Building Homelessness Prevention Practice: COMBINING RESEARCH EVIDENCE AND PROFESSIONAL KNOWLEDGE

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The authors and their recent reports
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Introduction

This report is a contribution to the development of services to prevent homelessness. Over the last 15 years, services for rough sleepers and other homeless people have developed considerably in Britain. The number of people sleeping on the streets has reduced, hostel accommodation has improved, and much more active resettlement preparation and follow-up tenancy support are in place. In addition, special measures have been taken to reduce the number following specific pathways into homelessness, e.g. young people leaving statutory care, and people being discharged from the armed forces and prison. These groups are unusual in being a ‘captured audience’: they are already in contact with professional welfare staff, their departure date is usually known in advance, and with appropriate staff and resources housing can normally be arranged.

These groups make up, however, only a small fraction of those who become homeless. Even if rough sleeping has declined, there is no evidence that the annual incidence of new cases of homelessness has reduced. While the last few years have seen increasing emphasis in government policy on prevention, as with the exhortation to reduce both the ‘revolving door’ syndrome (the movement ‘in and out’ or ‘circulation around’ hostels) and repeat applications to local authorities for priority re-housing, few practical ideas for prevention measures that can be applied to the general, community-living, population have emerged.

The contribution of this report is based on prevention proposals that the authors developed from new research evidence, and the reactions of various professionals to those ideas. More precisely, the report contains prima facie evidence of other particular pathways into homelessness with a relatively high percentage of ‘avoidable’ cases. The evidence comes from a recent study of the causes of and pathways into homelessness among people aged 50 or more years. It then sets out our views of practice changes that might have prevented what we argue were ‘avoidable’ cases, and summarises the opinions of a small number of health, social service and housing staff about these proposals. It also gives examples of prevention practice innovations that local authorities and other professional agencies are running successfully, several of which we were told about by the professionals who we consulted. In other words, the report includes a synthesis of professionals’ views and knowledge about what they believe to be effective homelessness prevention among the general population.

The research study

The research evidence came from a comparative study into the causes of homelessness among older homeless people in England, Boston (Massachusetts) and Melbourne (Australia) that was completed in 2003. The aims were: (i) to increase understanding of the reasons for homelessness
among older people, and (ii) to inform prevention practice, by identifying the sequences of events that precede homelessness, and the risk factors and ‘early warning’ indicators of serious difficulties. The conceptual model underpinning the study was that homelessness is a function of structural and policy factors, health and welfare service organisation and delivery factors, and personal problems, incapacities and behaviour. The main instrument of the research was an interviewer-administered survey of recently homeless people and their key-workers. The featured topics were the subjects’ backgrounds, recent housing biographies and problems, and the policy and service context in which they became homeless.

Interviews were conducted with 131 people who became homeless during the previous two years and were aged 50 or more years when they became homeless. People who had been homeless before were included if they had been housed for at least 12 months prior to the current episode of homelessness. In England, the sample was obtained by referrals from street outreach teams, tenancy support teams, hostels, day centres, local authority homeless persons’ units, and housing advice centres, and the sample was drawn from 22 organisations, mainly in Birmingham, London and Sheffield (Table 1.1).

Table 1.1 Source cities of the respondents

<table>
<thead>
<tr>
<th>Location</th>
<th>Men</th>
<th>Women</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>London</td>
<td>51</td>
<td>4</td>
<td>55</td>
</tr>
<tr>
<td>Sheffield</td>
<td>25</td>
<td>5</td>
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</tr>
<tr>
<td>Birmingham</td>
<td>24</td>
<td>2</td>
<td>26</td>
</tr>
<tr>
<td>Nottingham</td>
<td>9</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Manchester</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Leeds</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Doncaster</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>114</td>
<td>17</td>
<td>131</td>
</tr>
</tbody>
</table>

The formation and testing of the prevention proposals

Among the principal findings of the English study were that approximately two-thirds of the respondents had *never* been homeless before, most cases of homelessness had multiple causes, and that a large minority were associated with vulnerabilities and pathways that could readily have been identified and averted. In particular, three pathways included a high percentage of apparently avoidable cases, namely homelessness (i) following bereavement, (ii) associated with mobility or functioning difficulties derived from physical and mental health problems, and (iii) prompted by rent arrears due to Housing Benefit claims, renewals or payment delays. These three pathways amounted to 34 per cent of all cases. Section 2 presents the findings more fully.

Drawing on the research findings, a Discussion Paper set out our practice innovation and development proposals. Two broad questions were asked about what could be done by service-providers and professional groups to identify or ‘case-find’ older people who are at high risk of
becoming homeless, and how could they respond more effectively to the needs of these people. These questions translated into several day-to-day practice questions, such as the feasibility of housing providers setting up monitoring systems to detect changes in rent payments and uncharacteristic rent defaults, and the most appropriate agency to investigate the underlying circumstances. The Discussion Paper was circulated with an invitation to a workshop and a request for written feedback to health, housing and social welfare managers and front-line staff likely to come into contact with older people at risk of homelessness. Variant questions for the different professional groups were then posed at the workshops. Six were held with staff from housing providers, social services departments, tenancy support teams, advice centres and primary health care services, and one was held with older people who had become homeless.

More than sixty people attended the staff workshops. The details are:

1. The Homeless Working Group of the London Standing Conference for Nurses, Midwives and Health Visitors (viz. ten primary health-care nurse practitioners).
2. The Health Inequalities Special Interest Group of the Royal College of General Practitioners (viz. eight GPs).
3. Social housing management and tenant support staff in Sheffield (viz. 14 people from local authority housing and social services departments, social housing providers, housing advice agencies, and tenancy support teams).
4. Tenancy support teams in Sheffield for older people (17 staff).
5. Twelve staff in London from homeless sector services, social services departments, housing associations, housing advice agencies, and tenancy support teams.
6. Six older people who had newly become homeless. Three had been interviewed for the study, the others became homeless later. The workshop was held at St Mungo’s Harrow Road Hostel in London.

The workshop exchanges with staff included discussion of the likely preventability of different causes of and pathways into homelessness – in effect, an evaluation of our interpretation of the research findings. The participants provided their own examples of preventable cases and how they had been and could be avoided, and gave examples of working prevention practice. Many suggestions were made about ways in which they and their colleagues could advance prevention, often through improved assessment and more or better joint working with other agencies.

Prior to the workshop for older people who had become homeless, the participants were asked to think about what would have helped them when they were having difficulties at home. Suggestions from the staff workshops were also put to them. The older people described ways in which they had been let down by services, the difficulties of getting help, and suggested ways that services could be improved. They also discussed the merits and problems of some of the ideas made at the staff workshops.
The practice recommendations presented in this report have been developed from the suggestions and information received during the workshops. They are offered for the consideration of local service commissioners and managers. Many of the examples given of prevention practices are, however, new and have not been formally evaluated. The next section of the manual summarises the pathways into homelessness for the English respondents in the study. Sections 3 to 5 discuss the contributions that housing staff, tenancy support workers, and health-care workers can make to the prevention of homelessness. Section 6 discusses the case for more homelessness prevention and the practicalities of prevention measures.
Pathways into homelessness and prevention

This section describes the research study on which the prevention proposals were based and the main findings about pathways into homelessness. It focuses on the pathways and sequences of events that produced cases of homelessness that might have been prevented if they had been detected at an early stage and appropriate responses deployed. Examples of six ‘avoidable’ pathways are given. The section concludes with a preliminary discussion of what constitutes appropriate and effective homelessness prevention. It distinguishes those prevention practices that could readily be introduced by managers and front-line workers from those that require more strategic changes, such as population screening, new services, or radical changes in the responsibilities of existing agencies and staff.

The subjects’ characteristics

In England, 114 men and 17 women were interviewed for the study. Two-thirds were aged 50-59 years and most were born in the UK. Nearly two-thirds were separated or divorced, 28 per cent had never married, and five per cent were widowed. Their histories were diverse. Two-thirds had never been homeless before. Some had lived in their last housing for many years either as owner-occupiers or local authority tenants until a stressful event or change in their circumstances resulted in their eviction or abandonment. A second group had not previously been homeless but had recent unstable housing histories and had lived for a few years in ‘insecure’ housing. Some had been renting from private landlords or lived in accommodation attached to jobs, while others had been staying with friends or in shared housing. Many became unsettled and moved several times before they became homeless. A third group had previously been homeless and then had been rehoused in accommodation rented from the local authority or a housing association.

Health problems, poor coping skills, social isolation and a lack of contact with services featured strongly in the subjects’ histories. Before becoming homeless, 71 per cent suffered from physical illnesses, 60 per cent were depressed or had other mental health problems, and around one-third had been heavy drinkers. Most with physical health problems had received treatment, but only one-half who reported mental health problems had treatment before they became homeless, and only a minority were under the care of psychiatric services. According to the key-workers’ accounts, 10 per cent had known or suspected literacy difficulties, and for one-quarter (24%) poor daily living skills were believed to have contributed to homelessness.

One-half of the subjects had been living alone, and around 40 per cent had had no contact with relatives or friends during the previous few years. Only 11 per cent had received help from home and community support services before they became homeless, including eight who had...
help at home from a housing support worker, and three who had attended a day centre or luncheon club. The subjects in housing association tenancies and with alcohol or mental health problems were those most likely to have been receiving ‘tenancy support’ or ‘social care’. One-half said that they did not seek help when they were having difficulties. Some did not know where to go for help, while others were unaware of their problems and believed that nothing could be done to resolve them or that they were ineligible for services.

**Pathway 1: The death of a relative or ‘carer’**

Thirteen subjects reported that the death of a relative or ‘carer’ had contributed to them becoming homeless. They described two ways in which they became homeless. Some men abandoned the accommodation after their wife died, because they were depressed and distressed, and found it too painful to remain in the home. In Bill’s case (the name has been changed), he gave up his home and job soon after being widowed, left the area where he had lived for years, and slept on the streets (Box 2.1). His wife had died unexpectedly soon after being diagnosed with a serious illness; and shortly before his mother had died. The close succession of the bereavements may have been too much for him to bear: his key-worker believed that his reaction was to begin drinking heavily.

Other studies have also found that a traumatic event, such as the death of a close relative, leads to depression, unsettledness and homelessness (Crane 1999; Goodman *et al.* 1991; North and Smith 1992). Widowhood is stressful and requires significant readjustments. It is believed to have a greater impact on men than women because they are generally more isolated and have fewer close friends (Stroebe and Stroebe 1983). Most men who become widowed do not however become homeless. The outcome implies the absence of relatives, friends or supporters to help the person through the transition. In Bill’s case, he was unable to discuss his emotions with his immediate family. Bereavement counselling may have helped him through the grief.

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**Bereavement leading to distress and abandonment**

Bill was 54 years old when he became homeless for the first time. He had lived in a private-rented flat in Cambridge with his wife for 25 years, and had always been in work. His wife was suddenly diagnosed as having cancer and she died just one week later. This was a great shock to him, particularly as shortly before his mother had died. Bill was still working at the time. He said that he was devastated by his wife’s death and became depressed. He found it painful and distressing to stay in the marital home because of the memories. He received medication from his GP but did not ask for other help as he was not bothered what happened to him. He had weekly contact with his three children and father but did not tell them about his problems – he did not want to be a burden on them. He denies drinking heavily after his wife died, but the case-worker believes that this was the case. He gave up his home and job just two months after being widowed, travelled to London, and slept on the streets.
A second pathway from bereavement to homelessness involved some of the subjects who had lived with a parent or spouse who had been responsible for carrying out the household tasks including paying the rent and bills. After their deaths, the subjects were unable to cope on their own and were evicted for rent arrears. Most had mental health or literacy problems and poor daily living skills. Some did not understand about paying rent while others failed to renew a Housing Benefit claim. For many years it has been recognised that some people who have poor social and daily living skills are at risk of becoming homeless after the death of a long-term supporter or ‘carer’, usually a spouse or parent (Crane 1999; National Assistance Board 1966; Walker et al. 1993). This was Peter’s situation, a man with very limited basic living skills (Box 2.2). There were manifest signs that he was not coping with living alone, as when he failed to re-register with the primary care practice and rent arrears began to build. Although we only have information from Peter about the attempts to advise and support him and about his responses, the ‘descent’ into homelessness appears to have been preventable at several points.

Rent arrears and eviction following the death of the main ‘carer’  

<table>
<thead>
<tr>
<th>Box 2.2</th>
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<tr>
<td>Peter had been married for 27 years and had lived with his wife in a council flat in London. He became homeless for the first time at the age of 55 years. Peter suffers from epilepsy and is illiterate. Throughout the marriage, his wife managed all the paperwork and finances. Peter had not worked since being made redundant when he was 49 years old. In 1999, Peter’s father died and a few weeks later his wife died suddenly. Peter became depressed and drank heavily. He could not cope with household tasks or the payment of bills. He did not renew his claim for Housing Benefit and so rent arrears built up. A housing benefit officer visited three times, and Peter believed that the claim had been sorted but this was not the case. Two years after his wife died he was evicted because he had rent arrears of £15,000. Although a housing benefit officer visited, Peter believes that the person ‘did not explain things properly’ and that this was amplified because he was depressed and ‘could not take things in’. Peter received no support or help for his depression or heavy drinking after being widowed. He had three sons but rarely saw them. He visited his mother once or twice a month and she gave him food and money. Although he suffered from epilepsy, he was not registered with a GP and received no treatment. His former GP had died and Peter said that he had not followed through with the re-registration procedure. He cannot recall receiving an eviction notice or a court repossession order (which he would have been unable to read). When the bailiffs arrived, they gave him 10 minutes to vacate. He left his possessions and furniture behind and slept rough.</td>
</tr>
</tbody>
</table>

For the 13 cases where the death of a relative or ‘carer’ resulted in homelessness, there was a characteristic sequence after the bereavement, involving first a change of tenancy or of the person paying the rent, followed by social isolation and the beginning of either protracted depression or
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rent defaults. The pathway leading to rent arrears would in most cases have been readily identifiable through routine housing management records. The progression through the ‘protracted depression pathway’ is more difficult to detect, and primary health care-workers could have a valuable role here. They may be aware of patients who have recently been bereaved and should be alert to changes in their mental states. If questions were asked about how they were managing at home, difficulties may be detected.

Pathway 2: Ill-health leading to mobility and functioning difficulties

More than one-third of the interviewees said that physical or mental health problems were a factor in them becoming homeless. Twenty-four associated their homelessness with physical illnesses and disabilities, and 29 said that depression or other mental health problems had been contributory factors. Some people had had to stop work because of ill-health and subsequently experienced financial difficulties, while several said that ill-health led to family and marital problems and relationship breakdown (discussed later). For one-in-six (17%) of the subjects, mobility and functioning difficulties arising from ill-health meant that they could no longer manage in their accommodation, and this led to them becoming homeless.

Nine subjects said that their housing was unsuitable once they became physically ill or were injured, mainly because of access difficulties. Frank’s case illustrates the sequence (Box 2.3). Information is available only from Frank about what attempts there were to help him and his reactions, but his ‘descent’ into homelessness appears to have been preventable. An assessment

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**How Frank’s accident contributed to homelessness**

Frank was born in Ireland, served six years in the British army, and then settled in England and worked until retirement at 66 years of age. He never married, and his only relatives are a brother and sister in Ireland. When in work, he used to drink heavily, but since retirement he has just a couple of pints of beer each day. He became homeless for the first time when he was 78 years old, having lived for 20 years in a Housing Association shared house with five other tenants. Frank had his own room on the top floor – there was no lift and three flights of stairs. He enjoyed living there until he had an accident and was admitted to hospital, where his toes were partially amputated.

When discharged from hospital, Frank received physiotherapy for a few weeks at the hospital but found that he could not manage the stairs. The landlord moved Frank’s bed to a ground floor communal lounge. Frank found the arrangement unsatisfactory because he had no privacy and it disturbed the other tenants who used the room to watch television. Frank decided that he needed more suitable housing, and approached a housing advice centre. The advice worker contacted Frank’s housing provider, but they said that no appropriate housing was available and that his only option was to give up his home and move into a hostel (which he did).
of his housing situation prior to the hospital discharge or while under the care of the physiotherapists would have identified its unsuitability. Moreover, when the housing provider became aware of his predicament, despite Frank’s age and eligibility for priority re-housing, he was informed that no appropriate housing was available. According to Frank’s account, he had not been seen by a social worker since his injury. This suggests that neither the hospital staff nor his housing provider referred his case to social services. The problems of premature and poorly managed hospital discharges and people being discharged to unsafe environments are well-documented (Health and Social Care Joint Unit and Change Agents Team 2003).

Fourteen subjects said that mental health problems made them lethargic, unable to cope and unsettled, and so they gave up their tenancy. Most were living alone and had no support. Other British studies have also found that some mentally-ill people become homeless because they are unable to cope at home (Craig 1995; Crane 1998; Crockett and Spicker 1994). Dementia and paraphrenia (late-onset schizophrenia) are forms of mental illness that present in later life, and can affect the ability of some older people to manage at home. Some are evicted because of squalid living conditions or a failure to pay rent; some abandon their accommodation because of persecutory ideas about relatives or neighbours; and some are confused or mentally disturbed and wander away from home.

Most of the study subjects whose housing was unsuitable because of physical health reasons had treatment from their GP and some also had hospital care. Among the 14 who said that they could not cope at home because of mental health problems, six had medication from their GP, six had no treatment, and only two were under the care of mental health services. The study’s findings suggest that health service providers are failing both to detect mental health problems among clients and to identify unmet support needs among people who are mentally or physically ill. Although it is hard to identify people with health problems and unmet needs if they are isolated and unknown to services, it is likely that ‘front-line’ health workers, i.e. primary health care and community mental health teams and hospital staff, come into contact with older people who are struggling in tenancies and at risk of homelessness.

Pathway 3: Rent arrears due to Housing Benefit claims or payment problems
Twenty-six subjects (20%) became homeless after being evicted for rent arrears, and nine others abandoned their tenancy because they could not afford the rent. In many cases, the arrears were associated with Housing Benefit (HB) claims, renewal or payment problems. Four people failed to return their HB renewal form and so rent arrears built up. All had mental health or literacy problems and were living alone. As in Peter’s case, described earlier, his wife had been responsible for their finances and he could not manage when she died. Six respondents returned the HB renewal form but there were administration problems and the benefit was not paid. The pathway is exemplified by John’s case (Box 2.4). Five subjects could not afford rent after they stopped work and were unaware of their entitlement to HB. Another four in private-rented
accommodation needed HB to be able to pay the rent after they stopped work, but the landlord refused to accommodate HB-claimants and evicted them.

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**Housing Benefit payment problems leading to rent arrears**

John first became homeless when he was 63 years old. For most of his adult life, he had worked and lived in private-rented accommodation. After retirement, he could not afford the rent but did not know that he was eligible for Housing Benefit. He therefore gave up his tenancy and slept rough. He had no family contacts – both his parents had died and he did not see his only sibling. He had been married, but had divorced years earlier and had no children. He was found on the streets by an outreach team, and transferred to temporary accommodation where he stayed for a few months. Later he was rehoused in sheltered accommodation managed by a co-operative housing association.

John became homeless for a second time at the age of 72 years, when he was evicted from his sheltered flat for rent arrears of nearly £3,000. He had lived there for two years and it appears that the arrears accumulated over 18 months, but John denied any knowledge of them and said that there had been no correspondence. He said that he returned his Housing Benefit renewal form, and had regularly paid each week from his state pension the service charge of £10.40 (most of his rent should have been paid through Housing Benefit). From John’s own account, the first he knew of the arrears was when the secretary of the co-operative called to inform him that he was to be evicted. John said that he went to two housing advice services for help, and showed the staff his eviction notice. Both agencies said that they were unable to help him.

The HB system is complicated and there have been endemic problems with its administration (Audit Commission 2002). Local authorities are responsible for assessing and paying HB claims, but flawed assessments and delays in payments frequently occur and lead to rent arrears and occasionally eviction (Phelps and Carter 2003). These difficulties are well known among housing and tenancy support staff. In the case of John (Box 2.4) and several others, it is unclear why his rent arrears were allowed to accrue to the point of eviction. The housing provider must have known from their records that the HB element of his rent was not being paid. It would have been helpful to both John and the landlord if a worker had intervened when arrears began to grow and helped to sort out the payments.

Changes are underway to improve the HB system. Until October 2003, HB claimants were required to renew their claim at least every 60 weeks. Elderly people and those with mental health problems were often confused by this requirement and failed to complete the renewal forms (National Association of Citizens’ Advice Bureaux 2002). From October 2003, HB for pensioners is now awarded for up to five years before renewal. Another radical proposed change applies to private-sector tenants – instead of HB being paid directly to the landlord (as now), a
flat-rate ‘local housing allowance’ will be paid to tenants who will then pay the rent and keep any surplus. The scheme is being piloted in nine towns and cities, including Leeds and the London Borough of Lewisham. Concern has been raised however that vulnerable people with poor budgeting skills will not pay rent and will accrue arrears, and that private landlords will be increasingly reluctant to let their properties to social security claimants as their rent will no longer be guaranteed (Hawkey 2004).

**Pathway 4: Mental health and alcohol problems that contribute to relationship breakdown**

Twenty-one men and eight women associated their homelessness with the breakdown of a marital or cohabiting relationship, among whom 18 blamed heavy drinking or depression for the deteriorating relationship and separation. Several linked the onset of these problems to a specific stress, most often redundancy, having to stop work for physical health reasons, or the death of a close relative. After the relationship ended, some subjects immediately became homeless, while for others the pathway was a move to private-rented accommodation where they did not settle and which they abandoned after a few months. Most did not seek help to find alternative housing. Some said that they did not know where to go for advice, while others believed that they would be ineligible for priority re-housing by the council. Most were aged in the fifties when they became homeless. Brian’s case exemplifies the pathway (Box 2.5).

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**Box 2.5**

**Relationship breakdown leading to homelessness**

Brian, a Sheffield steelworker, separated from his wife in his early thirties but formed a new relationship and lived with his partner for 22 years in a council house. The tenancy was in his partner’s name. When he was 44 years old, Brian suffered a back injury at work and afterwards was unemployed on health grounds. After stopping work, he suffered from panic attacks and spent most of his time at home drinking heavily and sleeping. He received substantial compensation from his employer and Incapacity Benefit of £92 a week, much of which he spent on drink. He was admitted into hospital for detoxification, but subsequently resumed heavy drinking.

Twelve months before he became homeless, his mother died. He was depressed and his GP prescribed medication. His relationship with his partner was deteriorating, and a point was reached when his partner demanded that he stop drinking or leave the house. As Brian was neither the tenant nor willing to address his alcohol problem, he had to leave. He had two children and nine siblings but had had no contact with them for years. He had no idea of where to get help and so asked a neighbour to put him up. The neighbour contacted a hostel on his behalf. He left his partner’s house and became homeless for the first time in his life at the age of 54 years.
The breakdown of a marital or cohabiting relationship is commonly cited in applications to local authorities for priority re-housing and in survey reports as a reason for homelessness, but the sequence or pathway is exceptionally difficult to prevent. Family mediation services attempt to help the members repair strained relationships and, generally, to remain as a single household. Clearly, premature help to find alternative housing could have the opposite effect. Local authorities only accept responsibility for re-housing the ‘priority needs’ groups designated in statutory instruments, such as those with dependent children or physical or mental disabilities, and people aged in the fifties (and men in the early sixties) who leave the marital home are not entitled to social housing unless they have serious health problems. They often have few housing options other than to rent in the private sector. This distances them from social housing providers and housing professionals with welfare insights and responsibility.

In a few cases, interventions at an early stage for people who are depressed or drinking heavily might however help to prevent relationships breaking down. According to Brian, his problems began with his industrial injury and with having to stop work when relatively young, and they appear to have worsened after his mother died (Box 2.5). He was admitted into hospital for detoxification and later treated by his GP for depression, but these interventions were insufficient to prevent the breakdown of a long-standing marriage. More specialist help from mental health and alcohol workers might have helped him adjust better to the stresses of his injury and to his mother’s death.

Pathway 5: Harassment leading to forced displacement

Eleven subjects (8%) abandoned their homes because they could no longer stand harassment and vandalism by local people. Most had mental health problems and were vulnerable. One such man had been the victim of persistent abuse from local youths since his mother had died. He had always lived with his mother, had literacy problems and poor coping skills, and was evidently recognised by local youths as defenceless. In London, a few subjects became homeless because heavy drinkers and drug users moved into their accommodation, created an intolerable situation, and the subjects either abandoned the tenancy or were ousted out by the new arrivals. This is exemplified by Alf’s case whose vulnerability is manifest (Box 2.6). Despite complaints by Alf’s sister and the neighbours to the local housing department, Charlie and his mates lived in Alf’s flat for more than two years while Alf slept on the streets.

Such a situation is not unique. There have been several reports in recent years of heavy drinkers or drug users moving into the homes of elderly and mentally ill people in London. In Camden, a 75 year old man was turned out his flat by drug users.1 Other cases have been

reported in Catford and Streatham. On 11th September 2003, a debate in the House of Lords on the Anti-social Behaviour Bill raised the issue of crack dealers taking over the homes of vulnerable people, and intimidating and threatening them. Speakers expressed concern that elderly people might be deprived of essential support if drug dealers stopped welfare professionals from entering the accommodation, and that they would lose their homes if the premises were ‘closed’.

Vulnerable people forced to abandon their tenancies

Alf became homeless for the first time in 2001 when he was 65 years old. He was born in Ireland and came to London in 1969. At first he lived in a lodging house, and was later offered a council flat where he lived for 20 years. He never married and worked until he was made redundant at the age of 58 years. He has had a severe speech impediment since childhood and it is difficult to understand what he says. He did not drink heavily while employed, but after being made redundant his alcohol consumption increased (as his sister confirmed). One year after stopping work, he had a hip replacement as he was suffering from arthritis. On discharge from hospital, his vulnerability was recognised and arrangements were made for him to receive home-care services and meals-on-wheels. According to Alf’s sister, the services stopped after a few months because he was drinking heavily and unco-operative.

From 1995 until 2000 Alf continued to live alone and to use the local pub. His sister visited him regularly and had a key to his flat. In 2000, Alf allowed a heavy drinker from the pub, Charlie, to stay in his flat. Shortly afterwards, five of Charlie’s circle of heavy drinkers took over Alf’s flat. They stole his social security benefit book and cashed his money each week. They caused persistent problems for the neighbours, were noisy and disruptive, and smashed windows and doors when drunk. They locked Alf out and, as he had nowhere to go and his sister could not accommodate him, he slept rough nearby.

When Charlie moved into the flat, he changed the locks and would not allow Alf’s sister to visit. She was intimidated by the drinkers and did not pursue this. According to her, she and the neighbours complained several times to the housing department about the situation but no action was taken. The rent was paid through Housing Benefit and it appears there were no arrears (which might have initiated action by the housing department). Alf had originally claimed Housing Benefit and the payment continued after he left, as Charlie and his mates returned the renewal forms on Alf’s behalf. At the time of Alf’s interview, Charlie and his friends were still in the flat and had been there for more than two years.

2. ‘Renewed pride on changed estate’. http://icsouthlondon.icnetwork.co.uk/0100news/0500lewisham/page.cfm?objectid=12862028&method=full&siteid=50100
Preventing homelessness in such cases requires collaboration between the police and housing providers. The Anti-social Behaviour Act 2003 enables premises to be closed where drugs are used unlawfully, but consideration has also to be given to the elderly person who may lose their home. In May 2004, the London Borough of Southwark produced a Crack House Protocol, which is a joint agreement between the police, the Council, registered social landlords and voluntary agencies, including Southwark Drug and Alcohol Action Team.\(^5\) It includes steps to offer support and re-housing to elderly and other vulnerable people who have been ousted from their accommodation by drug dealers.

**Pathway 6: Disruptive behaviour leading to eviction**

Nine subjects became homeless because they or their friends were noisy and disruptive, which led to complaints from neighbours and eventually eviction. They were all heavy drinkers and allowed other drinkers to congregate in their accommodation. All except two received a great deal of help from tenancy support workers in the months before they were evicted. Seven of this group had not previously been homeless. Bert was one of the exceptions – he had a long history of homelessness (Box 2.6). Although he had been rehoused, he continued to mix with his street drinking friends and to hold ‘drinking schools’ in his flat even though he knew that this put his tenancy at risk. He had had no family contact for many years, and his social network was entirely made up of homeless people and street drinkers. This pathway among heavy drinkers, a cycle of being re-housed, disruptive behaviour, eviction and repeat homelessness, is well-documented (Crane and Warnes 2002).

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### Box 2.6

**Heavy drinking leading to complaints from neighbours and eviction**

Bert first became homeless at the age of 33 years when his marriage ended. For the next 20 years, he worked intermittently and was homeless for long periods. He had been a heavy drinker for years, had poor memory, suffered from epilepsy and depression, and had been prescribed Valium. Without supervision to budget and to pay bills, he spent all his money on alcohol. He had no family contact. He was eventually rehoused into a Housing Association flat in a block with a resident caretaker. After being rehoused, Bert received weekly help from a tenancy support worker with shopping, budgeting and paying bills. He continued to socialise with street drinkers (a long-standing habit), and let them drink in his flat. They disturbed and were aggressive to the neighbours and the caretaker, and smashed the entry door on several occasions when the caretaker tried to stop them coming in. Bert was drunk repeatedly and on many occasions had to be escorted to his room by the caretaker. The other tenants complained several times about noise and threatening behaviour, and one year after moving in Bert was evicted.

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\(^5\) Available online at http://www.safersouthwark.org.uk
Helping people with difficult and inconsiderate behaviour to retain tenancies is very challenging. There is neither sufficient specialised accommodation nor effective ‘tenancy support’ to curb their anti-social behaviour and the eventual consequence, eviction. In June 2004, the government announced new approaches to anti-social behaviour, including powers to require ‘nuisance neighbours’ who have been evicted to attend rehabilitation programmes, which will include courses on basic living skills and ‘social responsibility’, before they are re-housed. These programmes will however be costly. The ‘Dundee Families Project’, developed by the City of Dundee Housing and Social Services Departments in partnership with the NCH Action for Children Scotland in 1996, assists families who are at risk of homelessness as a result of anti-social behaviour. Intensive support is given to four families who reside in clustered accommodation and outreach support to others in dispersed tenancies. In early 2000, the scheme cost about £345,000 per year. Its long-term effectiveness is unknown, but an independent evaluation found that the behaviour of a few families deteriorated and neighbour problems were renewed once they no longer received support (Dillane et al. 2001).

For many older people who have long histories of heavy drinking, chaotic behaviour and intermittent homelessness, long-term supported accommodation rather than rehabilitation programmes may be the most realistic option. Many have serious physical health problems and cognitive deficits as a result of years of heavy drinking, and are unable to live independently. Moreover their comradeship with other heavy drinkers has been their only social contact for many years, and if this is taken away then they could become isolated, lonely and depressed.

**Preventing homelessness**

Six distinct pathways into homelessness with many presumptively avoidable cases have been described. Most involved a combination of personal problems, poor living skills, policy or welfare-state support gaps, and service delivery deficiencies. For some subjects, their behaviour rather than external factors triggered homelessness. For several others, homelessness occurred because they could not manage when their circumstances changed, and there was a failure on the part of professional workers to recognise their difficulties and intervene. Other cases involved problems with the administration of services and poor collaboration or information co-ordination among different agencies.

There are likely to be preventable cases on many other pathways into homelessness. One example is the chain that links heavy drinking with difficulties at work, the loss of a job, rent arrears or relationship problems and homelessness. Early interventions that correct the foundation problem manifestly will reduce homelessness, but the connections between the cause and the outcome are so extended that large scale interventions could not be justified as homelessness prevention. Practical homeless prevention in almost all cases will be directed at three groups of people: those who are already experiencing housing difficulties, those who at a known date will require housing and can be predicted to have difficulty making their own
Building homelessness prevention practice

arrangements (as with care leavers and those being discharged from the armed services), and those who are or are potentially vulnerable to housing stress through poor living skills, ill-health, or impaired functioning.

Turning to the opportunities that can be created to interrupt the chain of causes and effects that lead people into homelessness, it is suggested that the six identified pathways can be organised into three groups that require different policy and service responses. This first group are the pathways in which the subject loses control of their home situation or fails to cope with increasing housing difficulties that are not primarily or entirely of their own making. The common denominator is that they are cases of vulnerable people who run into severe housing difficulties through benefits and services limitations and maladministration. These cases have been exemplified by the subjects who became homeless after their main carer died, by those who experienced impaired functioning through ill health, and by those who accumulated rent arrears through Housing Benefit maladministration (Pathways 1-3). To combat these cases, small administrative changes and low technology aids could surely be adopted. Monitoring systems could easily be introduced by managers and front-line workers to detect people in these categories? Once the severe vulnerability is identified, there are many ways in which appropriate advice and support can be orchestrated.

The second group are the cases of vulnerable or mildly irresponsible people whose actions have compounding harmful effects, but for whom early interventions, advice and support could in some cases reverse the descent into homelessness. They are exemplified by Pathways 4 and 5. While there are many more of these cases than in the first category, realistically only a lower percentage are likely to be preventable. It is intrinsically difficult to identify people in this category as many are unlikely to be in contact with health and welfare services. Nevertheless, help at an early stage for people who are identified as depressed or drinking heavily might prevent the irreparable breakdown of marital and family relationships and subsequent homelessness. Screening by front-line workers, such as primary health-care teams, might detect some of these cases. It is also recognised that if housing advice and particularly alternative housing is offered prematurely, it may encourage rather than mend partner estrangement and separation, which could perversely increase financial pressures or loneliness in the fissured households.

The third set of opportunities to prevent homelessness concerns those cases of people exhibiting feckless and irresponsible behaviour and who are neither restrained nor helped by current community policing and tenancy support arrangements. They have been exemplified by Pathway 6. This is again a relatively small group but they are by definition ‘known’ or identified. The required response is however quite different to that of the first group, for minor changes in existing practice, responsibilities or awareness will be insufficient. The requirement is for intensive new services, such as specialised accommodation and intensive tenancy support to help
and persuade them to control their anti-social behaviour and to sustain housing. Such specialist projects are costly and there is no requirement on local authority housing or social services departments to provide them. If homelessness is to be prevented among people with very difficult and challenging behaviour, new policy, funding and tenancy support arrangements are required.

The subjects interviewed in our research became homeless between 1999 and 2003, but recent years have seen a substantial increase in services to prevent homelessness, such as tenancy support teams, housing advice and debt counselling. Collaboration between local authorities and voluntary sector agencies has improved, and new primary care services that target under-served and disadvantaged groups have proliferated. The next sections discuss the ways in which housing staff, tenancy support teams, and health-care workers can detect and respond to older people at risk of homelessness and give examples of these schemes.
Building homelessness prevention practice

3

Housing managers and staff

Social housing managers and staff could play a valuable role in identifying and responding to older people who are at risk of losing their accommodation and becoming homeless. They will be aware when rent arrears begin. They may also become aware of disputes and harassment between tenants and their neighbours, and of tenants who are experiencing problems with accessing or maintaining their home. This section describes ways in which housing officers and local estate managers could identify and respond to some of these problems. Several housing providers have already developed schemes to help people sustain tenancies and examples of these are given. This section does not cover tenancy support services, which are described in Section 4.

Monitoring rent arrears

Monitoring systems could be set up to alert housing managers of rent arrears among vulnerable people. The ‘warning signs’ are changes in the pattern of rent payments and uncharacteristic rent defaults, particularly if a person has recently taken over a tenancy, lives alone or is known to be vulnerable. It may be that the person is having problems claiming or renewing Housing Benefit, or that their mental health is deteriorating, or that they are unable to cope. At present, rent defaulters are sent standard letters, but some older or vulnerable people cannot read, and some are scared by official letters and do not open them. If home visits were carried out in cases where people had arrears but did not respond to a standard letter, then an assessment could be made of the reasons for the arrears.

In the clients’ workshop, several attenders said that they would have welcomed a visit rather than a letter from a housing officer when they were having difficulties. They were stressed and depressed at the time, and did not feel able to tackle their rent arrears alongside other problems. Several housing staff who attended the workshops believed that there could be improved monitoring for rent arrears within social housing, but raised concern that older people in private-rented accommodation would be missed. One idea was that the council tax is a common thread and that it might be possible to develop a system using this as a starting point.

Examples of good practice

Some local authorities have designated workers who are responsible for investigating rent arrears, and a few have developed ways of identifying at an early stage when Housing Benefit claims are not renewed. The Housing Benefits Department of Brighton and Hove City Council alerts its Homelessness Prevention Team when a Housing Benefit renewal form is not returned within four weeks. The team follows this up with the claimant and can help with the completion of claim forms (Brighton and Hove City Council 2003). Colchester Council has developed a ‘Vulnerable Claimant Register’ to keep track of Housing Benefit claims among vulnerable people (Box 3.1).
Westcountry Housing Association in Devon and Cornwall has also introduced an IT system to monitor arrears (see Box 3.2).

Box 3.1 The ‘Vulnerable Claimant Register’, Colchester Council, Essex

Colchester Borough Council introduced a ‘Vulnerable Claimants Register’ in 2002 because of the failure by many vulnerable people to renew their claim for Housing Benefit (HB). People who are at risk of not renewing their HB claim are placed on the register. Renewal forms for HB are sent out 10 weeks before the existing claim finishes, and a reminder is sent out four weeks before the expiry date. If the people on the register fail to return their claim form, they are contacted by a HB visiting officer who gives help with submitting the forms. Older people are the largest group on the register, followed by people with learning disabilities and mental health problems. About seven or eight names are added to the register each week, and by the end of 2003 it was expected to contain around 1,000 names. The council believes that there may be scope for using the register to ensure that tenants receive other forms of support. For details, see Tackling Homelessness: Colchester’s Review and Strategy 2003, Colchester Borough Council.

Box 3.2 Rent Control Team, Westcountry Housing Association

Westcountry Housing Association provides general needs and supported housing in Devon and Cornwall. Approximately 80% of its tenants receive Housing Benefit. It has developed a ‘Rent Control Team’ whose task is the collection of unpaid rent, taking this responsibility away from generic housing officers. With an emphasis on debt prevention and early interventions, the team work proactively with new tenants and with existing tenants when arrears start to build. When people start a tenancy, they are offered help to complete Housing Benefit forms, given an estimation of their Housing Benefit entitlement, encouraged to make regular payments of the shortfall while the claim is processed to avoid the build-up of arrears, and advised to contact the team if they have rent problems.

With existing tenants, they are offered help with the renewal of Housing Benefit claims, and the team liaise with the Housing Benefit department on their behalf. A full-time Welfare Rights Adviser is a member of the team and works with tenants that are struggling to pay rent. Court proceedings are never started if arrears are due solely to Housing Benefit delays. The introduction of a new IT system has helped to improve the recording and monitoring of arrears, which has the ability to separate the arrears attributable to Housing Benefit from other factors. An evaluation of Westcountry Housing Association by The Housing Corporation in November 2001 found that arrears had steadily reduced over the last two years, from 6-7% to 3.5%. Further details: The Housing Corporation Inspection Report: West Country Housing Association LH0945. November 2001.
Providing advice and information

Providing advice and information is important when people are having housing problems. Some older people, however, are unaware of the available help and how to access it. One of the attenders at the clients’ workshop said that he was unsure whether to approach his local housing or social services department when he was having difficulties. At the workshop held with nurses, some said that the impersonal character of many services, the closure of Social Services neighbourhood or local offices, and the demise of rent collectors had increased ignorance about services in the general population.

Holding local housing advice ‘surgeries’ on housing estates or at housing resource centres is one way of reaching out to people with housing problems who are ‘hard-to-engage’ and not in contact with services. They need to be well advertised, easily accessible and user-friendly. Posters about housing advice surgeries could be displayed in places that older people use such as GP surgeries, post-offices and libraries. The nurses at the workshops believed that more leafleting could be done from GP surgeries and by other agencies about local services. Most GP services have mail-outs that they send to older people when they arrange their health checks, and additional information could be included. Another suggestion was that organisations such as Age Concern and the Citizens Advice Bureaux should raise awareness of their services by providing advice to older people at day centres and luncheon clubs and even through television advertising.

Examples of good practice

Some housing providers have established local drop-in advice surgeries on estates and at housing resource centres. Tonbridge and Malling Borough Council in Kent holds weekly housing advice surgeries at three locations. The London Borough of Camden has developed a ‘Caretaker Visiting Service’. A caretaker visits elderly vulnerable tenants who have no support every two weeks to find out if they have problems, and a record is kept of each visit. Estate officers refer tenants who give their consent to the scheme, and if problems are identified during visits, the housing managers then arrange other services or support. Welfare advice services have also been set up in several health centres (described in Section 5).

Help with social security benefit claims, rent arrears and debts

Rent arrears are a serious problem for housing providers and the main reason for evictions. Evictions are however costly for the housing provider in terms of lost rent revenue, legal costs and time, and can lead to homelessness for the people affected. Although of course some people wilfully refuse to pay rent, for many arrears could be prevented or rectified if appropriate help is given at an early stage. Some older people run into financial difficulties when they stop work and need advice about the benefits to which they are entitled as well as help with filling in the claim forms. Some need assistance to chase unpaid Housing Benefit, and some would benefit from help with budgeting and debt restructuring.
At the workshops, several housing staff recognised these needs but described the difficulties that they would have in providing such help. They said that some people are embarrassed about their debts, and it takes time to build trust and rapport before they are willing to discuss the problems. Most housing staff do not have the time to develop a close relationship with tenants and to build trust. Nor do they have the time to undertake follow-up work, such as checking that social security benefits have been sorted out and that debts are being paid.

Examples of good practice

Some housing providers have dedicated welfare rights workers and debt counselling services to advise tenants on their eligibility for benefits, to assist with the completion of claim forms, and to help tenants sort out rent arrears. An example is *Westcountry Housing Association’s ‘Rent Control Team’* (described in Box 3.2). Some providers commission local *Citizens Advice Bureaux* or other specialist advice agencies to provide the service. In April 2004, the *Social Exclusion Unit* published seven *Fact Sheets* for housing, health, employment and other sectors on the problems caused by debt and the actions that can be taken by different agencies (Social Exclusion Unit 2004).

Schemes have also been introduced whereby tenants with rent arrears are given opportunities to sort out their debt as an alternative to eviction. *Cambridge City Council* has developed a ‘Rent Arrears Panel’ through its Housing Management and Homeless Services, which reviews all potential eviction cases prior to a decision being made. Box 3.3 describes *Broadlands Housing Association*’s partnership with *Norfolk Money Advice* to halt evictions. In the *London Borough of Camden* there is a joint housing, social services and health ‘Vulnerability Panel’ which makes decisions on the housing, care and support needs of people with mental health problems or other vulnerabilities who are at risk of eviction. Similarly, in the *London Borough of Tower Hamlets*, the Housing Department notifies Social Services staff of all potential eviction cases, and they work collaboratively with housing officers and other agencies to provide support packages in cases where unmet needs are identified.

**Box 3.3 Halting evictions, Broadlands Housing Association, Norfolk**

*Broadlands Housing Association*, Norfolk, has formed a partnership with *Norfolk Money Advice* to prevent tenants who have debt problems from being evicted. When a ‘Notice Seeking Possession’ is served for rent arrears, the tenant is offered help from *Norfolk Money Advice*. If the person accepts, the legal action is suspended. Likewise, if a tenant agrees to receive help at any stage in the rent recovery process, repossession action is halted to allow alternative strategies to be put in place. A tenancy support worker, employed by *Broadlands Housing Association*, liaises closely with *Norfolk Money Advice* to ensure that tenants are receiving the help they need to sustain repayments. Prior to the scheme, the housing association had increasing rent arrears but since its introduction they have stabilised (described in Phelps and Carter 2003).
Support for new tenants

Starting or taking over a tenancy and all the tasks and changes involved can overwhelm a vulnerable person, especially if they have no support network. People who move into a tenancy may have to apply for grants to furnish the property, arrange for the connection and payment of utilities, change the address for social security benefit payments, register with a new GP, and become acquainted with local services. People who succeed a tenancy may have to make new social security benefit claims, and change the arrangements for the payments of rent and utility bills. Regular visits and assistance with these tasks in the early months from housing officers or tenancy support workers may reduce tenancy failures. Such services could be targeted at new tenants who live alone and have mental health or substance misuse problems, or those with a history of repeated tenancy failures. Vulnerable people who succeed a tenancy following, for example, the death of their spouse or a parent should also be included. If people are assessed as needing support beyond the initial ‘move-in’ period, then referrals should be made to tenancy support teams (described in Section 4).

Examples of good practice

In some areas, specialist schemes have been introduced to identify the support needs of new tenants. Special-needs panels, involving housing, health and social services staff, review the housing and support needs of vulnerable people referred for rehousing, and arrange an appropriate support package at the start of the tenancy. Sandwell Council in the West Midlands, for example, has a ‘Community Care Housing Team’ of dedicated housing officers. They are responsible for housing vulnerable young and older people, those with physical disabilities or mental health problems, and young offenders. The team carries out joint assessments of housing and support needs with other agencies. The London Borough of Tower Hamlets is piloting a scheme for vulnerable new tenants who are visited during the first four weeks of their tenancy.

Specialised housing for tenants with disruptive behaviour

It is not easy for older people who are heavy drinkers and have problematic and challenging behaviour to be managed in general needs housing. At the consultation workshop with housing staff and tenancy support workers, there was a consensus that not enough is known about the most effective ways of working with this difficult client group. They find it hard to link these tenants with mental health and alcohol services, and there is insufficient specialist housing for them. One housing officer described a woman tenant with alcohol problems who was causing chaos in a shared house. She was moved into an independent flat away from her drinking friends. The woman now has a support worker and the move had so far been successful. At the discussion with the GPs, one described an elderly patient with mental health problems who was about to be evicted for rent arrears. The GP had had similar cases of people who were unable to manage at home but repeatedly refused offers of help. They have mental health problems but not
of a severity to be detained under the *Mental Health Act*. For some at least, eviction is perversely a ‘positive’ move, because it enables access to more appropriate housing and support services.

**Examples of good practice**

In a few cities, there is specialist accommodation with a high level of support for people who have complex needs and challenging behaviour. Examples are the ‘Multiple Needs Unit’ in Birmingham run by *Focus Housing*, and the ‘Heavy Drinkers Project’ in Manchester run by *Manchester Methodist Housing Group* (Box 3.4). Such projects are effective but costly to operate, and vacancies are infrequent because the clients have long-term support needs. Some housing providers have set up specialist tenancy support services for people with difficult behaviour who live in independent accommodation (see Section 4).

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**Box 3.4 Special needs accommodation projects in Birmingham and Manchester**

In 2001 *Focus Housing* in Birmingham established a **Multiple Needs Unit** for rough sleepers who had been excluded from the city’s hostels and had mental health and alcohol problems and challenging behaviour. It has 15 furnished apartments, each with a bedroom, sitting room, kitchen, shower room, toilet and communal areas. One flat was designed for a noisy client and has no party walls with any other flat, and some ground floor apartments lead off the communal lounge and reception area and are intended for clients who need close supervision. Staff are on duty all 24 hours. Referrals are assessed by a panel of partner agencies, including the community mental health team and the local authority social services team.

The **Heavy Drinkers Project** in Manchester was set up in 1985 by *Peterloo Housing Association* and is now managed by *Manchester Methodist Housing Group*. It offers supported accommodation for men and women who are unable to maintain independent accommodation because of alcohol problems. It comprises a group home (*Docherty House*) for seven older men which offers a high level of care and has 24-hour staff, and nine dispersed shared houses nearby. Staff from *Docherty House* support the clients in the houses. The project promotes harm reduction rather than abstinence, and individual ‘drinking plans’ are agreed with the residents. Support is also given with practical tasks and with health and social issues. Further details: [http://www.mmhg.org.uk](http://www.mmhg.org.uk)

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**Conclusion**

This section has described several ways in which housing managers and staff could identify and respond to older people who are at risk of losing their accommodation. Preventing the escalation of diverse and intractable housing difficulties into homelessness is by no means straightforward. The key requirements are procedures to detect those at high risk of critical problems and thereby to target scarce preventive resources. The examples of good practice that have been collated here exemplify the following practices: (i) the provision to new tenants of information and advice on their responsibilities and their entitlements to social security benefits in ways that are tailored to
the abilities and attitudes of the person – comprehensibility and accessibility are the keys; (ii) the routine monitoring of rent payments and especially of ‘signs’ or ‘indicators’ of embryonic problems, combined with follow-up interventions including individualised reviews, advice and interventions; (iii) providing a ‘reach out’ service that offers advice to people with housing problems who do not seek help; (iv) providing specialist projects with intensive support for people with challenging or disruptive behaviour; and (v) working collaboratively with other agencies and organisations to identify and address the support needs of prospective and current tenants.

Two best practice roles of housing staff in the prevention of homelessness are therefore envisaged: the provision of full and comprehended advice especially to new tenants and to those identified as potentially vulnerable, and establishing and diligently implementing routine monitoring of rent payments and defaults to identify actual vulnerability and a high risk of homelessness. To go beyond such work implies a heavy load of intensive, face-to-face contacts, assessments and advice. This is discussed further in the next section on the prevention role of tenancy support teams.
Tenancy support teams

Tenancy support services play valuable roles in helping people to sustain tenancies and in preventing them from becoming homeless. Many councils and housing associations now provide this support to vulnerable tenants either with their own dedicated teams or by commissioning the service from voluntary agencies. Among the respondents in the research, however, only a handful received help from a tenancy support worker before they became homeless (and clearly for these cases tenancy support did not prevent homelessness). This suggests that more needs to be done to ensure that tenancy support teams reach people who are at high risk of becoming homeless, and to develop more effective ways of working. With this in mind, this section recommends ways that tenancy support services can identify and respond to older people who are at risk of becoming homeless.

Targeting services to those most in need

Several pervasive difficulties of homelessness prevention in the general population are pronounced for tenancy support services. They include many aspects of targeting the service at those with greatest need, such as: defining vulnerability and its thresholds, developing operational indicators of these concepts, measuring change in vulnerability (especially the move out of risk), and managing the withdrawal of the service and the deployment of staff to a constantly changing client list. The other intrinsic problem is to provide appropriate (or required) and effective support, which is partly a function of skilful individual assessment, but also requires the accumulation of ‘learnt experience’. Given the short life of most tenancy support schemes, as yet there have been few rigorous evaluations, comparatively little dissemination of good practice, and experience is for the most part exclusively local.

People who are demanding or who behave in a disturbed or disruptive manner are more likely to come to the attention of service-providers than those who are isolated and keep to themselves. At the consultation workshops, several tenancy support workers expressed concern about whether their service was reaching people in need, and believed that older people in private-rented accommodation and owner-occupied housing were being missed. They said that many of their referrals came from social services, hospitals and community mental health teams, and relatively few from housing officers and primary health-care staff. From the opposite perspective, some health-care workers said that they had insufficient information about the roles and referral procedures of various local tenancy support services. Health, housing and tenancy support workers all agreed that it is easy to identify clients who have ‘low’ or ‘high’ support needs, the problem is to recognise those who have some vulnerability and the potential to become more vulnerable: for such people, support is not immediately critical but could be beneficial.
It is important that statutory and voluntary sector staff who come into contact with vulnerable and needy people are fully informed about local tenancy support services, their services and referral procedures. The relevant staff include estate managers, primary health care teams, hospital ‘Accident and Emergency’ personnel, wardens of sheltered housing schemes, the police, ministers of religion, and workers in advice centres, meals-on-wheels services and day centres. The services should also be widely advertised at places used by older people, such as GP surgeries, post-offices, libraries, community centres and luncheon clubs. As this could generate many referrals, it would be necessary to screen for the appropriateness of tenancy support and to prioritise cases.

**Examples of good practice**

As a way of detecting unmet support needs among older people, a tenancy support worker in London sent an introductory letter about the service to all the residents of a sheltered housing scheme. These were followed with home visits. As a result, several older people with financial difficulties and other support needs were identified and helped. Another scheme to seek out older people in need, the ‘Caretaker Visiting Service’ in the London Borough of Camden, was described in Section 3. Similar practices should be piloted elsewhere and in other settings and their lessons disseminated.

**Engaging older people who are distrustful or reluctant to accept help**

Some older people with serious housing problems are referred to a tenancy support service but are distrustful and hard to engage. They may require a great deal of persuasion and repeat visits before they are willing to accept help, and the case should not be closed if they are initially uncooperative. Mental health problems, for example, may affect their judgement of their housing predicament and of their need for help. Working with them persistently, flexibly and creatively can be beneficial. Consistent and persistent contact brings familiarity and demonstrates to the person that the worker is trustworthy and interested in their well-being. For example, Thames Reach Bondway runs a tenancy support service for Westminster City Council. It took months for one of the support workers to gain the trust of an elderly client. She had been in her tenancy for five years, without a cooker, fridge, heating or furniture except a bed. The worker eventually persuaded her to accept help (Crane and Warnes 2000).

**Examples of good practice**

In a few areas, tenancy support teams specifically for older people have been developed. Among the advantages of having either designated older person’s teams or workers in generic teams are that the workers’ time is not diverted by the needs of other age groups, and they can learn about the distinct needs of older people and the local services for them. The London Borough of Camden housing department set up an ‘Outreach Support Service’ specifically for people over the age of 55 years. The clients receive help with claiming benefits, managing tenancies, accessing
services and engaging in social activities. The work of an older person’s tenancy support scheme in Sheffield is described in Box 4.1.

Box 4.1  South West Sheffield Older Person’s Tenancy-Support Scheme

The South West Sheffield Older Person’s Tenancy-Support Scheme is one of four in the city which provides tenancy support services specifically to older people. Shelter is contracted by Sheffield City Council to run the service, which is funded through Supporting People. There is a project manager, two team leaders, an administrator, seven tenancy-support workers, and a DIY skills adviser. The service is free and available to council and housing association tenants, people in private-rented accommodation and owner-occupiers. It targets people aged 60 or more years who need support to enable them to live independently at home. The service includes: advice on housing rights and option; advice on debts and legal rights; assistance with applying for welfare benefits and budgeting; help to access medical and other specialist services; support to shop, cook and clean; practical assistance to help maintain a home and garden; and support to overcome bereavement and isolation. The scheme supports 125 clients. For further information see http://england.shelter.org.uk

Assessing and responding to needs

There are many reasons why an older person is not coping at home and has been referred to a tenancy support service. These include poor daily living skills, depression and low motivation, deteriorating mental health problems, cognitive impairment, and ignorance of entitlements. The help that they require depends on the underlying reasons for their difficulties. It is therefore important that thorough assessments are undertaken of their problems and needs. These should take account of recent changes and stresses that the person has experienced and which may be contributing to their difficulties, the immediate risks of eviction or abandoning the accommodation and becoming homeless, and the underlying vulnerability associated with poor daily living skills, self-neglect, physical and mental health problems, heavy drinking, disturbed behaviour, and the condition of the accommodation.

Input from other professional and specialist agencies may be required where, for example, mental health problems are indicated. Building links with various professional agencies and understanding their referral procedures is therefore essential. Several tenancy support staff who attended the workshops believed that there should be better collaboration between their teams and community mental health services. Ways of improving links should be explored. Older people’s needs change over time, and they may become more or less at risk of losing or abandoning their tenancy. Regular needs and risk assessments should therefore be carried out.

Examples of good practice

In some tenancy support teams, specialist staff work alongside generalist support workers. They offer expertise in their specialism, carry out comprehensive needs and risk assessments, and assist
with drawing up, implementing and reviewing support plans. For example, *Thames Reach Bondway* manages three tenancy sustainment teams covering nine South London boroughs. Each team has generic support workers, two substance misuse staff, a youth specialist worker, a meaningful occupation worker, and access to a mental health worker.6 Another example is the Elmore Team in Oxford (Box 4.2).

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**Box 4.2 The Elmore Team, Oxford**

The *Elmore Team* in Oxford was set up by a voluntary agency in 1988 to work with people who have complex and multiple needs. Most have mental health problems, and many also substance misuse, housing and financial problems, and challenging behaviour. They are marginalised from services, either because they do not fit the criteria or so chaotic that the services cannot cope, or because they are unwilling to engage. The team receives approximately 150 referrals each year, mainly from health, housing, criminal justice and social service agencies. It provides practical support with housing tasks and claiming social security benefits, emotional support, advocacy work, and re-engages clients with statutory services. The team works proactively and flexibly with the clients, and provides extra input at times of crisis and follow-on support to clients and agencies.

The staff team comprises a manager, seven support workers, and full-time secretarial support. The support workers have diverse skills and qualifications, and one is a community psychiatric nurse who is on permanent secondment to the team. Each has a caseload of approximately 20 clients at any time. The skill-mix of the team is reported to be extremely important. The team has compiled a comprehensive list of competencies expected of support workers, which is referred to when recruiting new staff. It regularly has nurses or social work students on placement. This enhances the skills of the team. For further details see Dewhurst and Bevan 2001.

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**Helping people with disruptive or challenging behaviour**

Providing tenancy support to older people who are heavy drinkers and have disruptive or challenging behaviour is not easy. They require intensive support and much of the work involves intervening in crises because of rent arrears, neighbour disputes, serious health problems and self-neglect. At the consultation workshops, the tenancy support staff believed that the problem is made worse because it is hard to link clients into specialist mental health and alcohol services. One worker said that it took 48 hours for a very disturbed client to be seen by a community mental health team. The staff described a characteristic pattern among this client group, of movement from one accommodation to another, tenancy failures and repeated homelessness.

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Examples of good practice

In some areas, specialist tenancy support teams have been established to work with people who have complex and multiple needs (see Box 4.2). Some housing providers have commissioned professional substance misuse agencies to provide the service, but *Brighton and Hove City Council* has employed its own ‘Special Needs Housing Officers’ (Box 4.3). As found by the Brighton scheme, the staff costs are offset by a reduction in rent arrears and defaults, fewer evictions, and the reduced incidence of having to re-house people with special needs. Another example, the *Alcohol Recovery Project*, provides tenancy support services across seven London boroughs to people who have substance misuse problems. The teams work flexibly to engage clients by offering early morning appointments and meeting people in local cafes and other informal settings. The teams described in this section emphasise the need for intensive and flexible tenancy support services by staff who are skilled to work with clients with chaotic and disturbed behaviour.

**Box 4.3 Special Needs Housing Officers, Brighton and Hove City Council**

Since 1999, four Special Needs Housing Officers have been employed by *Brighton and Hove City Council* to work with vulnerable tenants who have mental health and substance misuse problems, chaotic behaviour, and require intensive support to sustain tenancies. The officers have specialist training and work across the city, with one being based in each neighbourhood office. Their principal roles are to carry out intensive case-work and to co-ordinate a multi-agency approach to the clients’ needs. They have a small caseload of 15 to 25 clients, who are identified by housing officers through neighbours’ complaints, rent arrears and observations at visits. They provide help with lifeskills, budgeting, mediation with the landlord and neighbours, and linking clients into specialist treatment and support agencies. They also work with people in the private-rented sector. It has been estimated that 200 cases of homelessness have been prevented since the scheme started. The local authority have found that they have been able to save money equal to the support workers annual salaries by fewer voids in properties through evictions, fewer court cases, lower rent arrears, and lower rehousing and other costs arising from re-housing individuals with special needs (Rough Sleepers Unit 2001). For details, see *Strategy for the Prevention of Homelessness 2003-2006*, Brighton and Hove City Council.

Conclusions

Tenancy support services can play a valuable role in helping people to sustain housing and in preventing them from becoming homeless. When this is achieved, not only is the quality of life of the person protected, but there are also direct financial benefits for housing providers and, more indirectly, for primary and acute health services and the social services. Reducing homelessness is likely to correlate with not only reduced rent and utility payment defaults, but also fewer admissions to residential care, hospitals and prisons. The recommendations made in
this section and the examples of good practice are characterised by three underlying principles: (i) target tenancy support services to those at high risk of losing their accommodation; (ii) work flexibly and persistently to meet the diverse needs of people; and (iii) work collaboratively with other professional and specialist agencies.

Although tenancy support services have multiplied rapidly since the late 1990s, much more needs to be learned about they ways in which they can be effective (or efficient). The requirement is both to target those who are most likely to benefit from their finite capacity, and to deliver advice and support that is individualised and that has the greatest chance of providing benefit. Only a few rigorous evaluations of tenancy support teams have been carried out. More evidence is needed on their roles and the best ways to target and deliver the support and to achieve the desired outcome of reduced homelessness (Goldup 1999; Quilgars 2000).
Health services staff could play a valuable role in identifying older people who are at risk of homelessness and in initiating support from other services. This is particularly true for ‘front-line’ health workers, i.e. GPs, primary health care nurses, and staff in hospital accident and emergency units. Four-fifths of all NHS contacts take place in primary health-care settings (Sainsbury Centre for Mental Health 2002). In the study, the only contact that some subjects had with formal services was with GPs and practice nurses. Primary health-care workers may be alerted to changes in a person’s circumstances, such as the death of a carer or marital breakdown, or to problems at home such as heavy drinking or domestic violence. This section describes ways in which primary health-care and hospital staff could detect and help older people who are having problems and are at risk of homelessness.

Assessing for housing vulnerability in primary care settings

Several health-care workers at the workshops agreed that more could be done in primary health care settings to assess the needs of older people who are at risk of homelessness. They agreed that routine health assessments concentrate on physical health problems, and that rarely is attention given to a person’s housing and social circumstances. The Department of Health’s Single Assessment Process for Older People gathers only brief information about housing, and in most practices it is administered only to very elderly people (aged 75+ years). This means that people aged in their fifties and sixties (which made up most of the study population) are missed. Nonetheless, they do become aware of patients (or at least co-resident close relatives) who have been bereaved if the deceased was registered at the same practice. Patients whose mobility is deteriorating or who have had to stop work because of ill-health also come to their attention.

At their respective consultation workshops, both the GPs and the primary care nurses said that during consultations it would be possible to ask a few additional questions about how a person is coping. They would require a template or instrument to identify those who are at risk of becoming homeless and who need further support. One GP explained that each year she sees many patients who experience bereavement or marital breakdown, but most cope and do not require additional help. The problem is to distinguish the minority who are at risk. One proposal was that there should be short sets of questions about patients’ responses to various ‘hazards’, e.g. a ‘bereavement protocol’.

A short protocol or assessment instrument of housing vulnerability could be designed and validated for use by primary health-care staff. The most useful items are likely to be about the person’s daily living and household management skills, financial situation and debts, and
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personal problems that are creating unsettledness. Following the workshop recommendation, the instrument might have ‘optional’ sections for different hazards, e.g. a ‘bereavement section’ would include a few questions about how a person is adjusting emotionally, practically and financially. The instrument could be administered to people not included in the Single Assessment Process for Older People but who are known or suspected to be vulnerable, particularly when changes occur in their circumstances, e.g. those discharged from hospital if living alone, recently bereaved or estranged from their spouse or partner, or those presenting signs of heavy drinking, deteriorating mental health problems or domestic violence.

Assessing daily living skills

The primary care nurses at the consultation workshops recognised that poor daily living skills can contribute to homelessness but described their problems in making assessments of an older person’s ability to function at home. They suspect that some people are not able to cope but find it almost impossible to arrange an assessment of their daily living skills by an occupational therapist when they make a referral. According to the nurses, the scarcity of resources means that occupational therapists tend to accept referrals only for people who require ‘aids and adaptations’. Their experiences were corroborated by some housing officers, who have found that it takes between six and 24 months to get an older tenant’s needs assessed by an occupational therapist.

Both the nurses and the housing officers believed that assessments of older people’s life skills should be available. A few housing organisations have purchased their own occupational therapy services, e.g. the London Borough of Tower Hamlets employs a team of occupational therapists who work alongside tenancy sustainment officers to assess people’s ability to sustain tenancies and the suitability of accommodation. They work with people in both temporary and permanent housing.

Assessing for housing vulnerability in Accident & Emergency departments

Some older people who are at risk of becoming homeless may be seen at hospital accident and emergency (A&E) departments. They may present with problems or be brought in because of concerns about their health or behaviour. In cases where complaints are indicative of social or mental health problems, questions about their housing and personal circumstances should be included in the assessments. Nurses and doctors in A&E are likely to come across problems or injuries that are linked to alcohol misuse or domestic violence, and see older people who are confused and have wandered away from home. A protocol similar to that proposed for primary health-care workers (described above) could be developed and piloted. Monitoring systems could also be set up to detect those who present frequently with complaints that suggest mental health or social problems.
Examples of good practice

Medical and nursing staff in A&E departments are generally very busy, and will not have the time to attend to patients’ social and welfare problems. Having input from other agencies has proved effective in some hospitals. A social worker who attended one of the study’s workshops described her role at the North Middlesex Hospital A&E. She assesses the needs of patients who are referred by the nurses as being vulnerable or having social problems, and links them into local authority social services. Examples are older people with dementia who are currently not known to mental health services, and some who require (additional) support at home because of physical health problems. The ‘Primary Care for Homeless People’ project, situated within Camden Primary Care Trust in north London, has two homeless patient co-ordinators who cover four hospitals. Their work is described in Box 5.1.

Box 5.1 Homeless Patient Co-ordinators in local hospitals, London

The Primary Care for Homeless People team is a Personal Medical Service that provides primary care to homeless people in the London Boroughs of Camden and Islington. The team includes two Homeless Patient Co-ordinators who cover four hospitals. They work closely with staff on the wards and assess the needs of patients, and arrange housing and access to substance misuse services where necessary. Their work also involves preventing homelessness. They liaise with landlords, local authorities and housing associations in the event of rent arrears, and assist with GP registration, social security benefit claims and legal issues. They also see referrals from A&E staff of older people who have arrived in the department but are confused and unable to confirm whether they are homeless or the address of their accommodation. The workers try to link them back into hostels or existing tenancies (Blood 2003; Gorton 2003).

Assessing housing and support needs prior to hospital discharge

Some older people are at risk of becoming homeless when they are discharged from hospital. They may have deteriorating health or mobility problems or increasing support needs, and their housing may no longer be suitable or they may require help if they are to return to the same accommodation. An example is the case of Frank described in Section 2 (Box 2.4). The nurses at the workshops were aware of many cases of people being discharged from hospital with no assessment of whether they could manage at home. They believed that more could be done when discharge from hospital is planned to identify those who require help.

Assessments should be undertaken of the housing and support needs of older people before they are discharged from hospital, particularly when their illness, injury or disorder is likely to have affected their ability to cope. An obvious parallel indicator of vulnerability is when no relative or carer visits or inquires about the patient’s progress. Such cases should be referred to social workers or occupational therapists. As this takes time to arrange, the referral should be
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made as early as possible after admission. Support packages should be in place if needed before an older person is discharged, and the responsible primary health care service notified of the pending discharge. In 2003 the Department of Health published a comprehensive report on hospital discharge procedures: Discharge From Hospital: Pathway, Process and Practice. Box 5.1 describes the work of ‘Homeless Patient Co-ordinators’ in four London hospitals.

Responding to depression and alcohol problems

Depression and alcohol problems are risk factors for homelessness, and can lead to the loss of employment, financial problems, and relationship breakdown. In some instances, homelessness might be prevented if primary health-care staff detected depression and alcohol problems at an early stage and initiated treatment. The problems may be secondary to stresses or losses such as the death of someone close. In such cases, bereavement counselling may help to reduce depression, unsettledness, and alcohol misuse. Similarly, if a person’s depression was treated, their motivation and self-esteem may improve and they might be enthused to tackle other problems.

There are difficulties in identifying depression and alcohol problems in primary health-care settings, but some of the nurses who attended the workshops believed that more could be done. They explained that nurses and GPs sometimes know or suspect that an older person has an alcohol problem but that this is rarely discussed with patients, especially older women. They treat health problems or injuries ascribed to heavy drinking but the alcohol problem itself is ignored. This means that the underlying reasons for the behaviour are not addressed.

Collaborating with other professional agencies

Collaboration between health staff and other professional agencies is necessary to meet the multiple needs of older people, and to prevent them from slipping through the welfare safety-net and becoming homeless. Several nurses at the workshops believed that primary health care and community mental health teams should have better links with housing and welfare services. Nurses do not generally inform housing officers of tenants who are depressed or have mental health problems. At the same time, housing workers do not inform primary health care teams if an older person is threatened with eviction. Yet mental health problems may be a contributory reason why a person is not coping at home and is being evicted.

Examples of collaborative working

Many initiatives have been developed to build links between health workers and other agencies. Some primary health-care teams have social workers based in the health centres. Although few of these schemes have been rigorously evaluated, reports suggest that they encourage early and more appropriate referrals from GPs to social services, and that people are seen who would not accept a referral to an area social services team. It has been found that when primary health-care team contacts with social workers increase, this leads to a better understanding of the social
worker’s role (for review, see Kharicha et al. 2004). Some health centres and GP surgeries have introduced link workers who visit projects used by homeless and vulnerably housed people, and advocate on their behalf with housing, health and social security benefit agencies.

Since the early 1990s, sessions have been provided in some GP surgeries by Citizens’ Advice Bureaux and other welfare benefits and advice agency staff. Approximately 53 per cent of primary care settings now have these services on-site (Harding et al. 2002). Help is given with sorting out debts and rent arrears, claiming social security benefits, and accessing support services such as ‘dial-a-ride’. Evaluations suggest that the schemes complement the work of the primary health care team and allow easier access to welfare benefit services (Abbott and Hobby 2003; Galvin et al. 2000). They are reported to be particularly beneficial for older people who are reluctant to use general purpose or housing advice centres in towns and cities. An example of a scheme in Middlesex is described in Box 5.2.

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**Box 5.2 Welfare advice services in health centres, Hillingdon, Middlesex**

*Hillingdon Citizens’ Advice Bureaux* in west London provides an ‘Outreach Advice Service’ at three health centres in the Borough. The scheme commenced in 1997 at one centre and has since expanded. Its overall aims are: (i) to reduce the workload of primary health workers by advising on non-clinical problems that are beyond their remit; and (ii) to improve the health and well-being of patients, by providing a holistic approach to their care. Weekly sessions are held at each practice, and appointments are made for clients through the practice receptionist. Any member of the primary health care team can make referrals. Posters are displayed in the surgery reception areas and clients can book appointments. During the six months to September 2003, 175 clients used the service, of whom 23 per cent were aged 45-59 years and 27 per cent were older. Most were owner-occupiers or in council tenancies. During this period, 294 separate issues were handled. Most (74%) advice and help pertained to welfare benefit matters, and other problems dealt with concerned housing, employment and rent arrears (Jesse 2003).

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**Conclusions**

Over the last ten years, many new initiatives have been introduced to build links between primary health-care staff and social work and welfare services. It is recognised that improvements in a person’s social and welfare circumstances can also lead to improvements in their health. As a result, many health centres and GP surgeries now provide a hub for advice services and links to other agencies. The only service contact or information point for some older people is with GPs and primary and community health care centres and clinics. Among the health-care staff who attended the workshop, there was strong agreement that more could be done to assess housing vulnerability among their patients. One way to achieve this would be for a short assessment instrument to be designed and piloted among vulnerable patients who experience problems that are known to be triggers to homelessness.
6

Conclusions and recommendations

The case for more homelessness prevention

There is a broad consensus that more resource and professional effort should be dedicated to homelessness prevention. The case is rarely set out, but there are three strands to the argument. First, there is the case that homelessness is an absolute social malaise that is intolerable. The reasoning is that becoming homeless is a dire condition and if protracted highly damaging to an individual’s identify, self-worth, morale and physical and mental health. The experience stigmatises not only the individual but also the society that permits (or fails to prevent) the occurrence. Put colloquially, many would agree that in affluent societies ‘it shouldn’t be allowed to happen’.

Reducing inequalities in health and life chances

The second argument draws from an awareness that the high level of economic growth in Britain and our unprecedented general affluence comes at a price, rising inequalities in life chances, material standards and health. The changed economic situation has been partly responsible for a long-term, undeclared but now established change in the broad goals of British social policy (although the incremental adoption of American neo-liberal policies has played a large part). In the particular sense of tackling social exclusion, the reduction of inequalities is now a high government priority, as apparent in its policies for education, social policy, the National Health Service and public health.

If in the post-1945 Beveridge-inspired welfare state, the aim was to raise the level of living of substantial sectors of the disadvantaged population, such as ‘the elderly’ or later the ‘children of single mothers’, now the welfare state gives less emphasis to redistributive ambitions and more to helping the weakest, the severely disadvantaged and the socially excluded. The aims have changed and have become more ambitious. Government-backed interventions not only seek immediately to raise the level of living of these disadvantaged groups, but also search for ways of raising the individuals’ skills, ambitions, life chances and achievements. The first manifestations in homelessness policies and services were the funding of employment preparation, skills training and meaningful occupation courses for adolescent and young adult homeless people. The principles and ethos are however extended to all ages: in the interests of communitarian social inclusion and reducing inequalities, the government genuinely wishes to prevent homelessness at any age.

Prevention to achieve net savings in social and health spending

The third strand to the argument for more homeless prevention is that will lead to a reduction in aggregate social expenditure (including NHS spending). The earlier sections have set out
elements of the reasoning. Common components are that preventing homelessness reduces losses to housing providers through rent arrears, rent defaults, eviction actions and re-housing, as well as the costs to the NHS of delayed presentations, special-needs clinics, emergency hospital admissions, and delayed hospital discharge. It has to be said, however, that no formal, comprehensive demonstration or cost-benefit analysis of the case is known.

The ‘net savings’ argument is most persuasive when it applies to a single organisation or agency, as most obviously to a local authority which has both the responsibility to secure housing for homeless people in the priority categories and substantial housing-rent revenue. The argument has less leverage if an increase in prevention expenditure by one agency (say, a local authority housing department) leads to savings for another (say, a housing association or a NHS Trust). The overall case has however helped to persuade the Department of Health and acute hospital trusts to promote improved discharge planning, intermediate care schemes, and services for special needs groups in the interest of reducing emergency hospital admissions (although of course the principal target population for these schemes is physically and cognitively frail older people).

**The practicability of prevention measures**

There is no doubt that homelessness prevention measures can work. Referring back to the case of Frank (Box 2.3), at several points – hospital discharge, while receiving physiotherapy, and during his consultations with the landlord and at a housing advice centre – an assessment of his capabilities and housing circumstances would have identified the unsuitability of his accommodation and need to move. If he had been found more suitable accommodation, it is likely not only that he would not have become a resident of a homeless hostel, an expensive outcome in terms of public expenditure, he might have been able to live independently or in another shared house for a few more years.

The problem is that we still know very little about which interventions work and how to deliver them with best value. As discussed in Section 4 with reference to tenancy support teams, the delivery of a mass prevention service raises difficult questions about targeting, the individual assessment of need and (potential) vulnerability, the contents of the support package, the measurement of the acquired benefit, the withdrawal of the package, and the management of dynamic case loads. Many of the benefits to the clients are subjective (which is not to say that they are not real): the senses of being in control, secure, recognised and supported, and the removal of housing-related stresses and anxieties. Other important positive outcomes of tenancy support are a reduction in negative events, such as relationship breakdowns, court actions, convictions, and moves into homelessness, but null outcomes are difficult to assess. Which services to provide and how best to arrange them therefore becomes a question of the available evidence, to which we now turn.
Developing and disseminating the evaluation evidence

The fact that the general case for more homelessness prevention has received very little critical attention may be largely because of the infancy of these services. The Homelessness Act 2002 placed a duty on local authorities to develop homelessness strategies with prevention in mind. Although the Rough Sleepers Unit published Preventing Tomorrow’s Rough Sleepers: A Good Practice Guide in 2001, there was a short section by Randall and Brown (2002) on preventing homelessness in Homelessness Strategies: A Good Practice Handbook, and in March 2004 the Homelessness Directorate produced a ‘Policy Briefing 4’ on the Prevention of Homelessness. This presents examples of best practice from local authorities with Beacon status for tackling homelessness. Otherwise there has been little information or guidance for local authorities on the success and cost-effectiveness of various prevention approaches for people with different problems and needs. The rapid expansion in 2003/04 of tenancy support and similar services funded through Supporting People and the huge ‘overspend’ of this programme may put an end to this ‘naïve’ phase. It will be found, however, that evaluating homeless prevention services is not a simple task, partly because the desired outcome, the absence of a movement into homelessness, as just remarked is a non-event and uncountable.

The feasible way to measure the impact of homeless prevention interventions is through system indicators rather than the outcomes for individuals. If homelessness prevention works in a local authority, a city or for a social housing provider locally or nationwide, the value of rent arrears and defaults should reduce, the number of eviction warnings and evictions should fall, and some improvement can be expected in the occupancy level (viz. a reduced vacancy rate). Before and after comparisons, year-on-year, may be highly suggestive but are compromised by other influences and their findings will be challenged. As one illustration, an upturn in the local economy will lead to less unemployment, reduced rent arrears and fewer evictions. To avoid these pitfalls, ‘controlled comparison’ studies should be established, which compare outcome indicators for housing sub-areas with and without the new prevention services. Similar controlled comparisons of the effectiveness of different types and intensities of homelessness prevention interventions should also be carried out.

The companion requirement is that a systematic approach to the collation and dissemination of evidence about the effectiveness of homelessness prevention services is required. Several bodies have the standing to undertake or participate in the role, including the responsible government departments, the Local Government Association, and the Social Care Institute of Excellence. Shelter, a national campaigning body for homeless people, proposes to develop an information resource about good practice models for the housing sector, by bringing together details of its own projects and innovative services from other agencies.7 It also recommends the introduction of a ‘multi-agency monitoring’ process (MAM), whereby standardised information

7. See http://england.shelter.org.uk
Research evidence and professional knowledge

is collected by statutory and voluntary sector agencies working with homeless people and those at risk. This would improve the quality and consistency of data sources, and could provide information for local authorities’ homelessness strategies about gaps in provision and the impact of local policies.

Practice development recommendations

This short report closes with a summary list of our principal recommendations. They are organised under three headings: ‘Changes in existing services’, ‘New services’, and ‘Information development’.

Changes in practice in existing services

1. Social housing providers, primary care health centres and hospital-based staff that come into contact with large numbers of people who are vulnerable or potentially vulnerable to homelessness should develop procedures and services (a) to detect vulnerability, (b) to provide information about advice and support services, and (c) to make structured assessments and provide individualised advice.

2. All public sector provided or funded housing, health and social services that have contacts with vulnerable or potentially vulnerable people should receive information and have an awareness of and, wherever possible, a person responsible for knowing about housing advice, debt counselling and other support services.

3. Arrangements for improving the exchange of information between the agencies that are best placed to detect housing vulnerability and those best placed to provide advice and support should be developed locally. Guidance on ways and means that are consistent with the confidentiality of the information provided to any single agency and the relevant legislation should be provided by the Office of the Deputy Prime Minister.

4. Local authority homelessness strategies should review the extent and effectiveness of information dissemination among the relevant agencies in their area, and include plans for improving and monitoring such information dissemination.

5. All rental social housing providers should introduce automatic systems for drawing a manager’s attention to sequential changes in the tenant, the household and the pattern of rent payments that indicate newly developed coping problems, e.g. successively bereavement, single person household, and arrears. When such sequences are identified, sensitive but tenacious investigations of the circumstances should be implemented before activating standard debt collection procedures.

New services

6. Intensive investigative and support services should be established in all local authorities to respond to serious cases of harassment by neighbours and of home incursions by anti-social people that threaten the continued occupation of their homes by vulnerable people.
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7. Intensive new services need to be developed to provide for vulnerable people with challenging or disruptive behaviour and for whom the government’s proposed rehabilitation programmes are not a realistic option. Such services should include specialised accommodation and intensive tenancy support.

Information development

8. Central government resources should be made available to design and implement a co-ordinated programme of trials and evaluations of homeless prevention services.

9. Central government resources should be made available to establish a clearing house of rigorous evaluation evidence with a responsibility for its widespread dissemination.
References


Sainsbury Centre for Mental Health 2002. *An Executive Briefing on Primary Care Mental Health Services*. Sainsbury Centre for Mental Health, London.


The authors and their recent reports

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Ruby Fu has been a Research Associate on the homelessness research programme since March 2002. She was the main interviewer for the three-nation study, and is now involved in a study of the role of homeless sector day centres in supporting housed vulnerable people. Prior to her present post, she worked in the field of homelessness for 13 years as a resettlement worker and a resettlement team manager.

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Recent reports and publications


This report describes the findings of a study commissioned by The King’s Fund and the Homelessness Directorate of the work of ‘wet day centres’ in England for street drinkers. It provides an overview of the centres currently operating in the UK, and describes the work of four centres that were studied in detail. Wet centres are not easy to develop or run, and the report provides guidelines on planning and setting up a wet centre, working with the clients, and day-to-day management.


This second edition of the *Homelessness Factfile* provides comprehensive, accessible and up-to-date statistics and information about single homeless people throughout the United Kingdom, and policy and service responses to homelessness and its prevention. It critically examines some of the most vigorously debated current policy and practice development issues.
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Crane M. and Warnes A.M. *Resettling Older Homeless People: A Longitudinal Study of Outcomes*, Sheffield Institute for Studies on Ageing (SISA), Sheffield, 2002, ISBN 0 9541612 2 X. Available from Kate Smith, SISA, Community Sciences Centre, Northern General Hospital, Herries Road, Sheffield S5 7AU. Price £7.50.

This report describes the findings of a study of the outcomes over two years for older homeless people who were resettled. It contains valuable information about the ways in which the informants rebuilt their lives, about the problems that occurred and how these were managed, and about the factors that brought about changes in their circumstances, behaviour and aspirations. It concludes with recommendations for resettlement workers, tenancy support staff and housing providers.


This report provides a comprehensive picture of single homeless people in London, from surveys of: rough sleepers, hostel residents, day centre attenders, resettled homeless people, media coverage of homeless issues, parliamentary debates, and the opinions of the staff working in the sector. Information from 82 organisations was collated and analysed.


Drawing from the experiences of pioneering projects working with homeless people in Britain, the United States and Australia, this is a guide to delivering practical and effective help to older homeless people. It has first-hand accounts of innovative practices and recommendations for future services.


The Lancefield Street Centre was set up as a pilot project for older people sleeping rough in London who were not accessing services. It provided a ‘pathway’ of services from the streets to long term housing, through street outreach work, a 24-hour drop-in centre, a 33-bed hostel, and a resettlement programme. It was established by St Mungo’s for two years (1997-98). Drawing on the findings of an evaluation of the Centre, this manual produces guidance about good practice in developing and delivering similar services.


This book presents research findings of the causes of homelessness among older people, and their problems and needs. Partial life histories were collected from older homeless people and their pathways into homelessness traced. The analysis throws light on the reasons for homelessness at all stages of the life course. Case studies are used to assist explanations.