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Policy and Service Responses to Rough Sleeping Among Older People

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ABSTRACT

Rough sleeping in Britain has a long history, and interventions have alternated between legal sanctions and humanitarian concern. This paper critically examines recent changes in homeless policies and services, with particular reference to the needs of older people who sleep rough. The characteristics and problems of the group are first described. Single homeless people were formerly accommodated in direct-access hostels but, from the 1970s, individualised rehabilitation and resettlement have spread. Most recently, services dedicated to older people have begun (although remain few and are unevenly provided). Their achievements are reviewed and drawn upon in formulating normative proposals of the appropriate service mix. The 1990s 'Rough Sleepers Initiative' and related programmes promoted a 'social care market' of not-for-profit organisations that compete for increased (but short-term) funds to provide services, and the new Labour government will build upon these changes and increase funds. Low tolerance towards the 'social exclusion' of homelessness is promised but unerringly constructed as exclusion from work; while rough sleeping is dubbed as anti-social, coercive approaches to achieve a two-thirds reduction are foreseen. The proposed target might stall the development of diverse and effective services, or reduce providers' capacity to combat the perversities of resource allocation. The overall prospects for the improvement and expansion of services to provide significant help to single older homeless people are uncertain.

INTRODUCTION

Homelessness has recently increased substantially in the United Kingdom which, by the early 1990s, had the second highest rate of

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homeless people per 1,000 population (12.2) among eleven European countries (Daly, 1993). In 1996–7, English local housing authorities accepted 110,810 households as homeless, compared to 53,100 in 1978 (Bramley, 1993; Department of the Environment, Transport and the Regions (DETR), 1998a). In addition, many unregistered single homeless people sleep rough or live in temporary hostels and shelters: in London alone estimates range from 69,600 to 128,000 (Moore *et al.*, 1995; Single Homelessness in London, 1995). This paper examines the recent development of services for older single homeless people in the context of the Conservative government's Rough Sleepers' Initiatives and the modified approach of the new Labour government.

Primary research evidence on both 'subjects' and 'services' is drawn upon. An ethnographic study of 225 older homeless people was conducted in London, Sheffield, Leeds and Manchester during 1994–5, as well as later in-depth interviews with eighty-eight users of an experimental 24 hour drop-in centre and residential hostel for older rough sleepers at Lancefield Street in west London (Crane, 1997, 1998, 1999). Information on services comes from a 1997 survey of providers in London, Leeds, Liverpool and Glasgow, a study of sixteen projects working with older homeless people, and a monitoring and evaluation study of the two years' work of the Lancefield Street Centre (Crane and Warnes, 1997a; 1997b; 1999).

THE EVOLUTION OF SERVICES FOR HOMELESS PEOPLE

Legal and humanitarian interventions to address homelessness in Britain arguably date back to a 1349 statute to control the vagrancy which followed the Black Death, and to the relief for destitute people provided by the Elizabethan Poor Law in poor-houses and, through its nineteenth-century reform, in the 'casual wards' attached to workhouses (Chambliss, 1964; Hill, 1996, p. 48). Restrictive and supportive measures to tackle rough sleeping which were inherited from the Vagrancy Act 1824 (amended in 1935) continued until the late 1970s, with homelessness being 'contained' by the statutory, religious and philanthropic organisations which provided hostels and lodging houses for homeless men. Intensive resettlement programmes were rare, and retrospective assessments suggest that the policies and services of the time may have done more to maintain than to reduce homelessness. The government's Reception Centres (the former casual wards) allowed the users to stay only one night each month and required them to leave in the morning after a compulsory task,

encouraging transience and unsettledness (Rose, 1988; Berry, 1978). The hostels accommodated people in primitive, institutional conditions for years and the users had few opportunities to practise basic domestic and self-care skills: many progressively became 'deskilled' and dependent (Digby, 1976; Vincent *et al.*, 1995).

From basic shelter towards rehabilitation for homeless people

By the mid-1970s, the British social welfare consensus was critical of the custodial care of vulnerable people in institutions such as mental hospitals, and increasingly favoured individualised interventions and rehabilitation (Rogers and Pilgrim, 1996). Accordingly, programmes were established to close large hospitals for the mentally ill and handicapped and to resettle the patients in supported housing (Francis *et al.*, 1994; Pickard *et al.*, 1991; Ramon, 1992). There was also growing concern about the rising prevalence of mental health, alcohol and social problems among single homeless people (Archard, 1979; Home Office, 1974). The large traditional hostels and the Resettlement Units (as Reception Centres were renamed) were castigated for their low rate of resettlement and for promoting a 'circuit of homelessness' (Campaign for the Homeless and Rootless, 1985; Consortium Joint Planning Group, 1981; Deacon *et al.*, 1993). The 1980 *Hostels' Initiative* was launched by the government to replace the traditional hostels with small, special-needs housing units (Drake, 1989).

Meanwhile a new generation of homeless sector voluntary bodies was growing up, stimulated by the creation of the Housing Corporation in 1964 and the Housing Act 1974, which introduced a range of capital and revenue social housing subsidies (Lund, 1996; Malpass and Murie, 1994). Organisations such as the Carr-Gomm Society developed shared housing schemes nationwide to offer support to lonely people and to those discharged from specialist hospitals (Cooper *et al.*, 1994). Housing associations were founded to work with single homeless people, such as St Anne's Shelter and Housing Action in Leeds, St Mungo's in London, and The Talbot Association in Glasgow (Spiers, 1999). Many started as a hostel or day centre to meet local needs and developed detoxification centres, special-needs hostels and supported housing schemes. Teams were set up to rehouse hostel residents with help from local authority social services and housing departments (Dant and Deacon, 1989; Duncan and Downey, 1985; Duncan *et al.*, 1983).

This period also saw a substantial step towards eradicating the residue of the parochial poor law approach to homelessness. The

1977 Housing (Homeless Persons) Act imposed a duty upon local authority housing departments to house homeless people. For over a century, especially following the two world wars, their role as providers of subsidised (or social) housing had grown. The duty was to house people who applied for help, were 'unintentionally' homeless, and in 'priority need' (Jacobs *et al.*, 1999). There was no duty to anticipate cases, find homeless people, or help those who had volitionally abandoned accommodation. The effect was to dichotomise 'official' homelessness (usually of families or older people) from the problems of unregistered 'single homeless people'. Ever since, British academic and applied debates on homelessness have been confused by inconsistent definitions (for a detailed exegesis see Crane, 1999). The measures helped low income and vulnerable people whose housing was insecure or terminated, including the cases arising from housing shortages, mismanaged slum clearance programmes, and the actions of irresponsible and inadequately regulated private landlords.

The elaboration of rehabilitation and resettlement: the 1990s

During the late 1980s an increasing number of people were sleeping rough in central London and other major cities. Neither the voluntary organisations nor the local authorities had the resources to respond, prompting in 1990 the radical Rough Sleepers' Initiative (RSI) to make 'it unnecessary to have to sleep rough in central London' (Department of the Environment (DoE) *et al.*, 1995, p. 5; Randall and Brown, 1993). While the DoE retained responsibility for the final distribution of the funds, it invited non-statutory organisations to submit project proposals which had the approval of local authorities. Over three three-year phases, the RSI has allocated over £255 million for temporary and permanent accommodation, cold-weather shelters, and out-reach and resettlement workers. It was intended to return the responsibility to house rough sleepers to local authorities after two phases, but the 1995 White Paper, *Our Future Homes: Opportunity, Choice, Responsibility,* announced that the RSI would continue until March 1999 (DoE, 1995). In its first two phases (1990–6), RSI support was confined to central London, but from the third it was extended to other towns and cities, including Bristol, Brighton and Nottingham (DoE 1996a, 1996b; DoE *et al.*, 1996).

The Mental Health Foundation and the Department of Health (DH) simultaneously developed the *Homeless Mentally Ill Initiative* to help mentally ill people sleeping rough in central London, with over £22 million available for out-reach teams and specialist hostel places

(DoE, 1996a; Craig, 1995). Many psychiatric hospitals had closed and the number of beds had halved since 1954 (Craig and Timms, 1992). Under section 180 of the Housing Act 1996, a further £8 million a year was allocated to voluntary sector organisations for projects to help single people in housing need. The DH funded services for substance abusers through the Drug and Alcohol Specific Grant (£720,000 in 1997–8); and the Department of Social Security provided £18 million a year for hostel beds and move-on accommodation (Social Exclusion Unit, 1998).

The new funding has helped to improve the condition, standards and amenities of temporary accommodation for single homeless people. Many large old hostels and resettlement units have closed, while smaller hostels with single rooms and better facilities have multiplied. Rehabilitation and resettlement programmes have also proliferated, some for heavy drinkers and people with addiction and mental health problems. More out-reach workers and resettlement workers have been employed to work with single homeless people on the streets and in temporary hostels. Day centres and drop-in centres for homeless people have multiplied rapidly throughout Britain, although subject to 'whims ... and funding availability' with little attention to need (Waters, 1992, p. 7). There were only seven before 1970, but by 1995 there were over 250, used daily by approximately 10,000 people (Llewellin and Murdoch, 1996). There are more than 80 in London and they are found even in small towns, but there are few in Wales, and several urban areas with a recognised single homeless population have none (Jacobs *et al.*, 1998, Pleace, 1998).

Various long-term supported housing options, including models of shared, group, supported, and high-care housing that have been demonstrated to be of value for mentally-ill people have been adopted for homeless people by housing associations (HA), social service departments and mental health services. In London, beds in such schemes increased by nearly 4,700 between 1985 and 1994, although demand for independent and supported tenancies outstrips supply (Cripps, 1998; DoE *et al.*, 1996; SHiL, 1995). Among the innovative schemes, Thames Reach HA and Bridge HA in London have developed self-contained flats adjacent to a hostel or a group home, with the tenants receiving support from the attached project; while St Anne's HA in Leeds accommodates homeless people in grouped self-contained flats with visiting support (Crane and Warnes, 1997b; O'Leary, 1997). An increasing number of community housing support workers are assisting homeless people who have been rehoused.

The development of services dedicated to older homeless people

Only in the 1990s was it widely recognised that older homeless people's needs are inadequately met by generic homeless services. While most day centres and hostels for homeless people cater for all ages, their facilities and out-reach and resettlement work are usually dominated by adolescents and young adults. Many older homeless people dislike the noise and overcrowding in hostels and day centres, and fear violence and intimidation from young users (Crane and Warnes, 1997a). As has been found in American cities (Cohen and Sokolovsky, 1989; Doolin, 1986; Douglass *et al*., 1988), older users tend to be unassertive and their needs are readily over-looked. There is, however, considerable unmet need, for during 1997–8 in London, two outreach workers identified and helped 491 older rough sleepers (Crane and Warnes, 1999).

A few organisations have responded by developing services dedicated to *older* homeless people (Table 1). Four central London day centres have designated workers and sessions once or twice each week. In January 1997, St Mungo's opened a 24-hour drop-in centre and hostel for older rough sleepers at Lancefield Street, west London (Crane and Warnes, 1999). Dedicated resettlement programmes are multiplying. In Birmingham, London and Cardiff, short-stay rehabilitation hostels for older rough sleepers prepare their residents for moves to permanent housing; and in Leeds since 1991, the St Anne's *Over-55s Accommodation Project* has rehoused over 300 people, some with long histories of homelessness (Crane and Warnes, 1997b). In 1999 this service was extended by St Anne's to a former Resettlement Unit in Sheffield.

THE NEW LABOUR ADMINISTRATION'S HOMELESS POLICIES

The Labour government, elected in May 1997, has given mixed signals about the priority it attaches to rough sleeping and the marginally housed. Within a month of the election, the announcement of the Social Exclusion Unit (SEU) promised a determination to tackle the issues, but the strategy paper on rough sleeping did not appear until July 1998 (SEU, 1997; 1998). This specifies more continuity than change, for while the RSI was replaced in April 1999 by the Homelessness Action Programme, many established features continue, such as the triennial cycle of project funding (£145 million for London and £34 million for the rest of England during 1999–2002), and reliance on a 'social care market' of competing non-statutory service providers (DETR, 1998b). As the prime minister said, 'we will be

TABLE 1. *Examples of services dedicated to older homeless people in England and Wales*

Name of project (and organisation)	Year began	Type of service or help provided						
		OR	TA	DC	RS	SP	GH	DW
London								
Lancefield Street Centre, Westbourne Park (St Mungo's Community HA)[a]	1997	●	●	●	●	●[b]	●[b]	●
St Martin's Day Centre, Trafalgar Square (St Martin-in-the-Fields Social Care Unit)	1995	–	◊	●	◊	◊	–	●
St Giles Day Centre, Camberwell (St Giles Trust)	1995	–	–	●	●	●	–	●
North Lambeth Day Centre, Waterloo (North Lambeth Day Centre)	1995	–	–	●	●	●	–	●
Passage Day Centre, Victoria (Passage Day Centre)	1996	–	–	●	●	●	–	●
Older homeless Asian people project, Cricklewood (Paddington Churches Housing Group)	1982	–	●	–	●	●	–	●
Arlington Road/Mary Terrace Project (Bridge HA)	1996	–	–	–	●	●	●	●
Other cities and towns								
Zambesi and allied temporary housing projects, Sparkbrook, Birmingham (Focus Housing Group)	1987	–	●	–	●	–	–	●
Grangetown PREP (Preparation for Resettlement Scheme), Cardiff (United Welsh HA)	1992	–	●	–	●	●	–	●
Over 55s accommodation project, Leeds (St Anne's Shelter & Housing Action)	1991	–	◊	◊	●	●	–	●
Sandringham Road Supported Housing, Lowestoft (Suffolk Heritage HA)	1996	–	–	–	●	–	●	●

Key to services: OR: Street out-reach workers. TA: Temporary (hostel) accommodation. DC: Day or drop-in centre sessions. RS: Resettlement preparation and planning. SP: Continuing support for independent tenants. GH: Group housing schemes. DW: Workers dedicated to older people.
Notes: ● Service exclusively for older people. ◊ Not exclusively for older people. HA: Housing Association. [a] Closed December 1998. [b] Enlisting other St Mungos provision.

backing the thousands of "social entrepreneurs" – who bring to social problems the same enterprise and imagination that business entrepreneurs bring to wealth creation' (SEU, 1997).

The government's objective is to reduce the number sleeping rough to one-third of its current level by 2002. The main measures will be more spending, the better co-ordination of services and agencies (the 'joined-up' approach), more attention to prevention and resettlement,

and a surprising indication that rough sleepers may be coerced to accept hostel beds (SEU, 1998, Section 4.23). The first step – prompted by the imminence of the metropolitan London authority – has been the creation of the London Rough Sleepers' Unit, to manage as a single budget various programme funds, and to co-ordinate the work of central government departments, local authorities and voluntary organisations (DETR, 1999a). Outside London, the intention is that local authority housing departments will assume the co-ordination role, an echo of nine years ago.

In its wider housing policy, while the government has already removed some of the most criticised Conservative measures, such as the restrictions within local authority Housing Revenue Accounts on using receipts from sales for maintenance, it has broadly accepted the social housing policies (and trends) bequested by the 1990s. The 1996 Housing Act, which raised a considerable protest during the two years' consultation of the Green and White Papers (DoE, 1994; 1995), is intended to avoid homeless people having preferential treatment over non-homeless people on housing waiting lists, and includes the dilution of the local authority duty to house homeless people. The responsibility to find permanent housing was altered to temporary housing, and the definitions of priority need and eligibility were tightened (Lowe, 1997; Somerville, 1999). The new government is 'investing heavily to improve the social housing stock and tackle the problems of the most deprived communities, but extra money must go hand in hand with better management ... and reforms to personal housing support' (DETR, 1999b). While priority will be given 'to restore choice and power ... [and] make the market work for all the people, protect the vulnerable and reduce the scope for exploitation' (DETR, 1998c), responsibility for the provision of social housing will continue to shift from local authorities to 'registered social landlords' (now including for-profit companies) under the Housing Corporation's regulation (DETR 1999c).

The competitive social care market, homeless services and prevention

The SEU's strategy highlights prevention while services for homeless people will continue to be delivered primarily through the competitive 'social welfare market' (except that the new Primary Care NHS Groups and Trusts will attract supplementary funds for serving special-needs groups such as homeless people) (Department of Health, 1997). The obvious question is whether the means is suited to the task. Both *a priori* reasoning and experience in Britain and America

enable the most likely evolution of services in any large city to be described. In every setting the pathway from rough sleeping to tenured accommodation requires: out-reach work, temporary accommodation and day centres, services to combat health problems and heavy drinking, benefits and living-skills advice, resettlement programmes, long-term housing options, and continuing support for the rehoused (Figure 1). Wherever services develop, it will be discovered that no single provider has sufficient capacity or expertise to meet the needs of all groups of homeless people. Special services then develop, as for those with mental health or alcohol problems. Whatever the foundation project, the outcome of needs-led development is therefore likely to be federated, multi-agency provision across a similar service

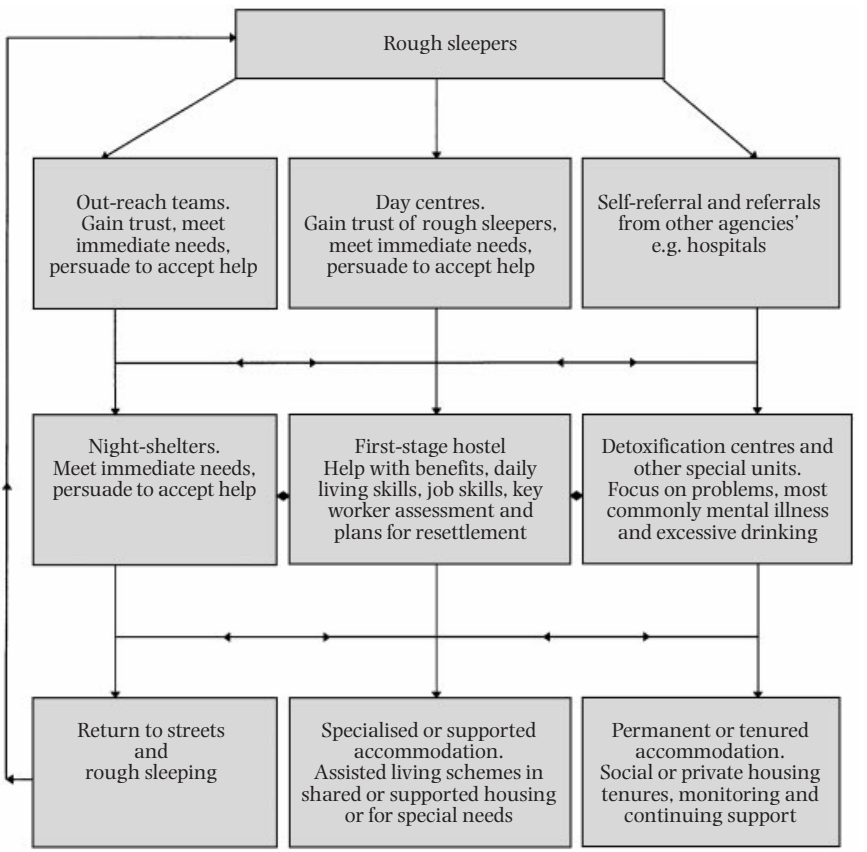

Figure 1. Pathways from rough sleeping to permanent accommodation.

spectrum. The normative reasoning can be extended to suggest that a 'mature homeless service system' will have: (i) effective links between all 'steps' in the pathway to enable onward referrals for specialist help; (ii) continuous funding to sustain services and accumulate experience; and (iii) an 'evidence-based' and evaluative culture to improve the efficacy of the services.

Homelessness as measured by the number sleeping rough on any one night can be prevented in two ways: through a falling rate of people become newly homeless, or a shortening duration of the episodes. A mature service system and the 'social welfare market' might substantially reduce episode duration but they will hardly affect the genesis of newly homeless people, *n.b.* although 4,500 homeless people were resettled during 1990–7 through the RSI, 1,800 *new* rough sleepers were found in central London in 1996–7 (Cripps, 1998). It is not surprising that a policy for prevention is elusive, for there is neither a consensus on the causes of homelessness nor hardly any theoretical or practical exploration of primary prevention. Reducing the incidence of homelessness could first address the most obvious proximate causes, such as eviction from social housing and discharge from custody and the armed services. It has been estimated that 60 per cent of London's social housing tenants in 1995 needed help with claiming benefits, budgeting and paying bills (Audit Commission, 1998). Some who are unable to manage and lack support are evicted or abandon their homes (Craig, 1995; Ford and Seavers, 1998; Morrish, 1996). Many single men leave the armed forces without help to adjust to settled living (Gunner and Knott, 1997; Randall and Brown, 1994), and at least two-fifths of prisoners are reported to be homeless on discharge (Carlisle, 1997; Paylor, 1992). From this catalogue of vulnerabilities, it becomes clear that systems are required which can detect, anticipate and alleviate marginality among the housed. Both income levels and personal competence are intricately involved.

Continuing emphasis on temporary shelter

For all the innovation of the 1990s, homeless people's services continue to be dominated by temporary hostel places, and large hostels, sub-standard accommodation and inadequate facilities still exist. Glasgow has 8 hostels with more than 100 beds, and London has 12 including Arlington House for nearly 400 men (Crockett *et al.*, 1997; Glasgow Council for Single Homeless, 1996). Only one-half of the 2,588 beds in London's direct-access hostels are in single rooms (Harrison, 1996). Some hostels and most shelters require the residents

to leave in the morning. Most linger on the streets or use day centres until the evening, reinforcing unsettledness, low self-esteem and health problems. As recently as 1995, Crisis developed several 'Open House' shelters for rough sleepers which opened only at night, even though three were in areas without day centres. The shelters had low rates of referral to other services, and most residents left without being resettled (Pleace, 1998). The focus on temporary hostel places is heightened by the RSI cold-weather shelters which provide free accommodation for rough sleepers. Their humanitarian (and media) appeal is strong: they open just before Christmas in a blaze of publicity, attract strong private-sector support, and close in March without remark. Even discounting the small proportion of the users who move to cold-weather shelters from temporary hostels, which offer more services and stability but charge rent, they offer only limited individualised help and many users are transferred to other hostels and temporary accommodation when the shelters close (Randall and Brown, 1996; Somerwill, 1996).

The service and prevention agenda for 2000–2

More emphasis is needed upon out-reach, rehabilitation and resettlement. Too many links in the 'complete pathway' from the streets to long-term housing are absent or haphazardly filled. The government favours helping young homeless people to gain job skills and to get work, and they may restrict hostel places to those willing to participate in an employment or training scheme (SEU, 1998, Section 4.27). Training in basic living skills is also important, however, but the main weakness at present is inadequate resettlement; it is unevenly available, follows an 'unjoined-up' approach, and is poorly informed by good practice. Some hostels lack resettlement programmes, for it is costly to employ resettlement workers, and there is a perverse financial incentive to minimise vacancies by retaining stable residents. Few hostels or day centres have the resources or trained staff to cope with the mentally-ill or heavy drinkers, whom consequently they exclude and evict (DoE, 1995; Ham, 1996; Harrison, 1996). Many rehoused homeless people experience problems, and many resettlements fail in the first two years (Craig, 1995; Morrish, 1996; Randall and Brown, 1996; Wilson, 1997). Of 4,865 tenancies created through RSI schemes, 787 (16 per cent) ended in abandonment or eviction, with a higher rate of failure in shared housing than in self-contained flats (Dane, 1998). This may result from differences in the tenants' problems and behaviour, or from the conflicts intrinsic to shared living

(Cooper *et al.*, 1994; Crane and Warnes, 1997b; O'Leary, 1997). The issue warrants intensive research.

There is scant attention to the most entrenched rough sleepers, many of whom are elderly, although it has been shown that persistent and intensive street out-reach work and early interventions are effective (Craig, 1995; Marcos *et al.*, 1990; Sheridan *et al.*, 1993). While older people still have priority rights to housing and community care, through the Housing Act 1996 and the National Health Service and Community Care Act 1990, and their needs should be met by statutory services, a precondition is that they present themselves to local authorities or to health and social care professionals. Few statutory services reach out to older rough sleepers, and even when aware of a need, they are sometimes unable to respond. The Lancefield Street Centre experienced many problems in obtaining both health-care and community care assessments for the residents, and in discharging the care and responsibility of their residents to statutory providers, because the formation at short notice of a concentration of vulnerable and special needs people presented the statutory agencies with intractable problems, not least in finding unbudgeted funds (Crane and Warnes, 1999).

CONCLUSIONS

Recommendations about services for homeless people and remedies for homelessness will always be contentious because homelessness has different causes at different times and places. It can be generated by both natural, geopolitical and political-economic conditions and personal states, sometimes independently and often in interaction. Some social formations accommodate the under-socialised, economically unproductive, mentally ill, addicted or traumatised; others abandon or incarcerate these unfortunate people. It may be a systemic tendency of highly developed economies and societies to exclude the least productive. In the absence of reliable familial, religious or community responses to the plight of the least competent, it falls to the government to establish a needs-led, evidence-based and professionalised approach to the support of the least proficient people.

The combination of substantial public funds and of competitive voluntary association and statutory agency providers has produced more specialist and, probably, more effective provision for homeless people. For single homeless people, as for other vulnerable groups, the principle of 'normalising' lives:

has become an increasingly powerful influence, with its emphasis on the rights of service users to be provided with individualised services which respect their dignity, maximise their capacities for independent living, and enable them to be integrated as fully as possible within local communities. (Wistow, 1999, p. 47)

The present approach does, however, have several endemic weaknesses. Much provision relies on short-term funding and is therefore insecure, which sits uneasily with the time required to rehabilitate and 'reskill' vulnerable, homeless people. It is labour intensive and costly to set up temporary services, and projects take time to identify effective ways of working, to become known, and to fit into a spectrum of local provision. The vigour, enterprise and merits of short-term projects should be balanced against the diversion of management resources into development and implementation rather than the provision of care, and against the benefits of the continuity and effectiveness of longer-term provision.

The social care market approach emphasises an organisation's competence to deliver relatively simple outcomes, like bed-nights, but is unlikely to foster the accumulation of experience and expertise for social work outcomes or make much contribution to primary prevention. Many service providers are keen to develop models of good practice, and from 1997 the National Resettlement Project has been developing a model of resettlement and standards for its staff (National Homeless Alliance, 1997). Evaluation programmes need to be built into all homeless services so that: (i) the lessons of experimental schemes can be disseminated; (ii) providers become knowledgeable about effective and ineffective care; (iii) appropriate staff training courses can be designed; and (iv) scarce resources can be targeted on key services. Few are convinced that changes in fiscal, education, employment or social housing policies are sufficient to eradicate homelessness. Policies and welfare practice must extend into the identification of the prevalent pathways into homelessness, the critical states and thresholds, and ways of detecting and responding to vulnerability and high risk. This will require a shared responsibility among independent providers and procedures that straddle housing, social and health service providers.

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