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Housing Learning & Improvement Network

Extra Care Housing Models and Older Homeless People

This factsheet explores the role of extra care housing models, intermediate care and hospital discharge arrangements in providing and accessing housing, care and support for older people who have been homeless or at risk of homelessness.

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The Health and Social Care Change Agent Team (CAT) was created by the Department of Health to improve hospital and social care associated arrangements. The Housing Learning & Improvement Network, a section of the CAT, is devoted to housing based models of care and support for adults.

DH Department of Health

Other Housing LIN publications available in this format:

Factsheet no.1: **Extra Care Housing - What is it?** *(28.07.2003 updated August 2004)*

Factsheet no.2: **Commissioning and Funding Extra Care Housing** *(28.07.2003 updated August 2004)*

Factsheet no.3: **New Provisions for Older People with Learning Disabilities** *(23.12.2003 updated August 2004)*

Factsheet no.4: **Models of Extra Care Housing and Retirement Communities** *(04.01.2004) updated August 2004)*

Factsheet no.5: **Assistive Technology in Extra Care Housing** *(20.02.2004 updated August 2004)*

Factsheet no.6: **Design Principles for Extra Care** *(26.07.2004)*

Factsheet no.7: **Private Sector Provision of Extra Care Housing** *(21.07.2004)*

Factsheet no.8: **User Involvement in Extra Care Housing** *(24.08.2004)*

Factsheet no.9: **Workforce Issues in Extra Care Housing** *(04.01.2005)*

Factsheet no.10: **Refurbishing or remodelling sheltered housing: a checklist for developiong Extra Care** *(04.01.2005)*

Factsheet no.11: **An Introduction to Extra Care Housing and Intermediate Care** *(04.01.2005)*

Factsheet no.12: **An Introduction to Extra Care Housing in Rural Areas** *(04.01.2005)*

Factsheet no.13: **Eco Housing: Taking Extra Care with environmentally friendly design** *(04.01.2005)*

Factsheet no 14: **Supporting People with Dementia in Extra Care Housing: an introduction to the the issues** *(04.01.2005)*

Factsheet no 15: **Extra Care Housing Options for Older People with Functional Mental Health Problems** *(04.05.2005)*

Case Study Report: **Achieving Success in the Development of Extra Care Schemes for Older People** *(July 2004)*

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1. Introduction

Extra care housing developments are increasingly seen as a more suitable option than residential care for older people with care and support needs. Provision of new models including extra care housing, and remodelling existing low-demand sheltered housing, provide opportunities to address the needs of homeless older people.

The Housing LIN promotes partnership working and a whole systems approach between health, housing and social care commissioners and providers in the statutory, voluntary and independent sectors in the English regions and London. All of these have an essential role to play in addressing the needs of older people vulnerable to homelessness.

Interest is now increasing but up to now, older homelessness has been a neglected issue. Older homeless people have missed out because of:

- the widespread but inaccurate impression that homelessness is primarily an issue to do with younger people; and
- their marginalisation by mainstream older people's services and strategies, which assume that older people have appropriate housing.

Older people who are homeless or at risk of homelessness have diverse and varied needs for housing, care and support and health services. Their health needs may bring them into contact with a wide range of health services, including Accident and Emergency departments, mental health services and specialist provision for certain conditions such as TB. Their needs are often different from older people who already have secure and appropriate housing, and almost always different from younger homeless people.

This Factsheet explores the role of extra care housing models, intermediate care provision and specialist hospital discharge arrangements in providing and accessing housing, care and support for older people who have been homeless or at risk of homelessness. It explores what we mean by older homeless people, and considers how extra care housing models may offer more appropriate accommodation and services for them. It also addresses the need for a strategic approach between health, housing and social care commissioners.

Examples are provided of both specialist provision for older homeless people, and using mainstream extra care housing and intermediate care beds for older people who have been homeless, or who are at risk of homelessness.

2. Policy context

Recent and current policy initiatives provide the chance to tackle older homelessness and some opportunities for new funding across the housing, health and social care divide, including:

- initiatives encouraging partnership, including the Department of Health Extra Care Housing Fund and the new Partnerships for Older People Projects (POPP), focusing on the government's preventative agenda;
- older people's initiatives including Better Government for Older People, Quality and Choice for Older People's Housing and the work of HOPDEV (the Housing and Older People Development Group);
- homelessness initiatives including the Homelessness Five Year Plan and the requirement for local homelessness strategies;
- the Social Exclusion Unit's work with older people;
- the recent Green Paper on Adult Social Care;
- the development of Regional Housing Boards;
- Supporting People;
- the introduction of policies and procedures to protect vulnerable adults from abuse; and
- the tackling health inequalities programme for action, including the target to reduce the gap between the areas with the lowest life expectancy and the population as a whole.

3. What do we mean by extra care housing models?

Extra care housing, sometimes called very sheltered housing, is increasingly popular but it is a concept, rather than a type of housing. In theory, it can vary in size and purpose to meet different needs and as such it can vary from place to place. Housing LIN Factsheet no.1 gives essential basic information, and stresses that:

'The most important fact is that extra-care housing is housing first. It isn't an institution and should not look or feel like one. People who live there have their own homes. They have legal rights to occupy. This means there is a clear distinction between extra care housing and residential care as recognised by the Commission for Social Care Inspection.'

Most extra care housing is provided by housing associations in partnership with local authorities, but some is available through commercial organisations. It can be for rent, shared ownership (part rent, part buy) or sale. Intermediate care beds and rehabilitation services are often provided in extra care housing (and also in sheltered housing), following hospital discharge or to prevent the need for hospital admission or re-admission. Further details in factsheets 7 and 11.

We have used the term 'extra care housing models' in this Factsheet to stress that there is a wide range of provision which meets the criteria.

4. How many older people are homeless, or vulnerable to homelessness?

In 2003/4 in England, around 4,000 people aged over 65 were accepted by local housing authorities as homeless and in priority need because of their old age (ODPM Homelessness Statistics 2003/4).

However, this is a massive under-counting of homelessness amongst older people, because of those it excludes. Many older people do not apply as homeless, or are refused. There are many 'hidden homeless', including older long-stay residents in hotels, bed and breakfast or hostels, and older people staying with friends and relatives, where they sometimes experience domestic violence or elder abuse.

Research undertaken for the UK Coalition on Older Homelessness in 2004 (Pannell and Palmer 2004) estimates that as well as these older people accepted as statutory homeless, there are approximately 42,000 older people who are homeless (using the legal definition of homelessness), and an unknown but much higher number at risk of homelessness. The research used the age of 50+ for two reasons:

- older people who have experienced long-term homelessness (especially rough sleeping) die at a much younger age and have the health problems of much older people; and

- people aged 50+ are more vulnerable to the known triggers of homelessness described below, especially bereavement, redundancy and chronic health problems.

In its examination of social exclusion and older people, the Social Exclusion Unit has also recognised that people from the age of 50 onwards can 'feel the effects of social exclusion alongside, because of, or through their ageing' (Social Exclusion Unit 2005 p6).

5. How can older people become and remain homeless in the 21st century?

To anyone unfamiliar with the detail of UK homeless legislation, it may seem surprising that older people can become and remain homeless in the twenty-first century. The legal definition of 'statutory homelessness' is quite broad:

- there is no accommodation they are entitled to occupy: this includes not only people who are street homeless or who have been evicted, but also people staying somewhere where they have no legal right to stay (for example with family or friends who ask them to leave);

- they have accommodation but it is unreasonable for them to continue to occupy it (for example because the housing is in poor condition, or because of domestic violence or elder abuse).

Reasons for homelessness in later life are complex, but a common trigger is bereavement or relationship breakdown, often linked to other risk factors including:

- limited or no support networks;
- physical health problems and disability which can lead to isolation and loneliness;
- mental health problems and/or dementia;
- substance abuse, especially alcohol, or other addiction including gambling;
- limited literacy and numeracy and lack (or loss) of confidence in coping with bills;
- relationship changes (especially later in life);
- a history of unresolved loss and trauma.

6. Do older people who have experienced homelessness have different needs to other older people?

Homelessness is especially damaging to the health and well-being of older people. The stigma and negative stereotypes attached to the label "homeless person" emphasise their social exclusion and affect both the older person and staff who come into contact with them. Staff in mainstream services are too often untrained and therefore unaware of their needs. Assumptions are made that because of the homeless label, their needs cannot be met in the mainstream.

Homelessness is a sign of failure, at a life-stage when "home" becomes more important. Older people who have led settled lives until they become homelessness in later life find the loss of home particularly damaging, not least because older people spend more time in their home than younger people, and it may be the focus of memories and attachment.

There is clearly a broad range of older people who experience homelessness, and their needs are not the same. What is clear is that without sensitive services and support, older people may end up in a cycle of homelessness and failed tenancies, and this can apply as much to people who become homeless in later life as it does to those whose homeless lifestyle is entrenched.

7. What do older homeless people say they want?

Clearly, older people who lose their homes want access to permanent accommodation in a suitable location. In most cases this is likely to be in social rented housing. People who are at risk of homelessness may prefer help to stay in their existing accommodation, be it private rented, social rented or owner-occupied; tenancy sustainment services can help to maintain people in their existing accommodation..

Older people who have been homeless have often experienced loneliness and isolation (Willcock 2004). Social isolation can precede homelessness; homelessness may intensify and exacerbate isolation, and lead to a downward spiral of repeat homelessness.

Older people who have been long-term homeless have often had to go through a process: shelter or direct-access hostel, then shared supported housing, and finally their own tenancy. Despite an often expressed desire for their own independent tenancy, they can often miss the social contact and staff and facilities available in hostels, homeless day centres or shared housing if eventually rehoused on their own. Too often, this leads to abandonment and a repeat cycle of homelessness. Resettlement and tenancy sustainment services can work to overcome this 'revolving door' problem of repeat homelessness.

Other older people whose care needs have increased beyond the capacity of homeless sector provision or an independent tenancy are referred to residential care or nursing care. Places are often difficult to find and the provision can be alienating for people with a history of homelessness, especially those with an alcohol dependence. They are accustomed to independence and don't like the regime or their limited personal budget. They would prefer to retain their independence but have access to care, support and company.

8. Why are extra care models and intermediate care suitable for older homeless people?

Specialist supported housing, sheltered housing and extra care models can provide the right blend of independence, communal facilities (including meals) and potential for social interaction for older people who have been homeless.

Extra care models are especially suitable for those who need 24-hour cover and on-site services (see the example of St Eugene's Court below). Such models may better meet the needs of some older homeless people than traditional sheltered housing with its more limited staff cover and facilities. Use of intermediate care beds (in extra-care or sheltered housing) can provide older people at the point of homelessness with suitable temporary accommodation, as described in the examples later in this Factsheet.

Older people who have led unsettled lives for long periods, in and out of hostels and shelters and perhaps with periods of rough sleeping, often (but not always) have complex needs, including alcohol issues, mental health problems, mild learning disability and dementia (including Korsakoffs, linked to alcohol abuse). Many die before their needs are met.

This group of homeless people have had to rely on the voluntary sector for housing and support. Neither they, nor those working with them, have found it easy to access mainstream housing, health and social care services. Yet as they age, mainstream voluntary sector homeless provision (for example all-age hostels or homeless day centres) become increasingly inappropriate. In response to this need, some leading voluntary sector providers have developed specialist provision for older people with a history of homelessness, which share many of the characteristics of extra care housing (see section 10 below and Annex B).

However, it is misleading to assume that older people with a history of homelessness will always need specialist provision and cannot be resettled successfully into mainstream housing. A long-term study of resettlement outcomes found that a high percentage of long-term homeless older people did resettle successfully. Sheltered housing models (but with additional support if needed) produced the highest success rate (Crane & Warnes 2002), even for older people with complex needs, including mental health and alcohol issues. Help the Aged and hact's Older Homelessness Programme funded a research project and report (Blood 2002) which highlights examples of good practice in working with older tenants who had been homeless, including partnerships and training by sheltered housing providers.

It is equally wrong to assume that older people who have led apparently settled lives and who become homeless later in life for the first time will not need extra help and support, both when they first lose their home and after they are rehoused. Placing an older person in bed and breakfast or an all-age hostel, or rehousing them with no support, may just mean that they end up homeless again. They are likely to need more than just housing, which is why extra care models can be especially suitable. Losing their home may be the culmination of other longstanding issues (for example domestic violence, mental health problems). Their experience of homelessness may trigger other problems (for example loss of confidence, depression, addiction) which will affect their future health and well-being and their ability to adapt to their new home successfully.

9. The links between domestic violence, elder abuse and older homelessness

Domestic violence and elder abuse can and do lead to loss of home or 'hidden' homelessness amongst older women and men. There has been increasing interest over recent years in elder abuse, and development work in social services on adult protection policies following the publication of 'No Secrets' (DoH 2000). However, there has been little consideration of links with homelessness, nor to the impact of current or past domestic violence on older people (mainly women).

As part of Help the Aged and Hact's Older Homelessness Programme, a research project and report (Blood 2004) examined these links. The report highlights examples of good practice, including partnerships between Womens Aid (refuges and outreach services) and housing providers (including sheltered housing). It argues for greater co-operation and closer links between adult protection and domestic violence services.

The examples in sections 12, 13 and 14 below show how extra care housing, hospital discharge services and intermediate care can help to meet the needs of older people who have become homeless because of elder abuse and domestic violence. These models can provide an environment that helps rebuild the confidence lost by experiencing abuse and violence, often over many years.

10. The need for a strategic partnership approach to tackle older homelessness and save public money

Homelessness has costs to the public purse across housing, health, social care and other budgets. Research for the UK Coalition (Pannell and Palmer 2004) found that there are significant cost savings if older people receive appropriate preventative or remedial interventions: examples included savings in the costs of failed tenancies and unrecovered rent arrears; GP and mental health services, hospital stays and specific interventions such as TB treatment; care home costs; and other costs including police and criminal justice. The examples in the full report illustrated potential annual savings of between £5,000 and £17,000 per case.

There is enormous scope to plan together, provide better service for this excluded client group, and save money. Some local authorities are showing the way (see Southampton, below). But why doesn't it happen everywhere?

Too often, older homeless people's needs fall between the gaps in planning and service delivery:

- older people's strategies and services assume that older people have adequate housing;
- mainstream services disregard the needs of homeless people and homelessness is looked on as purely a housing issue,
- attention is focused on homeless young people, or families with dependent children;
- links between strategies (housing, homelessness, older people, health, Supporting People) are weak;
- it is difficult to map the local incidence of older homelessness because age-related data is not collected or co-ordinated, yet this is an essential base from which to plan services;

- joint working between service providers (housing, homelessness, older people's social services, health) is poor across both statutory and voluntary sectors;
- some older homeless people (eg older drinkers) are "unpopular";
- older homeless people with complex and multiple needs (including mental health, alcohol and physical disabilities) are shunted between services and budgets, with no-one taking overall responsibility;
- the transition between working-age and older people's services (including pensions and welfare benefits) is difficult to negotiate, especially for people under retirement age;
- age-related criteria for services can exclude those under 60/65 who age prematurely.

Example: **A strategic vision for extra care housing: Southampton City Council**

This unitary local authority has included the needs of older homeless people in their Vision for Extra Care Housing. They also identify that, like people with learning disabilities, older homeless people can be vulnerable at a younger age and so services should consider a lower age-limit of 50 or 55. The Vision states that:

'Extra Care Housing is seen as a viable alternative to current and certainly some outmoded housing/accommodation provision for a number of client groups, particularly frail older people, older people with dementia, older people who have experienced chaotic lifestyles as a result of homelessness & rough sleeping and alcohol and substance misuse, people with varying degrees of learning disability and possibly those with challenging behaviours.'

They have already analysed relevant statistical information to map the extent of the need, by examining the records of the Homeless Health Care Team, their Lundy Close bed-blocking project (see section 12 below), and the housing department's special needs quota and homelessness statistics for people over 50. The Housing Strategy for Older People 2003-2007 identified there were 32 older people, 10 with dementia, living at that time in direct access hostels and 'move-on' accommodation. In the city's Heavy Drinkers Project, tthere were around nine people, all entrenched hostel dwellers and mostly over the age of 50. One was over 70, and at least two of them would benefit from 24 hour nursing care, but the problem was that no nursing home would accept them.

Following initial discussions with voluntary and statutory partner agencies, Southampton's specification for extra care housing for older homeless people is likely to include:

- a fully accessible scheme of no more than 10 or 12 units of accommodation (bedrooms with en-suite facilities) and communal facilities;
- a care/support team based on site 24 hours a day to meet the assessed personal and domiciliary care of individuals, including medication supervision, managing occurrences of double incontinence and changes in behaviour;
- possible use of assistive technology (to be explored further);
- communal facilities such as a communal room with kitchen, laundry, assisted bathing/shower
- joint assessments (including risk assessment) and agreement about alcohol use and medication, and appropriate management arrangements (probably with a voluntary organisation with expertise in the needs of this group).

11. Specialist provision for older homeless people

Example: **St Eugene's Court, Birmingham**

St Eugene's provides 44 self-contained flats and communal areas for older Irish men who have experienced social exclusion and have additional support needs around their health, living skills or alcohol use. The project is a partnership between a housing association, **Focus Futures** (part of the Prime Focus Housing Group) and a voluntary organisation, **Irish Welfare and Advice Service (IWAS)**. Focus describe it as a supported housing scheme, but it has most of the characteristics of a 'mainstream' extra care scheme.

This is an excellent example of culturally sensitive specialist provision, and shows that high quality accommodation and services can be provided for older people from a minority community with a history of homelessness. It was developed following research which highlighted the needs of around 600-700 older Irish people (mainly men) who were either homeless, long-term hostel dwellers or living in insecure and insalubrious private rented housing or lodgings. As they grew older and frailer, such accommodation became increasingly unsuitable.

The scheme is housed in a specially converted industrial building near the centre of Birmingham and in the heart of the Irish community. It opened in March 2003, and is bright, open and spacious, with furniture and fittings of a high quality. An atrium at first floor level provides light to the core of the building and an indoor garden (and smoking area) next to one of the common rooms.

Accommodation includes:

- 6 one-bed wheelchair flats with living room, kitchen and walk-in level-access shower;
- 38 spacious studio flats with separate sitting and sleeping areas, kitchen area and bathroom and over-bath shower;
- an assisted shower room on the first floor (for tenants);
- common room and atrium garden;
- spacious public access areas on the ground floor, shared with the drop-in, including a reception and office areas for the on-site management and IWAS, and the following facilities available to both tenants and drop-in customers:
- an assisted bathroom;
- a communal dining room/restaurant and commercial kitchen;
- a medical room used by a visiting chiropody service, optician and alternative therapists;
- a games room with pool table;
- TV room with an Irish channel (similar to Sky Sport) which covers Gaelic football and hurling;
- library.

Staffing is intensive, with support provided 24/7. There is a manager, deputy manager, and four full-time equivalent staff in the support team who operate a key worker system. Two night staff provide a concierge/security service (waking cover), because of the location of the building and the need to provide a safe environment for vulnerable tenants. There are two domestics, two cooks and a kitchen assistant.

Unlike mainstream extra care housing, the service charge includes two meals every day, at times to suit the tenants' lifestyles and ensure adequate nutrition. This can be a particular problem for older people with alcohol issues, and for older people (especially men) who have not acquired cooking skills. A cooked breakfast/brunch is served from 9.45am to 11am, and an early evening meal between 4pm and 5pm. However, tenants can and do still make their own meals in their flats if they so wish.

Capital funding came from the Housing Corporation and private finance. Revenue funding for the housing scheme is from tenants' rent and service charges, with in-house support costs met through Supporting People. Additional support (and care) is funded by social services, health and sometimes the individual from their benefits. It is estimated that between one-third and one-half of the tenants would otherwise need to be in residential care, but St Eugene's is much more cost-effective, costing only half as much.

At present, all the tenants are male, although there is no reason why women would not be offered a flat if they met the allocations criteria. A detailed needs and risk assessment is made for prospective new tenants, from which the support plan is derived; Focus Futures have developed this for all their supported housing. There is always a waiting list for places.

Each person's support package is co-ordinated by the in-house staff team and delivered alongside statutory and voluntary agencies including mental health teams, alcohol services, probation services and primary care teams. If tenants require care as well as support, this is provided by outside care companies under contract, or sometimes by relatives. In contrast to main mainstream extra care schemes, there is no on-site care service. At present, care companies provide mainly shopping and cleaning, but the intention is that if their health deteriorates, tenants can normally stay and receive increasing levels of care. However in one or two cases, tenants have had to move to nursing homes when their care needs became too great to manage and there were additional serious risk factors.

Tenant participation is highly developed, with monthly meetings, regular newsletters and a video magazine, and an ad hoc tenants surgery with a direct line to the manager to address particular concerns when they arise. Tenant representatives take part in staff recruitment panels, health and safety and risk assessment check for the building, and liaison meetings with Irish Welfare and Advice Service,

St Eugene's also houses a drop-in centre, managed by IWAS and separately funded, where up to 40 additional older people from the local Irish community can have a nutritious meal, company and activities. Some drop-in users have since moved into the scheme. IWAS provides its own cook for the lunchtime meal, which is separate from the tenants' meals. The drop-in centre adds a real sense to the scheme of being integrated into the local community, having a dynamic atmosphere and providing a sense of belonging.

Other examples of specialist provision

The UK Coalition website and the report Coming of Age (Pannell and Palmer 2004) give details of other organisations that also provide specialist provision for older homeless people, including supported housing with some of the attributes of extra care housing, tenancy sustainment services (including for people in sheltered housing) and residential care models.

Further details of these can be found on the website www.olderhomelessness.org.uk and in the report Coming of Age (see further reading).

12. Examples of using mainstream extra care provision for older people who have been homeless

Although there is a role for specialist provision as discussed above, many older people who have been homeless can settle well into mainstream provision. Housing LIN members were asked in February 2005 for examples of using mainstream extra care schemes and intermediate care for older people who have been homeless. Sections 12, 13 and 14 provide a selection of the many responses received, including discussion points raised. Contact details are in section 15 below.

Example: **Knaresborough, North Yorkshire**

Harrogate Borough Council reported that they had recently allocated to the new extra care scheme in Knaresborough (featured in Housing LIN Factsheet No1). Four allocations (10%) were made to older people who were described as 'effectively homeless' because they were temporarily in residential care or nursing homes and couldn't return to their previous home because of the housing conditions and their care needs, but were inappropriate for residential or nursing care long-term. Staff pointed out that there may also have been other allocations to older people in housing in poor condition, or 'hidden homeless' with relatives who couldn't cope. None of these allocations to extra care would have been recorded as homeless because they didn't go through homelessness channels. The joint allocations panel set up for the extra care scheme has also played a wider role in preventing homelessness. It has facilitated closer working relationships between **North Yorkshire County Council Social Services** and housing staff, enabling social workers to raise other cases at the panel, including an older homeless couple.

Other respondents who had rehoused older people who were homeless or at risk of homelessness into extra care schemes included **Suffolk County Council** and **Hanover Housing Association.**

The research for this Factsheet also produced examples of older women being placed temporarily in intermediate care provision, and rehoused permanently into extra care housing, following domestic violence (from partners) and elder abuse (from other family members), such as the following case study:

Example: **Rehoused to extra care after homelessness following elder abuse**

Mrs B, an older woman, was rehoused into an extra care scheme after extreme violence and elder abuse from family members. She was referred to social services adult protection team after medical intervention discovered the abuse and she was admitted to hospital. She was so affected that had extra care housing not been available, the only alternative safe placement would have been residential care, even though this would not have been an appropriate response, given her abilities. Over a year later, she had settled well, her confidence had returned and limited family contact had been re-established in accordance with her wishes.

13. Hospital discharge arrangements and older homelessness: examples of partnership working and strategy development

It has long been recognised that homeless people of all ages can face problems on discharge from hospital, or (too often) discharge themselves inappropriately. Over recent years much work has been done to improve the situation and to try to establish policies and procedures. Older people can face particular problems, and as part of Help the Aged and hact's Older Homelessness Programme, a research project and report (Blood 2003) examined hospital discharge issues.

The report points out the duty placed on health authorities, in conjunction with local authorities, to develop procedures for discharge and to take special care in planning discharge for people who are homeless or in hostels. It refers to research in Bristol showing that there was a highly significant increased rate of readmission in patients living in hostels compared to patients from their own home or other settings. Research for the report carried out in Manchester found that over 40% of older homeless people (aged 50+) had at least one admission to a general, psychiatric or detoxification ward in the preceding year, in contrast to 14% in a national survey with a much older average age.

The report discusses the barriers to developing effective discharge arrangements between partners with very different priorities and funding. It highlights examples of good practice to improve discharge services for older homeless people, including teams based in hospitals and in Primary Care Trusts, an example of a local protocol and a pilot intermediate care project in sheltered housing schemes.

Example: **London Standing Group of Nurses/Homeless Link: Principles and guidelines for hospital discharge of homeless people**

Work is currently under way (May 2005) to prepare principles and guidelines for the development of local protocols on the discharge of homeless people from hospital. The guidelines will apply to homeless people of all ages, to include:

- considering why homeless people self-discharge;
- discharge from Accident and Emergency departments and from wards;
- joint working between hospital staff and other agencies; and
- examples of good practice.

The protocol will be available on the Homeless Link website from August 2005 (www.homeless.org.uk).

The following **examples of positive working relationships** and Supporting People funding to access extra-care, sheltered and other housing were provided by Housing LIN members in February 2005:

Example: **Willow Housing and Care, London Borough of Brent**

Willow (part of Network Housing Group) is the main provider of older people's housing (for people aged 60 or over) in Brent following a stock transfer. They have established a hospital link worker post, funded through Supporting People as floating support, to work with hospitals and social services to prevent bed blocking and assist older people to move back to independence after hospital. Both the hospital discharge post and the work undertaken by St Mungo's floating support service to older people with alcohol issues (see below) were prioritised by the London Borough of Brent in key strategies including Supporting People and Older People.

The hospital link worker started in October 2004 and focuses on older people whose delayed discharge is linked primarily to housing issues. In the first four-five months, of the 31 clients aged over 60, she has rehoused nine older people who had been homeless (including one woman). All were in their 60s and 70s: seven went to sheltered housing and two to extra care housing. Two had been hostel residents, one had been rough sleeping on and off for six years, one was evicted the day he left hospital, and five couldn't return to their previous home because it was unsuitable (including a houseboat and a bedsit in a House in Multiple Occupation). Of these nine cases, three had alcohol issues.

Willow is able to rehouse them, and other older people from hostels or a history of rough sleeping, in mainstream sheltered or extra care housing because of the positive working relationship with St Mungo's: prior to this, scheme managers did not feel confident about them moving into mainstream provision. The social services hospital discharge manager said that the post has made a 'huge difference' in facilitating speedy discharges, including addressing many of the practical problems (such as accessing furniture), building relationships and knowing her way round housing issues.

Example: **St. Mungo's: Floating support to older people in the London Borough of Brent**

St Mungo's is one of London's leading providers of services for people who are homeless and most vulnerable. It provides floating support to vulnerable adults in independent accommodation across London; specialist resettlement, mental health, and substance use services; pre-tenancy training; work and learning programmes; street outreach; day centres; and over 1400 bed spaces through shelters, hostels, supported housing, and care homes. It has substantial expertise in providing services to older homeless people.

St. Mungo's Brent Tenancy Sustainment Service is funded by Supporting People to prevent tenancy breakdown amongst older people with alcohol problems in Brent. It is designed to increase clients' ability, skills and knowledge to maintain their tenancies; to increase their confidence & motivation to make changes themselves; to increase integration of clients into the community (thereby reducing isolation); to reduce clients' dependency on alcohol; and to reduce the impact of the clients' alcohol use on their community.

The service is managed through a successful tenancy sustainment team and staffed by a Coordinator (who has expertise as an alcohol worker) and a tenancy sustainment worker. It provides a flexible support service adapted to individuals' needs and delivered in clients' homes. This encompasses a range of practical interventions, with an emphasis on supporting clients to manage and address their alcohol use issues, and assistance in accessing appropriate further services as appropriate/requested by the client. Practical help is provided to clients to manage their tenancies; assume responsibility for their behaviour and manage neighbourhood issues; claim benefits; access detox and expert advice where appropriate, and to access statutory and community based services such as health services, social services and one stop shops. Tenancy rescue work is performed.

St.Mungo's established this service in September 2004. There is a maximum caseload of 45 clients aged at least 50. St. Mungo's works with people across the borough and in all tenancy types. It works closely with Willow Housing as one its

referral agents, and through its work increases awareness within Willow of best practice issues in working with older people with alcohol issues. The service compliments other provision to avoid duplication. When working with Willow's tenants the service focuses on those areas in which scheme wardens do not provide assistance.

St. Mungo's Brent Tenancy Sustainment Service takes referrals from a range of statutory and voluntary agencies, including hospitals; social services; alcohol agencies and advice agencies. Brent is a racially diverse borough with significant Irish, African-Caribbean and Asian populations. Targeted efforts have been made to respond to the local profile through links with community groups, such as Brent Irish Advisory Service.

14. Intermediate care: a resource for older people who are homeless

Intermediate care beds can provide an excellent resource for older people who become homeless, and are usually much more suitable for older people than alternatives such as all-age hostels or bed and breakfast. Intermediate care beds can be in either sheltered housing or extra care housing but will provide a fully furnished and equipped flat or bungalow available for a temporary period, and appropriate support and care. There is currently discussion about whether they could also be located as a specialist unit within homeless hostels. The main purpose is to avoid prolonged and unnecessary stays in hospital for older people. Criteria, financial arrangements, care providers and lengths of stay vary according to how the scheme was set up. One issue that has been identified for homeless people is that schemes can require a discharge address before they will accept someone, due to the concern that an intermediate care bed will become blocked.

Housing LIN members came up with the following examples of older people at risk of, or actually, homeless who accessed intermediate care services, including:

- a couple in their early 60s who could not stay in their mobile home after the husband had a leg amputated, and later moved on into sheltered housing;
- a woman in her 60s who became homeless when she left her husband following abuse;
- an older man experiencing violence from his family (who would normally have been placed in residential care as a place of safety)
- older men who were unable to return to Salvation Army or YMCA hostel accommodation following hospitalisation, and who later moved into sheltered housing permanently
- older people who could not remain in their housing because it was unsafe (for example dangerous electrical wiring), following fire or flood, or because of self-neglect and insanitary, filthy conditions (St Helens has a partnership with their local Care and Repair, although finding anyone to do clean-ups is problematic)
- a man who became homeless and was suffering from depression after separation from his wife (see case study below).

Example: **Relationship breakdown, depression, homelessness**

Mr M was in his 60s and had been admitted to an acute ward of a local mental health unit. He had recently split up from his wife and was suffering with severe depression. He was also now homeless. As he began to get better some thought was given to his future. He felt he would be unable to cope on his own – his ex wife had done everything for him. He had lost his confidence but it was totally inappropriate for him to be considered for long-term residential care.

He went into the intermediate care flat with support from intermediate care staff linked to the mental health unit. Although they were providing the psychiatric support, Mr M needed a lot of practical support in the form of activities of daily living so that he could cook and look after himself independently. One of the worries was that he might slide back into depression without the support of the psychiatric staff to hand.

Initially over the first few weeks, Mr M was visited several times a day, which allowed staff to build up a very close and supportive relationship with him. Meanwhile the Occupational Therapist in the mental health unit keyworked the case and put forward a good case for urgent rehousing. After five weeks, Mr M was found a flat nearby and the rehab assistants followed him into this just as a supportive role as Mr M was now doing everything for himself quite ompetently. He is now successfully living independently on his own.

The following examples show the different types of intermediate care provision amongst Housing LIN members who responded:

Example: **Gloucestershire NHS Trust**

This NHS Trust has a number of intermediate care sheltered housing flats in partnership with a housing association and a district council. The Intermediate Care Co-ordinator points out that these are ordinary sheltered housing flats, not extra care, with a warden on site during weekday office hours. Intermediate care is provided by NHS staff (therapists and rehab assistants), usually for a maximum of six weeks.

Example: **South Gloucestershire Council**

This unitary authority has a two-bed bungalow and a one-bed flat available for intermediate care in two local sheltered housing schemes. As well as using the properties for people who cannot return home after a hospital admission because they need active rehab or are awaiting housing adaptations, they are also available for homeless people who need extra care and support, including older people.

Example: **Southampton City Council: Lundy Close bed-blocking project**

This project ran from February 2001 to April 2005 and was primarily for people who were bed-blocking due to housing-related reasons. Seven homeless people were rehoused over the four years of the project, with ages raging from 47 to 78 and including one woman. Two went straight from hospital to sheltered housing, one was signed up but died before the move, and the others went to sheltered housing via the specialist project.

Example: **St Helens Metropolitan Borough Council, Merseyside**

The Commissioning Manager for the Social Services Promoting Independence Team has a budget to provide ‘transitional tenancies’ in both extra care and sheltered schemes. This is in partnership with housing colleagues within the council, extra-care providers and local housing associations including Helena Housing (the local stock transfer housing association), Arena, Housing 21 and St Helens Housing Association. Occupancy levels fluctuate but they are often all taken up. The main focus is on preventing older people ending up in residential care for a variety of reasons, including hidden homelessness. The transitional tenancy gives time for assessment and for finding the most suitable onward permanent move.

Example: **Oak Foundation, Huntingdon**

Oak Foundation owns and manages sheltered and supported housing as part of Luminus Group. They have a partnership with the local Primary Care Trust to provide six intermediate care beds at present, and the potential for further accommodation, in one sheltered scheme. An issue that has arisen here (also mentioned by others) is that some intermediate care schemes are funded by Health and only available whilst the older person has specific need for rehab, but then they may continue to ‘bed-block’ the intermediate care bed because their housing needs cannot be resolved. Oak Foundation’s Community Services Manager also identified that when an older person has been experiencing elder abuse/domestic violence, a period of hospitalisation may provide them with the opportunity to confront this because the older person has been away from the situation and does not want to return to it. She referred to a recent initiative in their local Accident and Emergency department which was running a pilot to try to identify people who had experienced domestic violence (of any age) and signpost them for further help and support.

Example: **Lambeth Homeless Intermediate Care Feasibility Study**

Lambeth Primary Care Trust is currently (May 2005) carrying out a six-month feasibility study on the best way to provide intermediate care to homeless people, including older homeless people. The options being explored are:

- increasing the flexibility of current provision;
- a mobile nurse led service which could go into homeless hostels; or
- a specialist unit with nursing care within a homeless hostel.

The feasibility study will concentrate on meeting the physical health needs of hostel dwellers and rough sleepers. The Pan London Homeless Intermediate Care Group is acting as a steering group: it includes representatives from the Health Protection Agency, Lambeth PCT (both homeless provider and commissioning elements), Homeless Link and St Mungo’s (voluntary sector) and Lambeth Council (Street Population Outreach Co-ordinator). For further information, contact the UK Coalition on Older Homelessness.

15. Practical steps to take in your area

To prepare for local strategies, it is essential to know the numbers of older people vulnerable to homelessness and their housing circumstances, as did Southampton City Council in the example above.

Data sources you can use locally include:

- Local authority homelessness and housing advice statistics: do they both record and report on age in your area? If not, why not?
- Data from local advice agencies (eg Shelter, CABx)
- Data from specialist services in your area (eg Women's Aid or other domestic violence agencies)
- Data from local institutions (eg prisons)
- CORE data on housing association lettings in supported, sheltered and general needs housing (NHF will provide local information by age for people classified as statutory or non-statutory homeless)
- Local data from voluntary sector provision (eg monitoring of hostel vacancies, age of people supported by resettlement or floating support services)
- Local data on rough sleepers from street outreach teams and street counts;
- Census and survey data on older people's housing tenure, and on the extent of housing with insecure tenure (eg mobile homes, Assured Shorthold Tenancies, tied housing) especially if this is significant in your area
- Data from homeless health teams/Personal Medical Services in the area (eg Southampton).

When **planning new extra care housing or intermediate care provision**:

- consider any specific needs for specialist services (like Southampton);
- monitor allocations to people who are homeless to build up a picture for future demand (like Harrogate BC);
- extend the criteria for intermediate care provision to include homeless older people (like South Gloucestershire and St Helens).
- remember that older people who have been homeless are likely to need the services of other health professionals, including occupational therapists, dentists, chiropody and dieticians.

Supply mapping for Supporting People will have identified all provision in your area, but:

- Do you know how much specialist homelessness provision is available and appropriate for older people?
- Does Supporting People monitor for age (ie if a service says they cater for all ages, are they asked for age data on their service-users)?
- Is there a gap in suitable provision for older people with specific needs (eg older women, older people with alcohol issues)? All-age services are unlikely to cater for the specific needs of older people.

It is also important to make **links between all the relevant local strategies** and to challenge them to consider the needs of older people vulnerable to homelessness.

16. Useful resources

Contacts (in same order as references in the text):

UK Coalition on Older Homelessness: Sarah Gorton
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Suffolk County Council: Judith Hawkshaw
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Hanover Housing Association: Juliette Daniel
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Willow Housing and Care: Mary Whitfield
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St Mungo's Tenancy Sustainment Team Manager
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St Helens Metropolitan Borough Council: Les Bond
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Oak Foundation: Anita Goddard
Community Services Manager
Tel 01480 396560
Anita.goddard@hhp.org.uk

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Annex 1: What do older homeless people say they want?

These quotes from interviews with older homeless people (Pannell et al 2002, Willcock 2004) reflect the views of older people who had been homeless for some time on their housing choices for the future.

Moving on from direct access hostels to supported housing projects (shared housing)

Interviewed in a dormitory-style night shelter whilst awaiting resettlement, a man aged 65 had lost his job over twenty years before after taking time of work to care for his sick mother and
then spiralled into homelessness, rough sleeping and a previous failed tenancy:

'It's depressing as a place [shelter], like something out of Dickens, or workhouses, but the bedding's changed, … there's food, three meals a day, there's services such as care workers, access to the health clinic … Places like this may not be perfect but at least they're there. I must admit it's handy having the staff around, and services, food provided but you've got to put up with the other residents.'

Another was fearful of being resettled from the shelter; he had a history of panicking and returning to rough sleeping when a move was imminent, and then returning to the hostel again:

'I wasn't happy about moving there … I've built up a lot of friends here [hostel], I know everybody … What they're trying to do is get me into a shared home, with my own room. I don't want my own place – I've tried that before. I'd like to live with other people, but with my own room where I have privacy.'

Deteriorating health (and sometimes serious or terminal illness) is often a spur to people who have been rough sleeping agreeing to 'come inside', as a 65 year old man now living in a supported housing project explained, but shared living can still create tensions:

'This last couple of years my health's deteriorated, at one time I wouldn't come in, I got used to sleeping out, as you get older you can't walk the same, breathe the same … when you get old, you get irritable, you want to watch your own telly, have your own things to do, there are three tellies here, they still argue over it … .'

Shared houses also meant that people had no choice over whom they shared with. This was especially problematic where shared houses were for homeless people of all ages:

'It was a rough place, all these men drinking, mostly younger people, you got to share a cooker and everything, if you bought something and put it in the fridge they'd eat it, I had this bedroom up in the attic … .'

However, those living in supported housing projects with high levels of staff support welcomed the security that gave them:

'When anything is really needful, like I was really ill, [floating support staff] stayed with me all day … .'

Individual tenancies

There can be mixed reactions to individual tenancies. For many formerly homeless older people, it was the ultimate goal:

'It was a rough place [shared house] … mostly younger people, you got to share a cooker and everything, if you put something in the fridge they'd eat it … I had to stick it and then they found me this place [own tenancy].'

'You're better off with a place on your own, aren't you? … I didn't like mixing with the young'uns [in night shelter] … Its easier to cut back [on drinking] because you're in your own place, it's easier than when you're with alcoholics all the time',

'When you're on your own you can do what you like, go out and come back when you want, there's no-one telling you what to do.'

'I can go to bed at night without anyone banging on the door.'

However, one older man 'bed-blocking' in a direct access all-age homeless hostel expressed a view reflected by others grown accustomed to a communal lifestyle. He had previous failed tenancies, of which he said:

'It's worse than a prison in your own flat staring at four walls all day, because in prison at least you would have a cell-mate.'

Others were clearly isolated, lonely and depressed:

'It's a bit boring being on your own, I go to bed early when I get fed up…'

'Look at this bare floor … look at all the nails sticking up, I wish I could buy a fitted carpet to make it more comfortable …and some more pictures, and a radio … .'

There was also an expectation that moving in later life would be to accommodation that would suit their needs as they grew older:

'I need a ground floor flat, I don't like climbing stairs … it is difficult climbing when the lift breaks down.'

Sheltered housing models

Older people resettled into sheltered housing liked the security and facilities, like this man in his 70s resettled after a lifetime of moving from hostel to hostel and, in later years, fear of the behaviour of younger hostel residents:

'I'm all right now, I've enjoyed it since I was here, it's the best place I've ever had, nice and quiet, nobody bothers me, there's two gates out there and they're locked at six o'clock.'

Others referred to the practical advantages, including:

- central heating (sometimes included in the service charge which helped with budgeting);
- carpets and curtains, and sometimes furniture form previous tenants;
- laundry facilities on site;
- social facilities (although their acceptance by other tenants varied).

However, some may find that being with much older residents is not ideal, like this man in his 60s who liked his sheltered flat but was less happy that most of his neighbours (in their 80s) were of his parents' generation:

'They just sit around all day and their lives are going by. I keep active, paint, drink, smoke, listen to rock music … .'

Residential care models

Residents in a specialist residential care home for older people who had been homeless were unhappy about being left with such a small amount of personal spending money but welcomed the meals and staff:

''I had me own flat, I had an accident [head injury], I couldn't cope on me own. I feel secure here, they'd help me if there's any trouble.'
Like others interviewed, he was terrified of dying alone, and no-one finding home for days or weeks.

'I couldn't really manage on me own in a flat, there's no pot washing here, you're all right.'

A man aged 80, terminally ill and in an ex-Forces dual-registered nursing home, had ended up sleeping rough after a traumatic relationship breakdown at about the time of his retirement. Accessing the nursing home enabled him to spend his last few months being cared for: interviewed after four months in the home, he said:

'This is nice, I'm absolutely at peace, people are nice and tidy and polite here, I'm super now, feeling really nice.' He died a few months later.

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