official figures of homelessness exclude many older people who sleep rough or stay in hostels and nightshelters, and are ‘unofficially’ homeless. They do not appear on electoral rolls or official housing and social services departments lists, many are not registered with a GP, and some do not receive social security benefits. There are no counts of the number of older people in this group. Assessing their number is particularly difficult. Many sleep rough in hidden sites, yet for safety reasons, enumerators and investigators tend not to search in isolated and dangerous spots such as derelict buildings, parks or underground tunnels. It is also difficult to identify older homeless people. Some are well-groomed, carry few possessions, do not socialise with homeless people on the streets, and it is not apparent from a single observation that they are homeless. Some deny that they are homeless to avoid being questioned, to preserve anonymity, or because they are distrustful and fearful.

There are indications that many older people are unofficially homeless. For example, two out-reach workers from the Lancefield Street Centre found 270 people aged 50 years or more sleeping rough in London in 1997. In 1998, they had contact with 305 older rough sleepers (including 235 ‘new’ cases), and in 1999 they had contact with 193 older rough sleepers (including 115 ‘new’ cases). Hence, at least 620 people (558 men and 62 women) aged 50 years or more slept rough in London at some time between 1997-99. Further evidence comes from the Outreach Directory, which records that 458 people aged at least 50 years were contacted on the streets in London between April 1998 and March 1999 (Housing Services Agency, 1999). This included 120 people who were aged 60 years or more.
The most recent and comprehensive information about older homeless people in London comes from a study of single homeless people commissioned by Bondway, St Mungo’s and Thames Reach, which was carried out in late 2000 (Crane and Warnes, 2000b). Evidence ascertained that at least 834 older people (aged 50+ years) slept rough in London at some time between April 1999 and March 2000 (Figure 2.1). Of these, 186 were aged 60-69 years, and 43 were aged 70 years and over. The older age groups (50+ years) comprised 19% of the total rough sleeping population over that period. The majority (91%) of older rough sleepers were men.

Figure 2.1
Age groups of rough sleepers in London, 1999-2000

There are also many older people in hostels for single homeless people. In January 1997, an enumeration found that 641 homeless men and women over the age of 55 years were staying in temporary hostels and ‘welfare hotels’ in Glasgow (Crane and Warnes, 1997a). A one-night survey on August 16th 2000 of residents in direct-access and first-stage hostels in London revealed that 700 residents (23%) were aged 50 years or more: 594 were men and 106 were women (Figure 2.2). Of these, 233 men and 45 women were aged 60 years and over. This included 94 people who were 70 years or more (Crane and Warnes, 2000b). There are, therefore, more than 3 times as many older homeless people: 105 residents aged 50 years and over had remained in their hostel for more than 10 years, including several for at least 20 years and two for over 60 years (Crane and Warnes, 2000b).

Figure 2.2
Age groups of hostel residents in London, August 2000

Compared to young homeless people, older hostel residents in the August 2000 survey tended not to be accommodated in small, specialist hostels, but in large ones with more than 100 beds. Whereas 59% of those aged under 25 years were in hostels of 50 beds or less and only 32% were in settings without being resettled. The one-night survey of London’s hostel residents in August 2000 found that older homeless people are much more likely than other age groups to have stayed in a hostel for a long period (Figure 2.3). Only a minority of people aged under 20 years had been resident for more than 12 months. This proportion increased with age, and it rose sharply among those aged 60 years and over. Although this is partly by virtue of age, it demonstrates the absence of effective resettlement programmes for older homeless people: 105 residents aged 50 years and over had remained in their hostel for more than 10 years, including several for at least 20 years and two for over 60 years (Crane and Warnes, 2000b).

Figure 2.3
Length of stay in London’s hostels by age groups, August 2000

The high prevalence of older homeless people in hostels is partly due to their long periods of stay
which had 76 beds or more, the comparable figures for residents aged 50 years and over were 25% and 63% respectively (Table 2.2). This is partly because many of the smaller projects are exclusively for young homeless people.

Table 2.2
Age distributions of hostel residents by size of hostel

<table>
<thead>
<tr>
<th>Size of hostels</th>
<th>Age Groups (years)</th>
<th>&lt;25</th>
<th>25-49</th>
<th>50+</th>
</tr>
</thead>
<tbody>
<tr>
<td>No of beds</td>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Up to 25</td>
<td></td>
<td>19</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>26-50</td>
<td></td>
<td>40</td>
<td>24</td>
<td>19</td>
</tr>
<tr>
<td>51-75</td>
<td></td>
<td>9</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>76-99</td>
<td></td>
<td>13</td>
<td>21</td>
<td>18</td>
</tr>
<tr>
<td>100 or more</td>
<td></td>
<td>19</td>
<td>38</td>
<td>45</td>
</tr>
<tr>
<td>No of residents</td>
<td></td>
<td>635</td>
<td>1955</td>
<td>700</td>
</tr>
</tbody>
</table>

Conclusions
The extent of homelessness among older people in Britain is more widespread than is documented, and official figures represent only the ‘tip of the iceberg’. It is a much more extensive problem, and a large number of older people are sleeping rough and living in hostels and bed-and-breakfast or welfare hotels. Enumerating or estimating the number of older people who are homeless is complex, and without a detailed enquiry in each town and city over a period, no accurate figure of the scale of the problem can be ascertained. A single-night count of rough sleepers, for example, is likely to exclude many isolated and hidden older homeless people.

The few surveys that have been conducted of older homeless people have demonstrated that there are many on the streets and in hostels. They are more likely than younger homeless people to be in very large hostels and to remain in such accommodation for years. Yet Chapter 4 describes how this need not be the case. When suitable services are set up for this client group, they do respond and can be helped.
Older homeless people are more diverse than many would think. Their histories, problems, behaviours and needs differ greatly. Some have been homeless since early adulthood and have spent many years on the streets or in hostels. Others have married, raised a family and worked for years, and have become homeless for the first time in old age. After becoming homeless, some sleep rough and have no contact with services, while others stay in hostels and are known to at least some service-providers. This chapter presents an overview of the circumstances of older homeless people. It describes their backgrounds, problems and needs.

The backgrounds of older homeless people

Pathways into homelessness

Older homeless people have diverse histories. Some have been homeless since adolescence or early adulthood and have become ‘entrenched’ in the lifestyle and elderly while homeless. As shown in Figure 3.1, among 267 older homeless people in the Four-City Study and at the Lancefield Street Centre, 18 (7%) had been homeless continuously for 41 years or more.

Figure 3.1
Duration of homelessness

They first became homeless after experiencing broken and disturbed childhood homes, or following either discharge from the armed forces or marital breakdown when young adults. A second group have been homeless since middle-age. This group includes some people who had always lived at home with their parents, could not cope when their parents died, and were evicted for rent arrears. Others had worked as merchant seamen or labourers on building sites and had for years stayed in missions, lodgings and work-camps. When they could no longer find work, they had no settled base and either slept rough or booked into hostels. Most were aged in their forties or fifties at the time.

A third group become homeless for the first time in old age, some having married, raised a family and worked until near retirement. For them, homelessness is triggered by problems such as widowhood, marital breakdown, or a mental illness. Some men abandon their accommodation and sleep rough when their wives die, finding it too distressing to remain in the marital home. Mental illness and memory problems result in some older people being evicted for not paying rent, while others abandon their homes because of paranoid ideas about neighbours. Other older people remain single, work for years in hospitals or hotels, and live in housing attached to their job. On retirement, they are required to manage on their own in accommodation (often for the first time), experience difficulties in coping, and either lose their tenancy or are evicted for rent arrears.

The pathways leading to homelessness among older people are therefore several and complex. Although a single incident, such as widowhood, may be the direct cause of a person being evicted or leaving their home, other less evident factors are usually involved. These include multiple or prolonged stresses, poor coping and social skills, a deficient support network, and mental illness and alcohol problems.

The problems and behaviours of older homeless people

Physical health problems

Physical health problems are common among older homeless people, particularly among those who sleep rough. Street living causes health problems and aggravates existing illnesses. The problems are exacerbated by age, lack of treatment, and the lifestyle. Common conditions include respiratory disorders; stomach ulcers and gastritis; circulatory problems such as oedema, leg ulcers and cellulitis, caused through prolonged standing and persistent walking; and scabies and lice. Older rough sleepers are susceptible to infections such as gastroenteritis and tuberculosis. In the early 1990s, high rates of active tuberculosis were reported among homeless people in London, the most vulnerable being
middle-aged and elderly men who were heavy drinkers and slept rough or stayed in hostels (Citron et al., 1995). Mortality rates are high, and the average age of death of those recorded as homeless in coroners’ reports ranges from 42 to 53 years (Keyes and Kennedy, 1992; Wright, 1989). This compares with the late seventies in the general population.

Many older rough sleepers have no contact with GPs, receive no treatment, and their physical health problems become complicated through chronicity and poor management. One elderly man in London was found on the streets by out-reach workers. He had slept rough for years, was physically ill, and the workers arranged his admission to hospital. He was suffering from frost-bite and gangrene and both his feet required amputation (Crane and Warnes, 1999). More than one-half (55%) of older rough sleepers admitted to the Lancefield Street Centre had physical health problems, yet three-fifths had had no contact with a doctor for more than five years (for some, more than 20 years). Some were suffering from tuberculosis, liver and renal failure, carcinomas and severe anaemia, yet had not sought medical care (see case study 6, Chapter 5). Some were depressed, had low self-esteem, and feared illnesses and doctors. Others did not recognise the severity of their illness and feared being shunned by staff.

Depression and demoralisation
Homelessness is associated with demoralisation, depression, loss of self-esteem, and feelings of hopelessness and despair. The opinion is that people become increasingly despondent, apathetic and resigned to their circumstances with prolonged homelessness (Rosenthal, 1994). Some reports suggest that one-half to three-quarters of homeless people are depressed and demoralised (Belcher and DiBlasio, 1990). A study in Chicago found that the highest rates of depression occurred among homeless people aged under 25 years and over 45 years (Rossi et al., 1986). Seventy residents at the Lancefield Street Centre were interviewed four months after admission: three-fifths had feeling depressed some or most of the time, and 27% perceived their future as hopeless and expected to be dead within six months. Similarly, two-fifths of older street men in New York City were reported to be depressed and nearly one-third expressed a wish to die (Cohen and Sokolovsky, 1989).

Table 3.1
The prevalence of mental health problems among London's hostel residents, August 2000

<table>
<thead>
<tr>
<th>Age groups</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>years</td>
<td>%†</td>
<td>%†</td>
</tr>
<tr>
<td>Under 20</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>20-29</td>
<td>14</td>
<td>16</td>
</tr>
<tr>
<td>30-39</td>
<td>19</td>
<td>25</td>
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<td>40-49</td>
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<td>50-59</td>
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<td>57</td>
</tr>
<tr>
<td>60+</td>
<td>20</td>
<td>76</td>
</tr>
<tr>
<td>Total†</td>
<td>18</td>
<td>26</td>
</tr>
</tbody>
</table>

Notes: 1. The proportion in that age group with such problems.
2. Includes those whose ages are unknown

For many older homeless people, a mental illness distorts their perceptions of reality, influences their capacity to seek and accept services, and thus helps to sustain homelessness. One man, aged in his sixties, had slept rough in London for seven years but refused to access day centres. He believed that psychoses and dementia. In Britain and the USA, 40-68% of older homeless men are estimated to be depressed, and a similar proportion of older homeless women manifest psychotic symptoms or memory problems (see Crane, 1999). In Chicago, homeless women over the age of 40 years were found to be more ‘confused and incoherent’ than other age-gender groups (Rossi et al., 1986). In the Four-City Study, older homeless women were more likely than the comparable men to have mental health problems, and a high proportion of both sexes who were sleeping rough (75%) had such problems. Some expressed persecutory ideas associated with royalty and politicians, while some were hallucinating and responding to imaginary voices. Less than one-tenth of the study subjects were, however, receiving psychiatric medication.

The survey of London’s hostel residents in August 2000 found that older residents were more likely than their younger counterparts to be suffering from mental health problems (Crane and Warnes, 2000b). Among both men and women aged under 29 years, the reported prevalence of mental health problems was low. The prevalence increased with age, and rose steeply among women. Whereas just 5% of women aged under 20 and 16% aged 20-29 had a reported mental illness, the proportion so affected increased to 76% among women aged 60 years and over (Table 3.1).
the staff were terrorists, and that they would ‘cut off my legs so I couldn’t escape, and cut off my arms so that I couldn’t write or phone for help’. A high proportion of older women sleeping rough have severe mental health problems and, according to out-reach workers, this group is most withdrawn, suspicious, hostile and reluctant to accept help (Crane and Warnes, 2000a).

Some older homeless people have severe memory problems and are disorientated and confused. These problems may only become apparent when they leave the streets and move into hostels. On admission to the Lancefield Street Centre, 16% of the residents had memory difficulties and for 12% these problems were marked. They required regular assistance with everyday tasks, such as attending to personal hygiene, managing finances, and laundry. They also needed to be constantly reminded when meals were served and how to reach their bedrooms. Three men were unable to find their way around the hostel after six months and would get lost when they went out (see case study 6, Chapter 5).

**Heavy drinking**

It is generally believed that many homeless people are heavy drinkers, because some drink in groups in city centres and parks and are easily visible. But it is not a universal problem and the majority of older homeless people are not heavy alcohol drinkers. In the Four-City Study, 42% of the men and only 12% of the women could be described as heavy drinkers, in that they drank alcohol most days (finances permitting) or excessively two or three days a week. A few had been drinking heavily for more than 25 years. Some related it to the stresses they had been through before becoming homeless, while others associated it with depression and feelings of despair and hopelessness. Alcohol abuse leads to poor functioning, self-neglect, cognitive impairments, nutritional deficiencies and serious physical health problems, such as neurological disorders, seizures, and cirrhosis of the liver. It is also a factor in early mortality.

**The Lancefield Street Centre** targeted older long-term rough sleepers and allowed drinking on the premises in designated areas (see next chapter). Hence, a high proportion of its residents (58%) were heavy drinkers. Most of them drank heavily most days, while a few were ‘binge drinkers’ and would drink heavily for a few weeks, abstain for a few weeks, and then resume. Many had serious physical illnesses related to years of heavy drinking, and were difficult to manage and help. Those who were heavy drinkers were more likely than abstainers to report depression, sleep disturbances, loneliness, and pessimism. They neglected to eat, to attend to their personal hygiene, were sometimes incontinent, and needed prompting or assistance with daily tasks. Some were admitted to hospital or to a detoxification unit for a few weeks, during which time they did not drink alcohol and their appetite improved. When they were discharged, however, they soon started drinking again.

**Mental illness and alcohol abuse**

A small proportion of older homeless people have dual problems of heavy drinking and mental illness. For some, heavy drinking induces psychotic thoughts and disturbed behaviour, while others drink heavily to mask the symptoms of a mental illness. People with combined problems are particularly vulnerable and difficult to help. Many display disturbed or aggressive behaviour and are evicted from hostels for violence. They tend to move from hostel to hostel without receiving consistent help, and some sleep rough because they end up being barred from all hostels in a town or city. In the Four-City Study, 9% of the women and 25% of the men were both mentally ill and heavy drinkers. Almost one-half (48%) had been homeless for at least 10 years, and 26% for more than 20 years.

**Social isolation**

Many older homeless people are isolated. The majority are estranged from their relatives and have no friends. Some have had no family contact for more than 20 years and do not know if their parents or siblings are alive. For some, estranged family relationships occurred at the time that they became homeless. In the Four-City study, four men who abandoned their homes when their wives died said that they did not keep in touch with their adult children because they did not want their children to know about their circumstances: they did not want to be a burden. Some men who became homeless after a marital breakdown described feeling angry and rejected at the time of separation. They deliberately severed family contacts. Some older homeless people have been raised in orphanages and have never had a close family.

Among those who sleep rough, many sleep in secluded and hidden places. In London, they have been found by out-reach workers away from the city centre in old cars, phone booths, sheds, disused toilets, cellars, woods and parks. Their situation may only become apparent when workers specifically search for them. One man, aged in his sixties, was recently found by an out-reach worker sleeping
rough in a park, where he had been sleeping for 12 years. Some go to great lengths to conceal their existence. An elderly woman slept for several months in the coal-cellar of an uninhabited mansion in central London. Others sleep in derelict buildings, ride on night-buses, or linger in cafes and hospitals that remain open 24 hours. Many are suspicious and hostile when first approached, and refuse to converse. Older women who sleep rough tend to be particularly distrustful, alienated, and alone.

**Reluctance to use services**

Some older homeless people have little or no contact with services, even with hostels and day centres that are set up to help homeless people. They sleep rough, claim no welfare benefit entitlements, and survive by eating discarded food from litter bins. One elderly man in London lived in this way for 15 years. Among 67 older rough sleepers in the Four-City Study, only 12% regularly used day centres and soup kitchens, and more than two-fifths never used them. The women in the study were much less likely to use the services than their male counterparts (Table 3.2). There are several reasons why older rough sleepers do not use services. Some are confused and are unaware of the location of services and unable to appreciate the help available, while others are paranoid and delusional about the services and the staff. Some older rough sleepers will only move into hostels which have single bedrooms and are deterred by shared bedrooms and dormitories (which many hostels used to have and some retain). Some are discouraged from using hostels if many residents are heavy drinkers. Likewise, some women will not use hostels that are predominantly used by men. Others refuse to use day centres and hostels because they fear violence, threats and intimidation from young users. Similar findings have been reported in the USA (Coalition for the Homeless, 1984; Cohen and Sokolovsky, 1989; Doolin, 1986).

A survey in 2000 of 177 homeless and formerly homeless people aged 50 years or more in St Mungo’s hostels, shared houses and residential care homes found that just over one-half preferred to live with people of their own age if they required shared accommodation. Among the respondents, 57% preferred to be with people of their own age, 36% with people of all ages, and 7% had no preference. There were marked age differences. Whereas just 45% of those aged 50-55 preferred to be with people of their own age, this increased to 77% for those aged 66 years and over (Table 3.3).

**Unsettledness and transience**

Some older homeless people are restless and unable to settle in one place. They frequently move from hostel to hostel, or alternate between staying in hostels and sleeping rough. One man in his seventies changed accommodation six times in London within 13 months. He moved successively from a hostel to sleeping rough, a bed-and-breakfast hotel, sleeping rough, and to two bed-and-breakfast hotels. A small proportion of older homeless men move from town to town and stay in

### Table 3.2

<table>
<thead>
<tr>
<th>Frequency of use</th>
<th>Men</th>
<th>Women</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>None used</td>
<td>14</td>
<td>31</td>
<td>28</td>
</tr>
<tr>
<td>Occasional¹</td>
<td>23</td>
<td>51</td>
<td>31</td>
</tr>
<tr>
<td>Regular²</td>
<td>8</td>
<td>18</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total known³</strong></td>
<td>45</td>
<td>100</td>
<td>22</td>
</tr>
</tbody>
</table>

**Notes:**
1. 1-3 times a week.
2. 4 + times a week.
3. Another four men were rough sleepers but their use of day centres is unknown.

### Table 3.3

<table>
<thead>
<tr>
<th>Preferred housing type</th>
<th>50-55</th>
<th>56-60</th>
<th>61-65</th>
<th>66+</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No %</td>
<td>No %</td>
<td>No %</td>
<td>No %</td>
</tr>
<tr>
<td>For older people</td>
<td>23</td>
<td>45</td>
<td>25</td>
<td>57</td>
</tr>
<tr>
<td></td>
<td>16</td>
<td>57</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>32</td>
<td>77</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For all ages</td>
<td>26</td>
<td>51</td>
<td>15</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>32</td>
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</tr>
<tr>
<td></td>
<td>7</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>No preference</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>9</td>
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<td></td>
<td>3</td>
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<td>7</td>
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<tr>
<td>Total¹</td>
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<td>44</td>
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<td>28</td>
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<td>44</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100</td>
</tr>
</tbody>
</table>

**Note:** 1. Excludes 10 residents whose ages were not recorded.
one place for just a few weeks. Most are isolated, travel alone and shun social contacts. Among 256 older homeless men in the Four-City Study and at the Lancefield Street Centre, 21% had stayed in at least four towns in the six months before being interviewed.

They report one of two reasons for their unsettled behaviour. Some have been itinerant workers or homeless for years, relate it to their biographies, and indicate that the behaviour is long-standing. They had become accustomed to moving from place to place since the time, during the 1950s and 1960s, when they used the government’s reception centres in England and were only allowed to stay in any one centre for one or two nights each month. They said that they could not now settle in one place. For a second group, mobility is related to depression and is their attempt to escape from uncomfortable circumstances. Several left their home town following widowhood or marital breakdown, and have since been unsettled and have moved from place to place. One man lived on the south coast with his wife for nearly 40 years until she died. He abandoned his home and since travelled around Britain (see case study 1, chapter 5).

Conclusions

The histories of older homeless people are diverse. While some have married, raised a family, worked for most of their life and become homeless in old age, others have been on the streets or in hostels for years. Compared to the general elderly population, homeless older people have multiple health and welfare problems yet little or no contact with services. Psychological problems are common among the group and range from generalised feelings of depression and demoralisation, to deep-seated mental health and behavioural problems, including unsettledness and heavy drinking. Their problems are interlinked. Demoralisation and feelings of hopelessness lead to heavy drinking and clinical depression, and heavy drinking provokes mental and physical illnesses. There are differences between men and women. Many older homeless women have mental health problems but only a minority are heavy drinkers. In contrast, heavy drinking is common among some men, with a small proportion being both heavy drinkers and mentally ill.

Older homeless people are a very needy group yet many do not receive the services that they require. Contact needs to be made with those who are sleeping rough to persuade them to accept help. Temporary (or first-stage) accommodation is required until the needs of older homeless people can be assessed and their problems stabilised. Attention has to be given to their physical and mental health states. Some require treatment for illnesses. Some have poor diets and need persuasion to eat nutritious food. Several have not claimed welfare benefits for years. They need encouragement and assistance to claim their entitlements. Both mental illness and heavy drinking affect the ability of some to cope with everyday tasks, and they require help with all aspects of daily living. Some report problems of heavy drinking, depression and restlessness which they associate with earlier life events, such as widowhood. They may require counselling and support to come to terms with unresolved traumas. Finally, they require resettlement programmes to help them move to appropriate long-term housing. At present, not enough is being done to help older homeless people. Most have little or no contact with statutory services, and some sleep rough for years without being known to any service-provider. The next chapter looks at how statutory and voluntary service-providers are currently responding to the needs of older homeless people.
Most elderly people in Britain are housed, receive a state pension or welfare benefits, have contact with their GP, and some are known to social services departments and receive community care services. But this is not the case for many homeless older people. Although statutory housing, health and social services have a responsibility to help vulnerable and needy people, the first section of this chapter explains how these services are organised and delivered in such a way that many vulnerable people fall through the gaps in these services’ frameworks. In contrast, voluntary sector organisations for more than a century have played a dominant role in service provision for single homeless people, and the indications are that their role in housing and supporting disadvantaged and vulnerable people will continue to elaborate. They are setting up innovative projects that allow staff to work flexibly and intensively with various client groups. This chapter reviews how voluntary organisations are responding to the needs of older homeless people, and describes a few successful projects that have been established in the last few years specifically for this client group.

The response of statutory services

Under the National Health Service and Community Care Act 1990 and the Housing Act 1996, local authority housing and social services departments have a statutory duty to help vulnerable people in priority need if they have a local connection with that authority. People in priority need include older people and the mentally ill, physically sick or disabled. In the recent Housing Green Paper, Quality and Choice: A Decent Home for All, it is recommended that the current definition of priority need should be extended to people aged 16-17 years, and to those who have been in care or are leaving prison and the armed services. The National Health Service is committed to providing health-care services to people in need, and the Benefits Agency to distributing social security benefits to those who are entitled. Despite the obligations and responsibilities of these services, many older rough sleepers have little or no contact with statutory agencies.

The prevailing assumption in welfare state legislation is either that people in need are able and will ask for help, or that they will come to the attention of services through the intervention of a relative or friend. There is no requirement upon the principal welfare providers or health or social services professionals to ‘case-find’, or to seek out and provide to vulnerable people who do not present. Housing officers, social workers, GPs, and staff from local social security offices rarely search on the streets for people with unmet needs who do not ask for help. But many older rough sleepers have mental health problems, literacy difficulties, low self-esteem, or lack insight into their problems, needs and entitlements. They are apprehensive about accessing bureaucratic services which operate appointment systems, have busy waiting areas, and require people to complete complex forms. Their circumstances only become apparent when workers spend time on the streets and proactively seek them out.

Furthermore, when statutory agencies are made aware of older homeless people’s unmet needs, they are not always able to readily help. Many GPs are reluctant to register homeless people, finding them expensive and difficult patients with multiple problems and high treatment needs (Connelly and Crown, 1994; Fisher and Collins, 1993). Even when older homeless people are admitted into hostels, the staff sometimes have difficulty obtaining mainstream housing and welfare services for the residents. To be considered for housing or community care services, a person generally needs to have a ‘local connection’ with that authority. This implies being resident in an area for at least six of the preceding twelve months (Lowe, 1997). Some older rough sleepers have stayed in one area for years but have been isolated, and it is difficult to prove their local connection. Others have moved around the country and have no connection with any authority. Many social services departments are reluctant to help older homeless people aged 50-65 years who require supported housing but whose problems are linked to alcohol abuse (see section in this chapter on the Lancefield Street Centre).

The response of voluntary sector organisations

During the 1980s and 1990s, there has been a growth of voluntary sector organisations in Britain working with single homeless people, ranging from church-based and neighbourhood groups to corporate-style non-profit housing organisations. They provide various services, including street out-
reach work, drop-in and day centres, hostels, resettlement programmes, and supported housing for people when they are resettled. As these organisations have expanded their range of provision, some have recognised that generic homeless people’s services, i.e. for people of all ages and with various problems, do not adequately meet the needs of some groups who require more focused and specialised help. For example, the needs of a young person who became homeless when he or she left care and has since slept rough differ from those of an elderly man who became homeless for the first time when his wife died. The former is likely to require help with learning domestic skills, settling in accommodation, and finding employment or job training. The elderly man may have the skills to manage a home but may require treatment for depression or counselling to help him come to terms with his wife’s death. Some organisations have responded by developing specialist services for particular groups, such as young homeless people and those who are both mentally-ill and homeless.

In relation to older homeless people, the practices and services of voluntary organisations vary. Some provide temporary accommodation in hostels and individual case-work, with the aim of addressing the residents’ problems and resettling them in permanent housing as soon as possible. Others do not provide this intensive help and older homeless people remain in hostels for years without being rehoused. Some organisations have special-needs projects for homeless people with mental health and substance abuse problems, and staff who are trained to work with this client group. Others have no specialist provision and accommodate such people in general-needs hostels. The outcome is that some older homeless people have been evicted from hostels because of disturbed or disruptive behaviour associated with mental health and alcohol related problems. Some organisations have developed various models of move-on accommodation for hostel residents who need both high-care and low-level support. Others do not have such provision, and accommodate people long-term in hostels designed to be short-stay and temporary housing.

Some hostels impose conditions which exclude the most disorganised, disruptive and disconnected homeless people, many of whom are elderly. Until recently it was rare for hostels to admit known heavy drinkers or to allow the residents to drink alcohol on the premises. Many maintain these rules, but a few ‘wet’ hostels admit heavy drinkers and allow drinking on the premises. These hostels recognise that prohibiting alcohol consumption excludes a very needy group of people who require to be accommodated as a preliminary to receiving help in tackling other problems. Some hostels will not accept homeless people who have no proof of identity and are not receiving benefits. Others recognise that unless rough sleepers are admitted and receive help to claim benefits, they will continue to be excluded from services. They therefore admit non-claimants with the knowledge that most are entitled to benefits and that arrears will be paid once a claim is processed.

**Services exclusively for older homeless people**

A few organisations in Britain, Australia and the USA have developed services exclusively for older homeless people. These include drop-in and day centres, temporary accommodation with rehabilitation and resettlement programmes, and various long-term supported housing options. In Britain, such services have been set up through the initiatives of the existing providers of homeless people’s services. In Australia and the USA, a handful of new non-profit organisations have been formed to work exclusively with older homeless people. These include *Wintringham* in Melbourne, and the *Committee to End Elder Homelessness* in Boston, Massachusetts. Services dedicated to older homeless people are successfully helping both those who are recently-homeless and those who have lived in hostels or on the streets for years (exemplified in Warnes and Crane, 2000). Yet they are not widespread and in no way compare to the rapid growth of services for young homeless people. A few British projects exclusively for older homeless people are now described.

**Helping older rough sleepers: the Lancefield Street Centre**

In response to research in the early 1990s which highlighted that many older rough sleepers in London were not accessing services, the *Lancefield Street Centre* was established as a pilot project in 1997 for two years (Crane, 1993). It was situated in west London, managed by *St Mungo’s*, and its main funding was provided by the *Henry Smith’s Charity*. Its aim was to provide a ‘complete pathway’ from the streets to long-term housing for rough sleepers (men and women) aged 50 years and over. This was to be achieved through a linked series of services: street out-reach work, a 24-hour drop-in centre, a temporary or ‘first-stage’ hostel with 33 beds, and resettlement in long-term accommodation.
The pathway of services

Two street out-reach workers were attached to the project. Their role was to find and engage with older rough sleepers, and encourage them to accept help. They used a van which enabled them to search in both central and outer London for potential clients. Through intensive work over many months, the workers successfully persuaded some older people who had slept rough for years to use the hostel and drop-in centre at Lancefield Street. The drop-in centre provided a stepping-stone or ‘halfway house’ from the streets to the hostel for those people who were wary about moving into the hostel. They stayed in the drop-in centre for a few days or weeks, gradually became accustomed to the project and to the idea of accepting services, and many eventually agreed to move into the hostel where further help could be given.

The hostel provided temporary accommodation and services while older rough sleepers became accustomed to being in accommodation and their problems and needs were assessed. Help was given with nutrition, income and personal hygiene. Many had high personal care needs and needed assistance with daily tasks such as attending to personal hygiene and budgeting. Some had lost conventional toileting skills while on the streets and required retraining. Approximately one-tenth were not receiving welfare benefits on arrival, and many others were not receiving their full entitlement. The staff helped them complete benefit application forms and followed up claims on their behalf. Many had severe physical health problems which required prompt attention, while some had mental health problems yet were unknown to psychiatric services. The hostel staff ensured that those who required medical care were seen by a GP or at the local hospital’s accident and emergency unit, and those who had a suspected mental illness were referred to psychiatric services. For those who could be encouraged to accept help for heavy drinking, the staff referred them to detoxification and alcohol counselling services.

The project’s ultimate goal was to rehouse the residents in long-term accommodation. A resettlement worker was employed to assess the housing needs of each resident, find appropriate vacancies in permanent housing, and arrange the move and follow-on support. Some residents could manage to live independently or in accommodation with a little support, and were either referred to a housing association or to a local authority housing department. Others required accommodation with a higher level of support and were referred to local authority social services departments for an assessment of their care needs, and funding for a place in supported accommodation. By the closure of the project, one-third of the residents had been resettled from the hostel, and a further one-tenth moved to other hostels until resettlement plans could be instituted. Of those who were not resettled, some returned to the streets or left and their destinations were unknown, while others moved to other hostels because suitable supported move-on accommodation was not available. This latter group were men in their fifties who were heavy drinkers and required a great deal of support.

Linking clients to statutory services

The hostel staff experienced great difficulties when they tried to link the residents to statutory services, particularly to local authority social services departments and to primary health-care services. Some social services departments were reluctant to accept responsibility for clients who had previously lived in their districts, and most were unwilling to fund places in supported accommodation for those residents aged under 65 years who were heavy drinkers and had high-care needs. Most local GPs were reluctant to register the residents. In the project’s second year, the Health Authority funded a local GP practice to treat the residents. A drop-in clinic at the GP surgery was arranged four afternoons each week, at which the residents were seen without appointments. This arrangement had several benefits for the hostel residents and the staff. Good links were developed with the GPs, and there was 24-hour cover. The residents got to know the GPs and were more willing to attend appointments and accept treatment. The unarranged appointments suited the residents who initially refused but later were persuaded to attend. The flexible hours meant that hostel staff could escort some residents to the clinic, liaise with the GP about a resident’s symptoms, and note prescribed medication and future appointments.

The success of the project

By providing intensive services exclusively for older people, the Lancefield Street Centre attracted and helped many rough sleepers who had been on the streets for years and who had seldom stayed in hostels. Because designated out-reach workers were attached to the project, their work focused on older rough sleepers and they were able to spend time building trust with those who were isolated and difficult to engage. The drop-in centre was open 24 hours and it was therefore possible for the out-reach workers to respond promptly when an
older rough sleeper showed a willingness to accept services. Many of the hostel residents were linked to much-needed services and received treatment for physical and mental illnesses, and help with claiming welfare benefits and other entitlements. For some, this was the first time in many years that they had received medical care or welfare benefits. Although the project successfully helped some groups of older homeless people, the majority of its users were men. The older women who slept rough tended to be hostile and resistant to services. Despite repeated contacts by the out-reach workers over many months, only a few women were persuaded to use the hostel or drop-in centre.

Rehabilitating and resettling older homeless people: the Zambesi Project

The Zambesi Project in Birmingham was set up as temporary accommodation for older homeless men in response to unmet need. It is managed by Focus Housing Group and provides temporary accommodation and a resettlement service to homeless men over the age of 45 years. It opened in 1988 following the death of an elderly man in hospital and a request for help from Birmingham City Council. The elderly man was emaciated and flea-infested when admitted to hospital, and had been living in appalling housing conditions in private-rented accommodation. Following an investigation into the man’s housing circumstances, the property where he had been living was closed and the Zambesi Project came into being to rehouse the other occupants.

The Zambesi Project comprises three adjacent Victorian houses which have been converted into one large home for 16 men, and another house opposite which accommodates 12 men. Both houses have staff on duty 24 hours, and an internal telephone links the two houses. The men in the second house can have meals in the main house. The project targets men with long histories of homelessness and unsettledness, as well as those who have recently become homeless. It is a ‘wet’ project and accepts men who drink alcohol. Its main purpose is to provide good quality accommodation and food, and encourage the residents to settle and feel safe and secure. Once this has been achieved then alcohol issues are addressed if the person wishes. Because of the project’s success, it has experienced difficulties in the latter years – the residents settled and the project became ‘silted up’. Men who had lived on the streets or had moved around the hostel circuit for years stayed at the Zambesi Project and did not want to leave.

Developing a rehabilitation and resettlement programme

The staff recognised that they needed to be resettling the residents so that the project could offer help to others. They also acknowledged that this would be challenging. Many older homeless people have never had a place of their own or have not lived independently for years, and lack the skills and confidence to manage alone. An opportunity arose when one of the organisation’s properties became due for refurbishment. It was taken over by the Zambesi Project and, in June 1998, became a rehabilitation and resettlement house for 18 men who wish to be rehoused. The house has large and small single rooms, and six self-contained ‘starter flats’. People move from the small single rooms into the large ones, and then into the starter flats. This creates a feeling of progress and prevents people becoming too settled. Meals are provided at all three stages if preferred or self-catering facilities are available. The men stay in the house for up to 18 months and participate in various workshops to build up skills and confidence. A ‘catering workshop’ enables them to practice shopping, cooking and clearing-up, and there are also workshops on ‘managing on a limited budget’ and ‘basic home maintenance’. When the men are ready to be rehoused, the staff accompany them to view properties and help them with applying for grants, buying furniture and furnishings for their new home, and arranging for the utilities to be connected and easy-payment schemes to be set up.

The staff visit the clients at home for up to six months after they have been rehoused. Many of the clients talk about the isolation that resettlement brings – it appears to be a major problem for those who have lived in hostels for years and are used to having other people around. The staff have therefore set up an ex-residents’ group, the Home Alone Club, which meets monthly at the project. Those who have been rehoused get together, share experiences, and seek advice from the staff if they are having difficulties. People who are thinking of being resettled can also attend the club and discuss about the merits and problems of being rehoused with people who have experienced resettlement.

Successfully responding to needs as they arise

The Zambesi Project is an example of how a voluntary organisation has successfully developed
new services as unmet needs have been identified. Houses close together were converted into temporary accommodation for older homeless men. After a few years, it became necessary to develop a resettlement programme to encourage the men to move into permanent housing. This has been achieved and a support group has now been set up for former residents. According to the staff, the resettlement scheme has had a cascading effect on the rest of the project. There is a heightened awareness of resettlement among both staff and residents. The staff are more able and willing to encourage residents to move on, knowing that this can be achieved and that there is support available. The residents see that whatever their age or background, it is possible to move to more settled housing.

**Supporting heavy drinkers in independent tenancies: the Green Lanes Project**

Many older homeless people express a wish to have their own tenancy, yet some cannot manage independent living without a high level of support. One effective solution is the Green Lanes Project in north London, which accommodates 15 older heavy drinkers in ‘clustered’ self-contained flats, with the tenants receiving daily support from workers. The scheme was developed by Bridge Housing Association (HA) and opened in May 1997. Each tenant has a one-bedroom furnished flat, with a separate living room, kitchen and bathroom. Two staff are based at the project and work mainly office hours, but also some evenings. When they are unavailable, staff at another Bridge HA hostel nearby provide advice and emergency assistance to the tenants if needed.

**The transition to independent living**

The majority of tenants at the Green Lanes Project have long histories of homelessness and have spent years in hostels and on the streets. Several have had tenancies in the past but have been unable to cope. Although they were all keen to have their own flat, they reacted to their move to independent accommodation in various ways. For some, the reality of having a flat and new responsibilities provided them with the motivation to buy possessions, create a home, and disengage from their previous lifestyle of street drinking and going around day centres. Others felt ‘stalled’ – obtaining a flat had disrupted their lifestyles and social contacts, and adjusting to their new accommodation and responsibilities had exhausted their capacity to absorb anything new. A few had once mixed with street drinkers but felt that they no longer fitted into the street culture. To alleviate loneliness, some brought street drinkers to their flats, but this put their own tenancies in jeopardy when the visitors disturbed other tenants.

Most tenants have been housed now for three years. Some still need a high level of support and encouragement to do things for themselves. Besides fulfilling ‘landlord’ duties, the staff provide help with accessing GPs and other services, and with budgeting, paying bills, and with the general responsibilities of managing a tenancy. Occasionally the tenants require assistance with minor difficulties, such as re-lighting boilers. The staff also intervene when conflicts arise among tenants, and when problems arise for individuals around tenancy breaches and hygiene issues. There has been a long settling-in period for both the tenants and the staff. The tenants are gradually gaining self-esteem and confidence, and learning to be independent. The staff for their part are learning to encourage this adjustment, to adapt to the tenants’ changing attitudes, and to offer support and advice that enables the tenants to make informed decisions as situations arise.

**The success of independent-living schemes**

The Green Lanes Project has demonstrated that it is possible to accommodate older homeless people in self-contained tenancies even if they are heavy drinkers or mentally-ill. A key factor in the project’s success is believed to be the high level of support that the tenants receive. This encourages stability and helps the tenants gain skills and build confidence and self-esteem. A similar supported housing project in Lowestoft, Suffolk, accommodates six older men with mental health and alcohol-related problems and long histories of homelessness (Crane and Warnes, 1997b). The men receive extensive help and support from the staff (about seven hours each day), and since moving, their behaviour has changed. One man had previously been in a hostel for 10 years during which time he had never left the building. He now goes to the local shops and has become interested in television and cooking. Another had never lived independently and was unable to make simple decisions when he first moved in. He now carries out tasks unprompted.

**Rehousing long-stay hostel residents: the Arlington Road Project**

Some older homeless people have lived in hostels for more than 25 years without being resettled into
The benefits of rehousing long-stay hostel residents

The Arlington Road Project has successfully resettled into high standard accommodation older homeless men who had spent many years in a large hostel. Factors contributing to its success are believed to be that there was enough time to plan a resettlement programme with the men, they were actively involved in the project’s development, and that they were able to be rehoused in the locality where they had lived for years. According to the staff, there has been a marked change in the men’s behaviour since moving. Their behaviour is less hostile and challenging, and they are taking greater care of their personal appearance and their rooms, and are drinking less and eating better (Crane and Warnes, 1997b). Similarly, in Bielefeld, Germany, 26 elderly men were rehoused from a traditional hostel into converted flats in three houses nearby, and in Melbourne, Australia, 36 older homeless men were rehoused from an old shelter into independent and supported accommodation. Since moving, many of the men have become more independent, learned to manage their own accommodation and finances, have engaged in new activities and social relationships, and some have renewed family contact (Hallebone, 1997; Harvey, 1998). There are also indications that many older homeless people who have lived in hostels for years want to be resettled once the idea is introduced. The Arlington Road Project could only accommodate 33 men, yet 78 older men in the hostel expressed a wish to move.

Supporting homeless and vulnerably housed older people: Spires Connect

Day centres for homeless people are an important contact point for rough sleepers. Besides offering basic services such as food and showers, they have a crucial role in linking their clients to services. They provide help with obtaining temporary and permanent housing, medical care, welfare benefits, and treatment for mental health and substance abuse problems. Day centres are also used by a large number of formerly homeless people who have been rehoused but require ongoing support and help with managing a tenancy, and by those who are lonely or bored at home and seek companionship. However, many older rough sleepers are reluctant to use all-age day centres, while some who do use the centres are unassertive and do not make known their needs (chapter 3). In a crowded day centre, older users can easily obtain

appropriate long-term housing (described in Chapter 2). As a few schemes in Britain, Germany, America and Australia have demonstrated, however, it is possible to resettle older homeless people who have stayed in hostels for years and many benefit from being rehoused in more settled accommodation. One such scheme in London, the Arlington Road Project, resettled 33 older homeless men from a large Victorian hostel (Arlington House) into a small purpose-built group home nearby. The project was initiated because many older men had been living in the hostel for 20-30 years, and were finding it difficult to manage in accommodation which was not tailored to meet their needs. It was developed through a partnership between the Community HA and Bridge HA, in collaboration with the London Borough of Camden’s Housing Department.

The Arlington Road Project consists of a group home for 25 homeless men aged at least 60 years with physical care and support needs, and two adjacent blocks of self-contained flats for 13 older homeless people (eight men and five women) with lower support needs. The group home is designed so that a high level of support is available to people if required. Each person has a large single furnished room with ensuite WC and washing facilities, and six rooms are designed for wheelchair users. The project encourages privacy and independence; each tenant has a key to the front door and each bedroom door has a letter-box. The tenants in the adjacent flats can have meals in the main project if they wish and join in the home’s activities. Staff are on duty 24 hours and in each of the adjacent flats there is an alarm that is linked to the main project.

Moving the men from the large hostel to the new project had to be managed carefully as most had been living in Arlington House for years. The men wanted to live locally, and therefore the new project was built on the site of an old car-park just five minutes walk from the hostel. The planning and preparation for the move lasted eight months. During this time, the staff discussed the move regularly with the men, who visited the project frequently as it was being built to watch its progress. Once the building work was completed, the men chose their bedroom and were involved in selecting the furnishings and furniture for their rooms and the communal areas. The scheme opened in October 1996. A few people were moved daily, so that the staff had the time to help each tenant settle in.
food or drink and leave without being engaged by the staff.

To address this problem, a few day centres in London have introduced workers and sessions exclusively for older clients. One such centre in south London, The Spires Centre, developed a project called Spires Connect. With funding from the Bridge House Estates Trust Fund and Help the Aged, the project was launched in mid-1999 and is aimed at people aged 50 years and over. It has sessions three afternoons a week and, because of its success, a fourth weekly session is soon to be introduced. Many of the project’s clients have slept rough for years, are lonely and isolated, and suffer from health problems and depression. A key priority for the project is therefore to ensure that they are linked into the services that they need. Help is given with housing, health and benefit problems, and the project has strong links with START, a mental health team which works with homeless people. A varied range of recreational activities are also arranged for the clients, such as bingo, swimming trips, and visits to places of interest, and support is given to clients in their own homes.

Spires Connect is used by approximately 127 older clients. Of these, just over one-third are over the age of 60 years. By having sessions specifically for older people, it attracts clients who refuse to use services for people of all ages, and the staff are able to carry out individual case-work without being distracted by other client groups. It is also playing a crucial role in preventing homelessness. For the clients who are rehoused, the staff are able to identify difficulties that they might be having with their housing or benefit claims, and act on them at an early stage. Because the project is small and targets a specific age group, some clients have made friends and these friendships are then continued in the main day centre.

Conclusions

This chapter has described how statutory and voluntary sector services are responding to the needs of older homeless people. It has shown that there are gaps in the current policy framework and in the welfare safety net, and that some older homeless people do not receive the generic health, housing and social services that most elderly people take for granted and are entitled to. Even when unmet needs are identified by hostel staff and other homeless people’s workers and presented to statutory agencies, difficulties sometimes arise and the agencies cannot provide the full range of services that are required.

Much of the help that many older single homeless people currently receive is provided by voluntary sector organisations. They are caring for people with complex behaviours and problems who are denied help by other agencies. As these organisations have developed and their staff have gained the skills and the experience to work with difficult clients, effective and innovative services have been established in response to identified unmet needs. Dedicated out-reach workers have gradually built rapport and trust with older rough sleepers who have been ignored for years and have persuaded them to move into hostels. Hostel staff have encouraged them to stay in accommodation and have linked them to a range of health and welfare services. Resettlement programmes have enabled hostel residents to move into suitable long-term housing, and ways to support them in their tenancies and prevent them from becoming homeless again have been developed.

Several lessons have been learned from these innovative projects. Older homeless people can be helped and their circumstances improved even if they have long histories of homelessness. Many benefit from such help and their well-being, motivation and sociability increases. They require a pathway of services from the streets to long-term housing, and intensive help and a range of individualised services at each stage. Some who refuse to use services for people of all ages will use day centres and hostels that target their age group. Some wish to have their own tenancies and not share with others even though they require a high level of support. Projects have been developed which effectively address this dilemma. To maximise the effectiveness of services for older homeless people, there need to be wide-ranging and well-established links to specialist help, such as primary health-care and mental health teams, alcohol services, local authority housing and social services departments, housing associations, and welfare benefit agencies.

Unfortunately, in Britain, services exclusively for older homeless people are scarce. In London, there are many older rough sleepers and many older hostel residents yet few services exclusively for this age group. Because of the Lancefield Street Centre’s success, St Mungo’s will be opening a replacement scheme, the Royal Oak Project, near Paddington. There are no other age-specific hostels for the group in the city. As highlighted in this chapter, many older homeless people will accept help and want to be rehoused in long-term accommodation. But the group
remain unnecessarily on the streets and in hostels for years because appropriate help is not always available. The next chapter illustrates how the circumstances of older homeless people can change if they receive suitable and empathetic services.
This chapter describes how the new wave of innovative services have helped and are helping older homeless people, by presenting six case studies of older rough sleepers who were admitted to London’s Lancefield Street Centre (described in Chapter 4). From out-reach work through to supportive resettlement, these diverse case studies demonstrate how people’s lives have been changed. Although the examples are drawn from one project, similar successes are recorded at other schemes (see Warnes and Crane, 2000). In order to preserve anonymity, the names of the clients and some identifying facts have been changed.

**Case studies**

**Case 1: Paul**

Paul, aged 69 years, came into the hostel in May 1998. He had been homeless for nine years before he was found on the streets by out-reach workers. Prior to becoming homeless, he had lived in a council house on the south coast and had always worked. He had been married for nearly 40 years and had grown-up children. Following the sudden death of his wife, Paul gave up his job, abandoned his tenancy, and slept rough. He explained, ‘there were too many memories in the house … I did not want to stay there … I stayed for a few months but it was too distressing so I left’. After becoming homeless, Paul moved around the country and slept in derelict buildings and isolated places. He never used hostels and rarely used day centres, for he was apprehensive about the younger users. He said, ‘when I met the out-reach workers and they told me there was a hostel for my age group, I decided to give it a try … I didn’t like being homeless … I wanted to settle again’.

Paul settled into the hostel quickly. He was independent, able to look after himself, and was always smartly dressed. He said that he had never suffered from physical or mental health problems, and denied being a heavy drinker. He was seen by the local GP who confirmed that he was healthy. He made friends with a few residents and in the evenings socialised with them in the TV lounge. He went out most days around London and enjoyed visiting the parks and museums. This was the first time he had spent any length of time in the city. Two months after moving into the hostel, Paul expressed an interest to be rehoused in London. He said that he had no wish to return to the south coast. He was seen by the resettlement worker and they discussed various housing options. Because of his age and the fact that he had never lived alone, Paul said that he would like to live in sheltered accommodation as a warden would be available if he needed help.

In August 1998, Paul was rehoused in sheltered accommodation in central London. The resettlement worker helped him apply for a community care grant, buy furniture and furnishings, and move into his flat. After moving, he was visited at home by a community support worker for six months but this contact ceased as he settled well. Since being rehoused, he has learned to cook and has become involved in a local club for elderly people. He attends the club most days and joins in discussion groups, outings, and other activities. He has renewed contact with his children and is saving for a holiday. He said that this is the first time he has felt settled since his wife died.

Although Paul had been homeless for several years, he was independent and had few severe problems that hindered him settling and being rehoused. If he had not been found by the out-reach workers, he may however have continued to remain on the streets. He did not use hostels and day centres and had not made enquiries about finding accommodation. Yet when the opportunity to change his lifestyle was introduced to him, he quickly responded. Without alert, proactive and responsive services, the needs of such a man can easily be ignored and he can remain unnecessarily homeless.

**Case 2: Fred**

Fred, aged 61, had been sleeping rough in London for about seven years when he was found on the streets by out-reach workers. He had previously stayed in a large hostel for a short while but left because he found it too noisy and disturbing - most residents were young. He was at first reluctant to use Lancefield Street, but after several street visits the out-reach workers persuaded him to stay for a few nights in the drop-in centre. He then agreed to move into the hostel. Fred had worked as a bus driver for more than 30 years. He had been married for 14 years and, after separating from his wife, he lived with his mother for a few years and then with a girlfriend. Fred had a stroke when he was in his mid-fifties and was admitted to hospital. At the time, he and his girlfriend were experiencing
financial difficulties and they separated. He associated these problems with the onset of his stroke. After leaving hospital he was physically unfit to drive, unable to find alternative work, and could not afford the rent on the flat where he had been living. He therefore ceded the tenancy and became homeless.

Fred stayed at Lancefield Street for five months. During this time, he was seen by the local GP who arranged for investigations at the local hospital. Fred had been drinking alcohol intermittently while sleeping rough and the GP wanted assurance that there were no underlying physical health problems. Fred settled in the hostel and socialised with the other residents. Most of the time he ate regularly and kept himself clean and tidy, but occasionally he had bouts of drinking during which time he needed prompting to eat and attend to his personal care. He expressed a wish to be rehoused but there was uncertainty as to whether he could cope living independently because of his bouts of heavy drinking and because he had never lived alone. There was also concern about his motivation and budgeting skills, as when he received his weekly benefits he occasionally spent all his money on alcohol, and was without funds for the rest of the week.

The resettlement worker discussed rehousing with Fred, the responsibilities of having a tenancy, and the options that were available. Although Fred wanted his own flat, he agreed with the resettlement worker that he should initially move into shared housing for a few months. In a shared house, Fred would have his own bedroom but would share a kitchen and bathroom, and he would be responsible for cooking his meals, cleaning his room and the shared facilities, budgeting and paying rent, and keeping himself occupied. At the same time, he would receive support if needed from a housing worker who visited the house several times a week. This arrangement would enable Fred to build confidence and become accustomed to looking after himself, and it would enable the staff to assess his alcohol consumption and his ability to live alone.

Fred has been living in the shared house for 17 months. Throughout this period, he has coped well and for most of the time his drinking has been controlled. He looks after his personal appearance, prepares his own meals, keeps his room clean, and is fully occupied each day. He goes to a day centre several times a week and also attends a course where he is learning computer skills. He pays his rent regularly and has never been in arrears, although he does find it hard to budget and sometimes runs short of money before his benefits are next due. Fred has faced a few difficulties since moving in, and at these times, he has become stressed and drank excessively. On one occasion, he had problems sorting out his benefit claim when his book was due for renewal, and this triggered heavy drinking for a few days. He now requires very little support from his housing worker and wishes to have his own tenancy. He has been seen by his resettlement worker who has applied to a housing association for Fred to be considered for independent accommodation.

For Fred, the Lancefield Street Centre was a turning-point in his life. After having worked for years, he encountered a series of problems in mid-life which resulted in him becoming homeless. He then slept rough for several years without trying to change his circumstances, until he was found by the Centre’s out-reach workers who persuaded him to accept help. Once he had settled in the hostel, Fred was encouraged to move to permanent housing, taking into account both his preferences and needs. His sporadic heavy drinking, however, raised concerns about his long-term housing options and his ability to cope alone. He attributed his heavy drinking to the stress of living on the streets yet this behaviour continued intermittently while he was in the hostel. A preliminary move to a shared house meant that Fred could gain skills and confidence in managing a tenancy, while his ability to live independently was further assessed.

It is important that all steps are taken to maximise the chance that resettlement is successful. In Fred’s case, an inappropriate housing placement could have negative repercussions for both him and the housing provider. For Fred, such a move could be extremely stressful and lead to a sense of failure (he had already had a stroke several years earlier which he associates with stress). For the housing provider, a tenant who cannot cope or is unmotivated may abandon the accommodation, neglect its upkeep, or not pay rent and have to be evicted. These are all costly outcomes for the social landlord.

Case 3: Derek

Derek was referred to St Mungo’s in early 1998 by a social worker from outside London. He was 75 years old, homeless, had mental health problems, and was a heavy drinker. He required supported accommodation but there was none suitable in his local area. Until his later years, Derek had had a settled life. He was married for almost 50 years, had three children, and worked continuously as an
engineer. He was made redundant at the age of 63, and shortly afterwards his wife developed a terminal illness. Initially Derek looked after her but eventually she was admitted to a nursing home and she died in 1996. Derek started to drink heavily while caring for his wife and, just before she died, he was admitted to a psychiatric hospital for a few months because he was depressed and neglecting himself and his home. After her death, Derek drank excessively and was readmitted to the psychiatric hospital. He was then placed in several residential care homes because it was considered that he could no longer live alone. He was unsettled in the care homes, drank heavily, and the staff found his behaviour chaotic and unmanageable. He had consequently been asked to leave the homes.

Derek moved into Lancefield Street in March 1998. While in the hostel, his mental state and drinking habits fluctuated. At times, he was depressed and tearful, drank heavily, neglected his hygiene and appearance, and was incontinent. During these episodes, he required assistance with bathing and changing his clothes. At other times, he controlled his drinking, attended to his personal care, and read books and newspapers. He was assessed by a psychiatrist and an alcohol counsellor but was reluctant to accept help. Because Derek intermittently required a great deal of support, he was initially considered unsuitable for independent accommodation. He agreed to move to a high-care residential home in London where the staff had experience of working with heavy drinkers, although his preference if similar accommodation had been available would have been to return to his home town where his children and grandchildren lived. The local authority social services department where Derek had lived for years agreed to fund his care in the residential home.

Derek has been living in the residential home for two years. At first, he found it difficult to settle and wished to return to his home town. He still would like this but says, ‘being here is acceptable to me now. I have a degree of independence here which I value the most. I’m relieved of the responsibilities of managing a home on my own. My unattainable rainbow is however to move back to my home town of managing a home on my own. My unattainable value the most. I like this but says, wished to return to his home town. He still would two years. At first, he found it difficult to settle and Derek has been living in the residential home for

years agreed to fund his care in the residential services department where Derek had lived for

months because he was depressed and neglecting himself and his home. After her death, Derek drank excessively and was readmitted to the psychiatric hospital. He was then placed in several residential care homes because it was considered that he could no longer live alone. He was unsettled in the care homes, drank heavily, and the staff found his behaviour chaotic and unmanageable. He had consequently been asked to leave the homes.

This case study demonstrates the importance of help being available to people who are going through very difficult periods in their lives, even if they are old. For those without confidants, there is a need to seek out the distressed and provide support. As discussed in Chapter 2, widowhood is an important trigger to homelessness among some men, who become severely distressed, neglect themselves, and abandon their homes. According to Derek’s history, there are signs that he was distraught even while he was caring for his wife. Following her death, he was admitted to a psychiatric hospital and then into several residential care homes. He therefore had to cope with the loss of his wife, the loss of his home, and the upheaval of being moved from place to place. Although he was not initially willing to confront his problems and the recent losses in his life, he was amenable to help once he was settled and felt safe and secure. It is unfortunate, however, that he has ended up in a residential home in unfamiliar surroundings away from his home town and his family, because the help that he needs is not available in his local area.

Case 4: Bill

Bill, aged 62 years, has been homeless for 41 years. He explained, ‘I left the army in 1957 and have since drifted without settling anywhere’. He has occasionally stayed briefly in hostels but has mostly slept rough. He said, ‘I didn’t like the hostels - there was too much fighting and arguments in them’. He has travelled all over the country and has camped in woods and on beaches in remote areas. He rarely drinks alcohol but has had a few admissions to psychiatric hospitals. Since becoming homeless, he has never been rehoused.

Bill was found by the out-reach workers who persuaded him to visit the drop-in centre at
Lancefield Street. He said, ‘I gave the project a try, only because it was used by older people’. He stayed in the drop-in centre for one week and was then encouraged to move into the hostel. While in the hostel, he was assessed by the local GP and a psychiatrist from the local community mental health team. He was found to have no current physical or mental health problems. Bill stayed in the hostel for eight months during which time he was fairly reserved, although he associated with other residents in the TV lounge. He discussed his long-term options with his key-worker and resettlement worker, and after a few months expressed an interest in being rehoused. He did not want the responsibilities of his own tenancy, but was willing to be referred to a St Mungo’s shared house.

Bill has been in the shared house for 18 months and is settled. He said earlier this summer, ‘this is the first time I’ve felt settled since 1957’. He cooks each day and is always smartly dressed. During the day he goes for long walks and tends to the garden where he lives. He describes himself as ‘a loner’ and keeps to himself, although he watches TV each evening with the other tenants in the home. The other three tenants in the house are of a similar age to Bill. He says that he prefers living in a shared house and would not like his own tenancy. He explained, ‘if I had my own flat I would get isolated mentally and feel shut in and alone’. This summer he intends to go to Scotland for a few weeks’ holiday and to sleep on the beaches. He said that he will pay his rent before he goes so that his tenancy is sustained as, ‘it will be nice to have somewhere to come back to - after all these years of sleeping in doorways and on beaches’.

Bill’s case is another example of how a homeless person’s life has been changed by receiving proactive and empathetic help. Street out-reach work was uncommon when Bill first became homeless and he drifted for years on the margins of society. Yet once in contact with understanding services, he did not need much persuasion before he readily accepted help. Unlike Fred (case 2) who is keen to move from a shared house into independent accommodation, Bill has settled in a shared house and does not want the responsibilities of a tenancy. He recognises his capabilities and, for him, shared housing is meeting his needs. His intention to pay rent and retain his accommodation while on holiday indicates his degree of settledness.

Case 5: Mary

Mary was aged in her fifties when she first became homeless. She had always lived at home with her parents and had seldom worked. She said that she had suffered from ‘an illness’ for many years that prevented her from working. Her description of the illness suggests mental health problems but she denies ever having had treatment. Her father died first and then her mother died in 1985. Following the death of her mother, she remained in their council flat but did not claim benefits or pay rent. She acquired rent arrears and was visited by a housing officer, who referred her to the local social services department. Because she refused to cooperate when visited by a social worker, she received no help and in 1997 was evicted by the council because she owed 12 years’ rent.

After being evicted, she slept rough for several weeks until she was found by Lancefield Street’s out-reach workers. She reluctantly agreed to use the drop-in centre and after several weeks agreed to move into the hostel. While at the project, she isolated herself and neglected to eat and to attend to her hygiene. She was uncooperative and hostile but the staff eventually managed to convince her to claim benefits (the first time in years), and helped her complete the application form. They also encouraged her to eat, to keep herself and her room clean, and to see a GP (she had cellulitis of both legs) and accept treatment. She was referred to the local community mental health team, assessed by a psychiatrist, and diagnosed as suffering from both a severe personality disorder and an obsessive compulsive disorder. Following referral to her home local authority social services department, a community care assessment was undertaken and funding was secured for Mary to be transferred in October 1998 to a specialist mental health project managed by St Mungo’s.

Since moving to the specialist project, Mary has made slow but gradual progress. Because the project is small, the staff have the time to work intensively with her and they encourage her to talk about her anxieties and difficulties. She has to perform certain rituals associated with washing, dressing and packing bags before she can go out, and this worries her. These rituals can last 2-3 hours and she says that her actions are controlled by ‘voices’. Despite her habits, she now goes shopping and prepares her own meals, although she needs help with budgeting. She also socialises a little with the other residents. The staff are arranging for her to see a psychiatrist again for a further assessment. Their plan is that she will remain at the project for 2-3 years, after which it is hoped that she will have acquired the skills and confidence to move to supported, long-term
accommodation.

Mary’s case is an example of the complexity of problems that many homeless people experience. From her account, besides being homeless she has suffered from long-standing untreated mental health problems. Her case is also an example of how some vulnerable people fall through the gap in the welfare safety-net. After her mother died, Mary was not coping and acquired rent arrears. Statutory agencies were aware of her circumstances, but because she was uncooperative, the situation was allowed to deteriorate and she was eventually evicted. It is very likely that Mary’s homelessness could have been prevented if appropriate action had been taken when she was experiencing difficulties. Instead, she became homeless and slept rough until street out-reach workers from a voluntary organisation found her and acted upon her unmet needs. It is through this channel that she has now been linked to the services that she required in the first place – mental health and social services.

Case 6: Tom

Tom, aged 70 years, was found by the out-reach workers asleep in an old garage in east London. According to him, he had been homeless for about 20 years, and had slept rough and drank heavily throughout this period. Prior to becoming homeless, he had been in the merchant navy for more than 25 years. He said that he did not use day centres and instead ate food from litter-bins and occasionally a passer-by gave him something to eat. He agreed to come with the out-reach workers to Lancefield Street only if he could bring with him his shopping-trolley, which was piled with old rubbish. The out-reach workers therefore brought him and his trolley to the Centre in their van. On admission, he was filthy, hungry, and his clothes were in tatters. He was examined by the local GP, referred to the hospital, and found to be suffering from severe anaemia and liver failure, caused by years of self-neglect and heavy drinking. He required an urgent hospital admission so that further investigations could be carried out and his anaemia treated. On discharge from hospital, he returned to Lancefield Street.

While in the hostel, Tom required help with bathing, shaving, and changing his clothes, and prompting to eat and take medication. He had marked memory problems and, after several months, was still unable to find his bedroom. Whenever he went to the local shops, he could not find his way back to the hostel and returned to the East End. On these occasions, the out-reach workers searched for him and brought him back to the project. After several months, he became accustomed to his surroundings and did not wander away as much. He had not claimed social security benefits for years and the staff helped him apply for benefits. He could not budget and the staff managed his finances and gave him money each day. Tom was referred for an assessment to the community mental health team. The psychiatrist confirmed that he had severe memory problems, could not live independently, and required long-term, high-care accommodation.

A community care assessment was carried out by a social worker from Tower Hamlets Social Services Department (as Tom had slept rough in that area for years), and a place was found for Tom in a residential home in Kent for people with dementia who had high-care needs. Twelve months after being admitted to Lancefield Street, Tom moved to the residential home. He stayed in the home for six months before his physical health deteriorated and he died.

Tom was highly vulnerable when he was found by the out-reach workers. He was sleeping rough, had no contact with services, and had serious physical health problems. Because of his poor memory, the circumstances surrounding his homelessness and the length of time that he had been in such a neglected state could not be confirmed. Once in the hostel, the extent of his needs soon became apparent and he was linked to the services that he required. For Tom, the success of Lancefield Street was that his last 18 months were spent not on the streets but in accommodation where he received care and attention.

Conclusions

The individual histories presented in this chapter demonstrate that older homeless people can be helped and their circumstances improved if they receive intensive and empathetic services. Many do not present to services and ask for help, but do respond to forthcoming and proactive help. Without this assistance, many will remain homeless indefinitely. Their problems and needs differ and therefore they require various services. Some have few problems that will hinder resettlement, and they can be quickly moved from the streets into temporary accommodation and then into permanent housing. Others have more complex mental health and behaviour problems and require intensive and prolonged services and specialist help. Some are not ready or willing to confront deep-seated problems, such as the death
of their spouse, until they are settled and feel safe and secure. It is essential therefore that older homeless people receive individualised services at a pace that they feel comfortable with.

There are many ways that older homeless people benefit from services and their responses to help will vary. Some want their own tenancies and if they move to a shared house, this is generally seen as an interim measure. Others do not want the responsibilities of their own home and, for them, a shared house is their preferred long-term option. Once resettled, some develop new interests and build social networks or renew relationships with friends and relatives. Others remain isolated although settled, and require ongoing support to ensure that they do not experience difficulties that put their tenancies at risk. Services need to be developed, therefore, that take into consideration both older homeless people’s needs and their preferences.

This chapter also highlights the importance of carrying out more work around the prevention of homelessness. In the cases of Paul, Fred, Derek and Mary, homelessness may have been prevented if they had received adequate help at the time that they faced losses and crises. Systems need to be established that identify vulnerable people who are experiencing difficulties at home, or whose circumstances change and this puts them at risk of becoming homeless. Effective ways of intervening in such situations need to be developed. The next chapter discusses the opportunities for developing services for older homeless people in light of recent policy and service changes.
The two previous chapters have highlighted how some recently-developed creative projects have made a substantial difference to the lives of older homeless people. This chapter discusses the current policy and funding environment for services for homeless people, and the opportunities that are available for organisations to contribute to the development of services for older homeless people and to the much-needed exploration of good practice. Some of these opportunities arise because of changes in recent policies and programmes. Others are created by the many charitable foundations and trusts which are willing to fund new projects for homeless people and other special needs groups.

**The Rough Sleepers Unit and the Homelessness Action Programme**

Following the establishment in April 1999 of a *Homelessness Action Programme* and a *Rough Sleepers Unit* (RSU) within the *Department of the Environment, Transport and the Regions*, new strategies are being developed to tackle the problem of rough sleeping and to prevent people from becoming homeless. Louise Casey has been appointed as the Head of the RSU, which has a policy and programme direction role for all England. Within London, *Contact and Assessment Teams* (CATs) replace RSI-funded out-reach workers, with a designated organisation having responsibility for street-work in a geographical area of London. Away from the city centre, the expectation is that day centres will provide an out-reach service to rough sleepers in their locality. There is to be additional accommodation for rough sleepers - 550 beds in hostels, 440 in special needs accommodation, 120 in ‘rolling shelters’ which open for just a few months at a time, and 1,000 units of move-on accommodation.

Other changes in London include a ‘night-centre’ which is to open in September 2000 within *St Martin-in-the-Fields Social Care Unit*, central London. Sixty new posts are to be funded for specialist workers to help rough sleepers with mental health and substance abuse problems. These workers will be linked to the CATs and to other projects working with single homeless people. An emergency special needs response team is to be set up to help rough sleepers with acute medical problems and mental illness who are not accessing services and require crisis intervention. Six *Tenancy Sustainment Teams* are to be created and organised in a similar ‘patch-based’ way as the CATs. The teams will provide ongoing support to homeless people who are resettled.

Outside London, local authorities are expected to be involved in the planning and co-ordination of services for single homeless people. The housing departments are required to develop rough sleeping consortia involving key voluntary and private sector organisations, and to work in conjunction with the RSU. Those with a significant problem of rough sleeping have to appoint a co-ordinator of local action, and other local authorities are being urged to do the same. From 2000, the *Department of Health* expect local authority social services departments with an identified problem of rough sleeping in their area to target funds from their *Mental Health Grant* on specialist services for mentally ill people on the streets. They are required to nominate a senior manager with clear responsibility for mental health services, whose task is to work jointly with housing departments and other agencies to ensure that there is a co-ordinated response to the problems of mentally ill rough sleepers (DETR, 1999).

**Implications for older homeless people**

The RSU’s programme has only just started and the extent to which it will make a contribution to meeting the needs of older homeless people is unknown. Several of its new strategies focus on helping long-term entrenched rough sleepers, many of whom are in the older age group. One of its goals is to get rough sleepers off the streets and linked into services by, for example, funding specialist workers and opening a night-centre. The night centre is comparable to the 24-hour drop-in centre at Lancefield Street, and is to target older people (RSU, 2000). It will probably attract older rough sleepers who are reluctant to use services for homeless people of all ages.

Another programme proposal, having out-reach services attached to day centres, should increase the opportunity of isolated rough sleepers being helped. Day centre staff are sometimes aware of rough sleepers in their vicinity, and workers can target those who are not accessing services. Unfortunately, several London boroughs have few services to act as contact points for rough sleepers.
For example, Newham, Haringey and Waltham Forest, have no day centres. If the new CATs do not work on the streets in outer London boroughs, the only way that some rough sleepers may get linked into services is to move into central London and sleep in doorways. This arrangement is highly unlikely to be adopted by older rough sleepers who often choose to sleep in secluded places away from the city centre.

Another of the RSU’s emphases is on resettlement and helping people to sustain tenancies and adopt a lifestyle away from the streets. Many homeless people who are rehoused experience problems with coping and loneliness, and there is a high rate of tenancy breakdown in the first two years. In the past, support was often only available to formerly homeless people for the first six months after rehousing. The Tenancy Sustainment Teams create opportunities for flexible and longer-term support. The RSU’s report (1999) stresses the importance of schemes to help former rough sleepers return to work or take up training and meaningful occupation. Less attention has been paid, however, to the needs of rehoused middle-aged and older people who for reasons of age or disabilities are unlikely to return to work. This is of particular concern as some London day centres now focus their services on rough sleepers and those who have been rehoused are excluded.

**Other central government initiatives**

Additional measures are being introduced by central government to help rough sleepers access services. A report of December 1998, *Supporting People*, outlines a new policy and funding framework for support services in England. The emphasis is on helping vulnerable and excluded people to gain access to services, by supporting people who ‘may not be seeking support, who have difficult behaviour or unconventional lifestyles, or who have multiple needs or fall outside traditional ‘client groups” (DETR et al., 1998, p. 17). A cross-authority fund will fund services for rough sleepers who move around, do not naturally fit into any individual local authority area, and require help in an area where they do not have a strong local connection. This should help to ease the difficulties that homeless people’s services experience when trying to access mainstream social care services for older rough sleepers who have moved from town to town for years and are unknown to local authorities.

Initiatives are being introduced to help rough sleepers access hostels more easily. At present, some hostels exclude those who have no proof of identity and are not receiving benefits. A pilot scheme has operated in Westminster whereby housing benefit payments are made to hostels during ‘a period of grace’, while hostel staff help new residents obtain identity and claim benefits. Once this scheme has been fully evaluated, the *Department of Social Security* are considering extending it nationally (Rough Sleepers Unit, 1999). This would mean that rough sleepers who are not claiming benefits will be able to use hostels and get the help they need. Because many older rough sleepers do not claim benefits, the scheme should prove useful when out-reach workers are trying to coax this client group to accept help. It is important that the workers can respond promptly when an older rough sleeper agrees to move into a hostel, and not have to ask the client to wait until their benefits are sorted out.

**Opportunities created by charities**

There is a strong need for innovative ways of working with older homeless people to be piloted and evaluated. Much more needs to be known about how older homeless people can be identified as quickly as possible, how those with chaotic behaviours and complex problems can be helped, and how homelessness can be prevented. Voluntary sector organisations can play a major role in this field through the opportunities that are created by large and small charitable foundations and trusts. For example, funding from the *Henry Smith’s Charity* enabled the Lancefield Street Centre to be set up for two years and a new way of working with older rough sleepers to be tested and evaluated. Evidence of the project’s success was then used to seek support for a replacement scheme.

In 1997, *Help the Aged* appealed for money and launched an *Older Homelessness Grant Programme*, in collaboration with *Crisis* and the *Housing Associations Charitable Trust*. It has so far raised £1.5 million and has funded 38 projects around the country to work with older homeless people. The schemes, developed by established voluntary sector organisations, include dedicated workers for older homeless people at day centres and on the streets in London, Newcastle-upon-Tyne and Edinburgh; supported accommodation for older homeless women in Nottingham; and resettlement workers and tenancy support workers in Cardiff and Leeds for older homeless people once they are rehoused. One project to benefit from this funding is *Spires Connect*, the older people’s service at a day centre in south London, described in Chapter 4.
**Conclusions**

Substantial changes are currently taking place to voluntary sector homeless people’s services, which could mean more efficient and inclusive services for older homeless people. The government’s emphasis is on reducing the number of people sleeping rough on the streets. With this in mind, the *Rough Sleepers Unit* and the *Homelessness Action Programme* have developed strategies to help rough sleepers move off the streets and into long-term housing. If successful, it should mean that many older long-term rough sleepers are identified and helped. Furthermore, if the *Tenancy Sustainment Teams* prove an effective way of helping formerly homeless people sustain tenancies, then the number of older homeless people being rehoused and re-entering homelessness should reduce.

Homelessness amongst older people, however, encompasses a much broader remit than rough sleeping. There are many older people who have been in hostels for years and wish to be resettled. Some remain in hostels and cannot be rehoused because efforts to control their mental health and alcohol abuse problems have not been successful. Others are in hostels because there is insufficient attention to resettlement and a shortage of good quality supported long-term accommodation. Although services for homeless people have improved substantially over the last 20 years, immense gaps remain and people are still unnecessarily becoming and remaining homeless. Voluntary sector organisations can play a vital role in filling some of the gaps by developing services through the RSU’s programme and through their own initiatives. The final chapter describes how this can be done.
This report has described the problems and needs of older single homeless people and their contact with services. It has highlighted that there is immense unmet need among the group. Older homeless people can be helped; their circumstances and quality of life can be improved, and their motivation and self-esteem increased. But much more needs to be done. Statutory agencies are not proactively seeking out and helping this client group, and although a few voluntary sector organisations have developed services for them, such projects are not widespread. Furthermore, because there is little evaluation of services, the most effective ways of working with homeless people are rarely reported. This final chapter focuses on the next steps in developing more efficient and comprehensive services for older homeless people.

The need for a full spectrum of services

Older homeless people require a full spectrum of services, which provide a pathway from the streets to temporary hostels and specialist projects, and then to rehousing in independent and supported accommodation. Progressive services have been shown to be helpful in persuading some older entrenched rough sleepers to leave the streets, and in resettling many older homeless people in long-term accommodation. Service-providers should assess the needs of older homeless people both within their organisation and collectively with other local organisations. In areas where many older people sleep rough, outreach workers are required and possibly additional temporary hostels. In locations where a large number of older people are in hostels, there is likely to be a need for resettlement programmes and supported move-on accommodation.

The need for services that target older homeless people

Older homeless people require services that target their age group. Many of this client group are more willing to use services exclusively for middle-aged and older people, and the staff at these projects develop expertise in working with the clients. Age-specific projects can be established either by creating new services or by changing existing ones. The Rough Sleepers Unit is promoting the development of additional temporary and move-on housing in London for rough sleepers. Some of this accommodation should be targeted at older clients. Many large organisations in London have several hostels. Changes could be made within organisations so that one of their hostels accepts just older residents. Likewise, there are several day centres in central London. One should target older clients.

The need for services that are proactive, intensive and individualised

Older homeless people require individualised and intensive assessment and care programmes to ensure that their needs are adequately identified and addressed. Many are too demoralised or unmotivated to seek help, while some have mental health problems that affect their ability to ask for and accept services. Workers therefore need to be proactive and seek out those who are isolated or unassertive. The clients need to be persuaded that their circumstances can be improved and they should be encouraged to accept services. Prolonged homelessness exacerbates health, social and behaviour problems. Rapid-response services are therefore required so that older people who become homeless are quickly recognised and helped.

The need for pilot projects to help older homeless people with complex needs

Some groups of older homeless people are especially difficult to help, even when dedicated services are set up. Such groups include those who have both mental health and alcohol abuse problems, and older women who sleep rough. Pilot projects need to be set up and evaluated to identify effective ways of working with groups who are not helped by current services. Compared to the men, older women sleeping rough tend to be more suspicious and less trusting, more resistant to services, and many have severe mental health problems. A small project should be piloted in London exclusively for older homeless women that has a similar pathway of services as the Lancefield Street Centre.

Through the RSU, several specialist workers’ posts have been created for people with mental health and substance abuse problems. Some of these workers should be involved in pilot projects to trial new ways of working with older clients who are
mentally-ill and heavy drinkers. They should be based at projects, be involved in planning programmes of care for the clients with the project staff, and provide support to the staff in caring for clients who have difficult behaviour. This may prevent the unhelpful eviction of those residents who become disturbed.

**The need for various models of permanent housing and support**

At present in London, there is a great shortage of supported move-on accommodation for older homeless people. As a result, some remain in hostels indefinitely while some are rehoused in accommodation with inadequate support and become homeless again. There is a need to develop various models of permanent housing and support for this client group. Many wish to have their own tenancy although they have high-care needs. Innovative ways of providing such housing have been developed by a few organisations, and should be further expanded. Some older homeless people do not want the responsibilities of their own home and prefer to live with others in shared housing. Shared housing should be developed which targets older age groups, is regarded as permanent housing, and provides services such as meals and help with laundry if needed.

**The need for statutory agencies to support older homeless people’s services**

For many years, voluntary sector organisations have been the main provider of services for single homeless people, and they are now experienced in providing a range of housing and support services to those with complex and intricate needs. Their role should be elaborated but with more support from statutory providers. Many older homeless people have health and social problems that require either direct input from statutory organisations, such as health-care needs, or that require services that are funded through these agencies, such as places in registered care homes. There is, therefore, a need for mainstream health, housing and social services staff to collaborate fully with voluntary sector homeless people’s services, so that older homeless people receive the help that they need.

**The need for monitoring systems and services to prevent homelessness**

There is little evidence about the ways that homelessness can be prevented and of how people at risk of becoming homeless can be identified and helped at an early stage. There has been very little exploration of the monitoring procedures, referral systems and interventions that can contribute to prevention. As a result, many people are becoming homeless for the first time in old age, and many older homeless people are rehoused but become homeless again. More work is needed to establish the most common ‘proximate causes’ or triggers of homelessness, to develop monitoring systems that can detect and anticipate people who are at risk, and to investigate various approaches to primary prevention.
References


