Wintringham

Homelessness among older people: a comparative study in three countries of prevention and alleviation

Wintringham

Bryan Lipmann, Frances Mirabelli, Alice Rota-Bartelink

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This Report represents the results and analysis of the Australian component of a tri-nation study of the causes of homelessness amongst newly-homeless older people in England, Australia and the USA.

The intention of the participating organisations in America, England and Australia is to produce a final report in one volume detailing the combined results and comparative analyses.

WINTRINGHAM

Wintringham is a not-for-profit welfare organisation that provides a wide range of services to elderly homeless men and women in Melbourne, Australia. These services include low and high care residential care, community based care, outreach and advocacy services and an extensive range of housing options.

Wintringham provides support and care to over 650 aged homeless people every night.

For a more detailed description of the services provided by Wintringham, or to make contact with the organisation, readers are referred to our web address www.wintringham.org.au

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Table of Contents

EXECUTIVE SUMMARY ..... **i**

1. STUDY BACKGROUND AND METHODOLOGY **1**

1.1 THE PREVALENCE OF HOMELESSNESS AMONG OLDER PEOPLE 1
1.2 PRIOR UNDERSTANDING AND THEORIES 2
1.3 AIMS AND CONCEPTUAL MODEL OF THE THREE-NATION STUDY 5
1.4 THE STUDY DESIGN AND METHODS 6
1.4.1 Population of interest *6*
1.4.2 The instruments *6*
1.4.3 Sampling and interviewing in Australia *7*
1.5 DATA RECORDING 8
1.5.1 The validity of the data *8*

2. OVERVIEW OF THE AUSTRALIAN CONTEXT **9**

2.1 BACKGROUND 9
2.1.1 Homelessness Services *9*
2.1.2 Health Care *10*
2.1.3 Aged Care *10*
2.1.4 Housing *11*
2.1.5 Social Security *12*
2.1.6 Summary: impact upon the elderly homeless *12*

3. BACKGROUND OF THE RESPONDENTS **14**

3.1 AGE, SEX AND ETHNICITY 14
3.2 MARITAL STATUS 15
3.3 WORK HISTORY 16
3.4 HOUSING HISTORY 18
3.5 PREVIOUS HOMELESSNESS 21

4. PROXIMATE REASONS FOR HOMELESSNESS **24**

4.1 HOUSING: PHYSICAL CONDITION AND TENURE 24
4.2 FINANCIAL PROBLEMS 27
4.3 PROBLEMS WITH TENANTS OR NEIGHBOURS 28
4.4 BREAKDOWN OF MARITAL OR CO-HABITATING RELATIONSHIPS 29
4.5 DEATH OF A FRIEND OR RELATIVE 30
4.6 PROBLEMS WITH OTHER RELATIVES 32
4.7 SUMMARY 32

5.0 HEALTH AND ADDICTION PROBLEMS **33**

5.1 PHYSICAL HEALTH PROBLEMS 33
5.2 MENTAL HEALTH ISSUES 36
5.3 ALCOHOL 37
5.4 DRUG PROBLEMS 40
5.4 GAMBLING PROBLEMS 41
5.5 SUPPORTS ACCESS PRIOR TO HOMELESSNESS 42

6. SERVICE AND POLICY GAPS **47**

7. REFERENCES **50**

Executive Summary

This report describes the genesis, design and preliminary findings of a study of the causes of homelessness among newly-homeless older people in England, Australia and the USA. The report concentrates on the Australian findings. Since the late 1980s, there has been an increased level of attention given to the problems of older homeless people and a few specialist services have been developed to meet their needs. It has been shown that many have recently become homeless for the first time, raising questions about the reasons why older people become homeless and whether their homelessness could have been prevented.

The aims of the three-nation study were: (i) to increase understanding of the causes of homelessness among older people, by examining the biographies of recently homeless people and the policy and service context in which they became homeless; and (ii) to inform the debate about prevention practice, by identifying the sequence of events that precede homelessness, and the risk factors and 'early warning' indicators of serious difficulties.

The tragedy of elderly homelessness is as much a blight on Australian society as it is in the other nation members of this study. The study highlighted and reinforced many of the experiences that Wintringham has gained over the past 15 years of working with aged homeless men and women, but also drew attention to causative factors which have not in the past been as widely acknowledged as perhaps they should be.

While the linkages between psychiatric disorders, ABI and depression with homelessness are well known, the study revealed new linkages with what has been described in the American literature as New Homeless: people who would normally have appeared to be unlikely candidates for homelessness, but whose changed circumstances have been sufficiently severe to culminate in the elderly person becoming homeless. Similarly, the linkages between gambling and aged homelessness is an area that needs further research if an effective preventative model is to be developed.

The study demonstrated that it is clear that the longer a person had been homeless, the less likely that they retained a belief that there were supports and services in the community that could assist them. This conclusion is entirely consistent with the experience of Wintringham which has found that it is invariably the most recently homeless of our clients who retain a positive outlook and optimistic view of the future.

The results of this study provide clear guidelines to potential improvements in policy and service delivery.

The study demonstrates once again, that perhaps more so than with any other homeless group, the role of the outreach worker is absolutely critical. It appears to be within the nature of elderly homelessness, that the aged person withdraws, can at times be reclusive, and rarely if ever, goes searching for services. Compared to the relative assertiveness of many of the young homeless, aged people live and die often in the most appalling circumstances, unable or afraid to seek help.

An effective outreach worker can, through a variety of informants and established linkages with local services, find these aged people and begin to broker services for them. In Australia, the nationally funded program Assistance with Care and Housing for the Aged (ACHA) resources such services, and has made one of the most effective and productive impacts on the steady flow into the homeless world of elderly and financially vulnerable people. Unfortunately however, the program is tiny and severely under-resourced. A clear recommendation arising out of this study, is that the ACHA program be expanded and refocused towards the most vulnerable of the impoverished aged. ACHA remains one of the most cost-effective services in the country.

The other clear outcome of this research is the need for specialised services to be developed or improved so that the aged homeless can gain access to them. There is in Australia, no clear Department or policy area that has responsibility for the aged homeless. Elderly homeless people have a variety of needs, the responsibility for which falls across Housing, Health and Aged Care as well as Social Security for income support and Veterans' Affairs for income and specialised support services.

The inevitable result is that the lack of services can be attributable to a variety of different jurisdictions and portfolio responsibilities. Wintringham has argued since its creation in 1989, that for the purposes of program responsibility, the elderly homeless should be considered to be aged and as such entitled to the same suite of services that mainstream elderly people are entitled to. By considering them as primarily homeless, departments are inevitably consigning the elderly homeless to a poorly resourced program area that has no experience or expertise in providing aged care services.

With regard to aged care services, it is clear that the elderly homeless need access to quality high and low care residential services. The responsibility of the Commonwealth Department of Ageing is to resource the capital construction of such services, for it is clear that the poverty of the homeless themselves prevents any organisation such as Wintringham from earning enough surplus income to finance the construction of additional services.

A further recommendation arising from this research is the clear and undeniable need for an increase in the provision of affordable housing for the aged homeless and for those at risk of becoming homeless. While it is apparent from the study that many of the respondents were unable to live independently and as a consequence, lost their housing, it is Wintringham's experience that the levels of support required is often quite low and able to be provided within the program parameters of the Community Aged Care Package Program. The lesson from our practical experience and from the results of this study is that the provision of affordable housing and the existence of low and medium levels of support can prevent vulnerable aged people from becoming homeless.

1. Study background and methodology

This report describes the genesis, design and preliminary findings of a study of the causes of homelessness among newly-homeless older people in England, Australia and the USA. This report concentrates on the Australian findings. Since the late 1980s, there has been an increased level of attention given to the problems of older homeless people and a few specialist services have been developed to meet their needs (Cohen *et al*., 1993; Crane and Warnes, 2000; Doolin, 1986; Warnes and Crane, 2000, Lipmann 1989). It has been shown that many have recently become homeless for the first time, raising questions about the reasons why older people become homeless and whether their homelessness can be prevented.

It was these issues that prompted the collaborative and comparative study. It was carried out by a partnership of researchers and service-provider organisations: The Committee to End Elder Homelessness and The Elders Living at Home Program in Boston, Massachusetts; Wintringham in Melbourne, Australia; and The Sheffield Institute for Studies on Ageing (SISA), University of Sheffield. The Australian element was funded by the Australian Government's Department of Family and Community Services; the UK component by the Economic and Social Research Council and The Leverhulme Trust; and the USA element through the general funds of the partner organisations. This chapter describes the study's background, aims, design and implementation, and the structure of the report.

1.1 The prevalence of homelessness among older people

There are no comprehensive statistics about the number of older people who become newly homeless in any of the three study countries. In England in 2002, local authority housing departments accepted almost 4,500 households in 'priority need' of rehousing on the grounds of old age – most used threshold ages of 60 years for women and 65 years for men (Office of the Deputy Prime Minister, 2003). In addition, many older people sleep on the streets or stay in hostels and night-shelters.

In London, 700 people aged 50 years and over were in hostels on one night in 2000, while 569 people in this age group slept on the streets in the city between April 2001 and March 2002 (Broadway, 2002; Crane and Warnes, 2001a). Around 15-20% of single homeless people in England are aged 50 or more years (Warnes *et al*., 2003).

In Massachusetts, a local census in 2000 enumerated 1,228 homeless people aged 50 years or more, of whom 610 were in the city of Boston (Boston Partnership for Older Adults, 2003).

In Australia, the 2001 Census and other sources identified 99,000 homeless people, of whom 24,227 (24%) were aged 45 years or more (Chamberlain and Mackenzie, 2003). Single-point counts do not however capture the 'flow' of people who move in and out of homelessness. Evidence suggests that the population that experiences homelessness over one year is three to five times the number on any one night (Wright and Devine, 1995).

Another data source used in estimating the demography of homeless in Australia is the SAAP National Data Collection which records those SAAP clients who are assisted by SAAP agencies for a period of one hour or longer (SAAP Monograph, 2002). This data set, however, reveals a deceptively low number of older homeless people primarily because SAAP does not target the elderly homeless people.

A more relevant source of information comes from the Commonwealth funded Assistance with Care and Housing for the Aged (ACHA) program. A national review of ACHA estimated that 250,000 people fell within the program target group (Alt, Statis and Associates 1996).

1.2 Prior understanding and theories

Empirical research findings and theoretical models of the causes of homelessness have emphasised the roles of structural economic and macro-policy conditions, such as poverty, scarce affordable rented housing, unemployment, and of personal vulnerability, disability and behaviour (Avramov, 1995; Greve, 1991; Lee *et al*., 2003; Shinn & Gillespie, 1994). Multivariate analysis of structural influences on rates of homelessness among US metropolitan areas found that the strongest predictors were the availability of low-cost housing and mental health services (Elliott and Krivo, 1991). Some argue that homelessness occurs among those who lack the ability or resources to cope with roles and responsibilities or to compete in the housing and employment markets, particularly when facing negative events such as the loss of a job, family breakdown, or the loss of co-resident support (Main, 1996; Shinn *et al*., 1991; Wolch *et al*., 1988). Sosin (2003) proposed that some needy people may experience difficulties in getting resources because of their poor interpersonal skills, the rules of various social programmes, and their negative experiences of services.

Hoch and Slayton (1989) are less equivocal stating that "… the primary reason for the unexpected rise in the number of homeless people and their persistent dependency has more to do with the nearly wholesale destruction of the SRO hotels during the past 30 years than either the changing social composition or personal vulnerabilities of the urban poor".

Blau (1992) similarly sees "… the rise of modern homelessness as the product of the political and economic changes that have occurred in the United States over the last generation".

Keigher (1991) agrees with Blau, noting the importance of single room occupancy (SRO) housing for the very poor. She states that the "wave of federal and local budget cutbacks" have impacted upon the very services that the urban elderly poor rely upon to prevent themselves from becoming homeless.

The linkages between structural and individual factors leading to homelessness are regularly debated in Australian and international research literature. In Australia, The Council to Homeless Persons (CHPA 2002) notes that the lack of affordable housing and inadequate income are the two main drivers leading to older homelessness. Lipmann (1999) states that the inability of older homeless people to access appropriate and affordable services is a major contributor to homelessness amongst the aged. He also notes that discriminatory and judgemental attitudes by mainstream providers can limit the opportunities for aged people at risk of becoming homeless from accessing appropriate services (quoted in Judd et al 2003).

Kavanagh's case study (1997), also noted that the prevalence of structural inequalities, often dating back to childhood, had a significant impact on the likelihood of homelessness in later life.

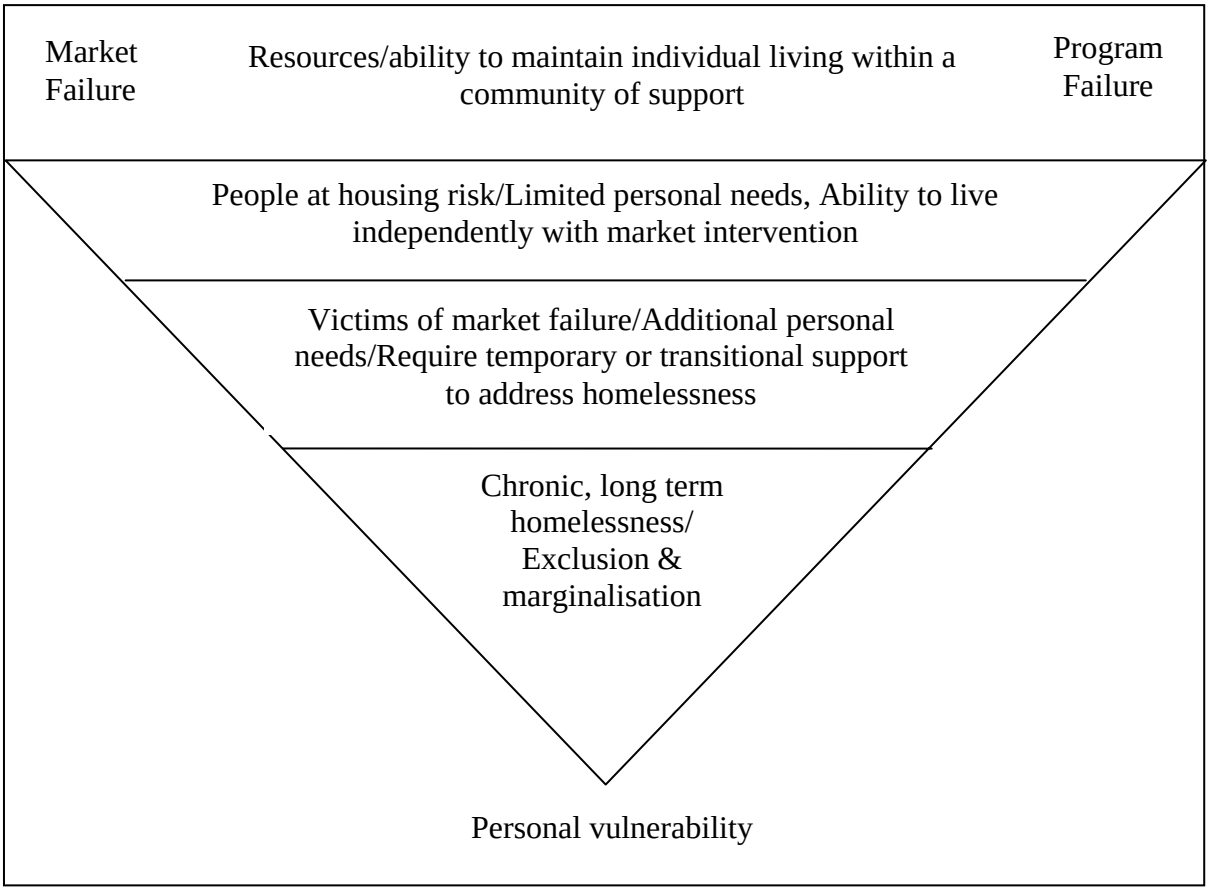
A major national study on homelessness amongst the veteran community (Thompson Goodall Associates 1998) highlighted the interaction of three important factors:

1. Failure in critical markets such as the housing and labour market in providing employment and an adequate supply of affordable housing

2. Failure in important government programs notably poor access to services, insufficient coverage of services, inadequacy of service models and cultural barriers.

3. Personal vulnerability to market and program failure potentially linked to the experience and status of veterans.

A veterans' risk of homelessness is linked to the interaction of these factors.



From the mid-1990s, systematic empirical investigations of the risk factors for homelessness identified high rates of mental illness, substance abuse and disruptive childhood experiences among homeless people compared to never homeless groups (Caton *et al*., 2000; Herman *et al*., 1997; Koegel *et al*., 1995; Odell and Commander, 2000; Sullivan *et al*., 2000). Susser *et al*. (1993) developed a model of causal pathways that incorporated various personal risk factors at different stages of the life course. This showed that in the USA in the early 1990s the most influential factors for homelessness in later life were economic and social resources, early acquired personal characteristics and current health status. Cohen's (1999) model of homelessness and aging proposed that the risk of homelessness accumulates over a lifetime and that the event occurs when several risk factors co-present. The most influential risks during middle and later adulthood were imprisonment, substance abuse, mental and physical health problems, victimization, lack of family and social networks, and low income.

There has been little rigorous research into the causes of homelessness in later life. Studies of older people have found that the transitions that commonly precede or 'trigger' the problem are widowhood, the death of the last surviving parent, marital breakdown, family disputes, and the onset or increased severity of a mental illness (Crane, 1999; Crane and Warnes, 2001b; Keigher, 1992; Kutza, 1987; Wilson, 1995). Among those aged in their fifties, enforced unemployment, income decline, and the age group's few entitlements to social security benefits and support services are also factors (Cohen, 1999). There is a need for strengthened evidence and age-group specific models of the trajectories that lead older people into homelessness.

For a more extensive Literature Review on Older Homeless People, readers are referred to the excellent review contained in Judd et al (2003).

1.3 Aims and conceptual model of the three-nation study

The aims of the three-nation study were: (i) to increase understanding of the causes of homelessness among older people, by examining the biographies of recently homeless people and the policy and service context in which they became homeless; and (ii) to inform the debate about prevention practice, by identifying the sequence of events that precede homelessness, and the risk factors and 'early warning' indicators of serious difficulties.

The conceptual model adopted for the study was that homelessness is a function of structural and policy factors, health and welfare service organisation and delivery factors, and personal problems and incapacities. By studying a relatively homogeneous category of homeless incidence, *i.e.* recent cases among late middle-aged and older people, in contrasting public welfare and philanthropic regimes, valuable insights into the operation and relative contributions of the policy, service and personal factors would be obtained. Evidence of unusually prevalent pathways into homelessness in one country might be explained by its distinctive welfare policies and presence or absence of services, or alternatively by atypical features of its social pathologies.

1.4 The study design and methods

Designing the study and its instruments took many months. Agreements had to be reached between the various international members of the study about the aims of the research, the rationale for studying only *newly* homeless people, and the best ways to collect information from a 'hard-to-reach' and difficult client group. On both strategic issues and specific design and methodological issues, such as the definition of 'homelessness', extended debates were conducted throughout the study by the exchange of 15 study development papers.

1.4.1 Population of interest

The study focused on *newly* homeless older people purposely to gather detailed and relatively reliable information about the circumstances that lead to homelessness. To have included people who had been homeless for several years would have reduced the quality of the data, as a person's recall of events that took place years earlier will normally have deteriorated. Being homeless was defined as: (i) sleeping on the streets, or in other public places or improvised dwellings; (ii) living in accommodation which is intended to be temporary with no lease or security of tenure, including 'doubling-up' with relatives or friends for less than six months; and (iii) being without accommodation following eviction or discharge from prison or hospital. The study sampled people who had become homeless during the last two years and were aged 50 years or over when they became homeless. People who met the above criteria and who had previously been homeless were included if they had been housed for at least 12 months prior to their current episode of homelessness. The target was 125 subjects in each country.

1.4.2 The instruments

The principal research instrument was a semi-structured questionnaire that collected details from the subjects about their circumstances and problems prior to homelessness. Topics included: housing during the previous three years and reasons for leaving, earlier homeless experiences, employment history, financial situation, contact with family and friends, health and addiction problems, and contact with formal services or reasons why not. The respondents were asked directly about whether specified factors were implicated in them becoming homeless using a threefold grading ('not at all', 'a little', and 'a lot'), and how these contributed to homelessness. The factors were: the death of a person, marital breakdown, other family changes, problems related to work, financial difficulties, physical and mental health problems, addiction (alcohol, drugs and gambling) problems, and criminal

convictions or charges. The subjects were also asked open-ended questions about the factors that they believed were instrumental.

A second instrument collected information from the key-workers (*i.e.* case-workers) of their assessment of the subjects' problems and needs, and their understanding of the events and difficulties that contributed to homelessness. This also had direct factor assessment and open-ended questions, and was self-completed once the key worker had become familiar with a subject's background and problems.

The instruments were developed collaboratively by the partners. The exercise demanded unusual attention to the underlying concepts and terminology to ensure consistent validity and meaning in all three countries. Consensus (and therefore generalized) taxonomies of types of housing, home support and health services were agreed. The final schedules were identical in all three countries, as was the coding scheme apart from country-specific categories for ethnicity. The two instruments were piloted in each country and revised twice.

1.4.3 Sampling and interviewing in Australia

In Australia, the sample was obtained primarily by those located in either Wintringham housing, residential care facilities or through Wintringham's outreach workers. To assist in obtaining the required numbers, other homelessness agencies were approached for assistance. The workers identified clients who fitted the criteria, and forwarded the names of those who were interested in being interviewed. It was the responsibility of the researcher to thoroughly explain the purpose of the questionnaire and to obtain consent from the respondent. Interviews were conducted with 125 subjects in venues which had been agreed to by the respondent. The interviews were carried out sensitively and 'paced' by the subjects. They were informed that they could refuse to answer any question or stop the interview at any time. In a few instances, more then one interview was required to complete the questionnaire.

In Australian (as in the other study areas) there was neither 'flow' data or a sample frame available of newly-homeless older people. To increase the sample's representation of females, efforts were made during the final months to recruit more women.

1.5 Data recording

A common coding scheme was developed, and each partner coded and entered the data into an identical pre-structured database. Initially, a database of variables and value labels for the pre-coded questions was created, and files of the transcribed responses to the open-ended questions. The second stage involved creating variables and value labels for the open-ended replies, and was undertaken once each country had coded 25 questionnaires. All partners contributed to this exercise. The augmented databases contained 290 variables. The three country databases were merged once the coding and data entry were completed, and the merged database has 377 cases. To protect the confidentiality of the subjects, personal names were not entered into the database nor exchanged among the partners.

Data quality-control procedures were followed in each country. The questionnaires were checked by a second person for legibility, appropriateness and completeness, and checks of the coding and data keying were carried out (including duplicate blind coding and 'read backs' of the database entries).

1.5.1 The validity of the data

While the instruments sought a detailed description of the events and states that preceded homelessness, it is impossible to collect comprehensive retrospective information about the causes. The primary informant is the person who went through the experience, and their accounts are subjective and selective. In many cases estranged relationships are implicated, and rarely is it possible to interview the others involved. Moreover, most people have only partial comprehension of the influence of the policy and service-delivery contexts. The key-workers' assessments supplemented and partially verified the subjects' accounts, but many had limited knowledge of the subject's circumstances before they became homeless. This was particularly true for the study in England, where a few subjects were placed by housing officers in bed-and-breakfast hotels and did not have contact with key-workers.

2. Overview of the Australian context

2.1 Background

This section provides a very brief overview of parts of the relevant policy and service context as it effects service delivery to older homeless people in Australia.

2.1.1 Homelessness Services

The Australian programmatic response to homelessness is the Supported Accommodation Assistance Program (SAAP) which was established in 1985 and is a joint Federal and State/Territory funded program administered by the State /Territory Governments (SAAP Monograph, 2002). Almost 1,200 SAAP Agencies are funded across Australia, including 326 services in more than 180 organisations throughout Victoria. Services provided include:

Crisis accommodation: provided in facilities such as night shelters and women's refuges;

Transition Support Services, delivered on an outreach or drop in basis. These are usually longer term support services designed to assist people with establishing a tenancy;

Homeless Persons Support Centres, which are generally day centres which provide meals, showers and recreation services; and a

Telephone Information Referral Service; providing the caller with information on available services and provides referrals on a statewide basis (Victorian Homelessness Strategy, 2000).

In the 2000-01 financial year, the relevant governments contributed $268.5 million towards SAAP agencies in Australia (SAAP Monograph, 2002).

While SAAP funds organisations that work with homeless people of all ages, it is clear that the "generic homeless service system is not adequate for meeting the needs of older people who are homeless" (Judd et al, 2003). The SAAP background paper (SAAP Monograph, 2002) also highlights the multiple problems that older homeless people face.

In addition to the SAAP services there are a number of programs which are either Federal or State funded. The following are some of those that target or may provide services to the elderly:

Assistance with Care and Housing for the Aged (ACHA): an outreach program designed to assertively seek out the elderly homeless and re-establish a tenancy with appropriate supports.
Community Connection Program: an assertive State funded outreach program similar to the federally funded ACHA program designed to identify homeless people and link them back into the community.
Homeless Persons Psychiatric Services: targeting homeless people with a mental health illness.
The Royal District Nursing Services Homeless Persons Program: providing direct health care and support to homeless people (SAAP Monograph 2002; Victorian Homelessness Strategy, 2000).

2.1.2 Health Care

Australia has a national health care system which provides universal health care to all Australians. Underpinning this system is Medicare, providing services either free of charge or through a co-payment by the users. All the services provided by medical practitioners, optometrists and all pharmaceuticals listed as part of the Pharmaceutical Benefits Scheme, are subsidised by Medicare.

In addition to services provided by Medicare, veterans and those in the armed forces are also entitled to supplementary benefits from the Department of Veteran Affairs.

2.1.3 Aged Care

The Australian Government is responsible for the funding and regulation of both Residential and Community based aged care services. Actual service provision is provided by a wide variety of for-profit and not-for-profit organisations, and in some case, State Governments.

The system is intended to ensure that there is universal access to aged care services for all Australians, irrespective of wealth. The reality is somewhat different, with the aged homeless often struggling to gain access to quality aged care services. This experience is by no means unique to Australia, with a 1995 study demonstrating that the aged homeless in USA and a variety of Scandinavian and European countries were living largely outside of the aged care service system (Lipmann, 1995).

There is no simple explanation why the aged homeless find it difficult to access mainstream aged care services, although a number of commentators have noted issues

such as independence and reluctance to accept services, lifestyle issues and reluctance of mainstream managers to accept people from a homeless background (Waanders, 2000; Lipmann, 1999; Purdon Associates, 1991).

In spite of these difficulties, some organisations such as Wintringham in Melbourne, have been able to develop a number of aged care services that are particularly targeted at elderly homeless men and women. The difficulties that these organisations face however, is that the funding and policy direction of the national aged care program is directed at mainstream society in general and not at the particular needs of the homeless.

2.1.4 Housing

The public housing sector is funded through the Commonwealth State Housing Agreements (CSHA) with matching funds from both the Federal Government and the State and Territory Governments. The construction, management and ownership of the housing are a State and Territory responsibility.

Housing services that have relevance to older homeless people include:
Crisis Accommodation Program: As described earlier, this provides short term accommodation in the form of night shelters or women refuges.
Transitional Housing Management Program: This program is multifaceted, providing medium term housing for those waiting for a long term vacancy to arise; Housing Information and Referral services, which guide and refer the homeless to appropriate housing services; Housing Establishment Fund, which provides financial assistance for the purchase of basic goods for those in crisis situations; and Public Housing Assessment, where assistance is provided to determine eligibility for public housing.
Long Term Housing: Access to permanent long term housing is through the Segmented Wait List which provides for four categories of housing client. Stringent criteria surrounds each segment and all the requirements must be fulfilled before an offer of housing is made. Segment 1,or highest priority, targets people with a history of repeated episodes of homelessness, while Segment 2 responds to people with high support needs or people whose disability requires modification to a home. Segment 3 targets people with special needs, such as someone whose current housing is unsuitable due to personal health or family reasons. Segment 4 is Wait Turn and directed at people who do not fit into the above criteria. While it considered that they are eligible for public housing their needs do not warrant urgent attention.

Victoria's housing program is divided into three programs: Aboriginal Housing; Direct Tenure Public Housing, which is the largest portfolio and includes rental general housing program, supported housing program and movable units; and the Community Managed Housing Program which includes, rooming houses, group housing, long term community housing, rental housing co-operatives and community housing programs (Summary of Housing Assistance Programs, 2001-02). These three housing programs are required to follow strict policy guidelines with regard to a range of areas including rental charges, security of tenure issues and dispute resolution.

In addition to the housing program funded through the CSHA, the Federal Government provides a supplementary housing payment to those people who live in private rental accommodation and who receive social security payments. In the mid 1980's the Federal government shifted away from funding the construction of public housing through the CSHA, and placed a greater emphasis on the provision of income support in the form of the Commonwealth Rental Assistance (Australian Bureau of Statistics, 2002). The result of this is that net additions to public housing stock have effectively fallen while rent assistance to private tenants now exceeds $1.6 billion (Affordable Housing in Australia, 2001).

2.1.5 Social Security

The Australian social security system, which has evolved since 1901, is administered and funded through general taxation revenue by the Federal Government. Social security in Australia differs to that provided in most other developed nations in that it is not a social insurance scheme but instead provides means tested flat rate income support payments to the elderly, those who are unable to work (disabled and the sick) and those who are unemployed.

Pensions for war veterans and their dependents, which encompass both income support and compensation, are also funded by the Federal Government via the Department of Veterans Affairs. The benefits are available to all and are available indefinitely, subject to regular income and assets tests.

2.1.6 Summary: impact upon the elderly homeless

In principle, the Australian welfare system benefits the elderly homeless in a variety of ways, notably through the existence of a minimum income through the aged or veterans pension, the provision of public housing, free access to public health and free and universal access to aged care services. In addition to these safety net services,

policy makers can point to the Supported Assistance Accommodation Program (SAAP) as a dedicated program that funds specific homeless services.

The reality for elderly homeless people however, is one of constant struggle to access most of these services. The clear conclusion of this report is that with improved access to existing mainstream services, the tragedy of homelessness effecting aged people who are at their most vulnerable stage of life, can be significantly reduced.

3. Background of the Respondents

3.1 Age, Sex and Ethnicity

Of the 125 people interviewed, the gender split was 93 (74%) male and 32 (26%) female. The age distribution shows that almost half of the study subjects were aged in their fifties, with 36% in their sixties and 16% in their seventies.

Table 1 - Ethnic Mix of Study Subjects by Country of origin

Country of origin	**Number**	**%**
Australian non-indigenous	77	62
Indigenous Australian	1	1
United Kingdom	11	9
European	22	18
African	4	3
Asian	2	1
Other	8	6

The number of Australian-born non-indigenous people is marginally lower than the national average which is 65% for people over the age of 50 at June 2000. (SAAP Monograph, 2002).

The ethnic mix of those questioned is reflective of the post war immigration patterns, which reached their highest levels in the 1960's and 70's. The cultural mix of that time was dominated by those born in the United Kingdom, Italy and Greece (Australian Bureau of Statistics, 2002). A large number of the post war immigrants arrived as young adults, leading to an increase in the number of elderly overseas-born Australians, which is reflected in our population sample. In addition, the older overseas-born population tends to be concentrated in urban areas with almost 80% living in the capital cities of the states.

Homelessness amongst indigenous Australians is disproportionately higher in all age groups than that found amongst non-indigenous Australians (Housing Assistance Act, Annual Report 2001 - 2002). The rate of homelessness amongst indigenous people in Victoria is the third highest in Australia (67 homeless clients per 10,000) (Berry, MacKenzie, Briskman, & Mgwenya, 2001), yet of all the subjects questioned as part of this study only one was an indigenous Australian. This probably indicates that homeless Aboriginals prefer to access culturally specific programs.

3.2 Marital Status

The study revealed that 30% of the respondents were single and never married, 49% were divorced or separated and a further 17% were widowed of whom 25% were women. Similar findings regarding marital status were reported in a South Sydney study of 67 homeless men utilising low cost accommodation and meal centres (Russel, 2002).

Case Study

Valerie, 58, had been homeless for six months when she was referred to Wintringham for assistance. Valerie had experienced a divorce with her husband of many years, and subsequently became homeless, moving from friend to friend before being placed in the transitional property. When Valerie was housed in the Independent Living Unit she was socially isolated, had been experiencing anxiety and panic attacks, and had a multitude of health problems and a disability which made it very difficult for her to cope living independently of her family. She was referred to her G.P. and local community health centre to address her health concerns, as well as making a referral for a community aged care package to assist her with meals on wheels, home help and laundry assistance.

Table 2 looks at martial status compared to whether the respondent had been previously homeless. 42% of those who had experienced previous episodes of homelessness were single and never married. When examining the marital status of men, it was found that 48% of those who had previously been homeless were single and never married. In contrast this only applied to 25% of men who had never been homeless. However a marginally higher number of men (37%) who had not been homeless were divorced. These figures reinforce assertions (and data discussed later in the paper) that the breakdown of a relationship can be a trigger for homelessness.

Table 2 Marital status by previous homelessness (all subjects)

Marital status	Not formerly homeless		Formerly homeless		Total	
	Number	%	Number	%	Number	%
Single, never married	17	23	21	42	38	30
Married / cohabiting	4	5	1	2	5	4
Widowed	14	19	7	14	21	17
Separated	12	16	8	16	20	16
Divorced	28	37	13	26	41	33
Total	75	100	50	100	125	100

3.3 Work History

Australia has a well developed social security system, which provides a means tested safety net income for those who are unemployed, the elderly and the disabled. There is also an additional social security system dedicated to war veterans, which is administered by the Department of Veterans' Affairs. Generally it was found that the homeless subjects of the study were all accessing some form of social security payment. The purpose of looking to the work history of the respondents was not to determine if there was further capacity to work, but to explore the work patterns and how the work patterns may have contributed to housing insecurity and homelessness.

The work history of the group was chequered with over half (63%) of the respondents having been mostly employed, 28% were employed intermittently and 9% were mostly unemployed throughout their adult life. The mean period of time that the respondents had been out of work was 12.7 years, with females tending to have been out of work for longer periods than men. Women frequently stated that they left work to maintain the home or look after the children. This fits with the social dynamic of the 1950's and 60's where women were expected to leave their place of employment when they married.

The men who had not been homeless before were more likely to have worked most of their adult lives than those who had been formerly homeless (74% compared to 50%), a figure which reinforces the linkages between unemployment and a low or minimum income and homelessness.

Table 3: Work history by previous homelessness (male subjects)

Work history	Not formerly homeless		Formerly homeless		Total	
	Number	%	Number	%	Number	%
Mostly employed	38	74	21	50	59	63
Intermittently employed	9	18	17	41	26	28
Mostly unemployed	4	8	4	9	8	9
Total	51	100	42	100	93	100

When examining the age the respondents ceased to work (Table 4), it was also found that the men who had previously been homeless were more likely to have stopped work before they were 50 years of age, with the largest number ceasing work between 40 and 49 years of age. It was also notable that 28% of respondents were still working at 60 years of age and that 12 people (10%) of respondents were still working when they became homeless. These findings are similar to a studies carried out by Horton (1990) and Anderson et al (2003) which found that 18% and 19% (respectively) of homeless people were employed.

Table 4: Age last worked by previous homelessness (male subjects)

Age group last worked	Not formerly homeless		Formerly homeless		Total	
(years)	Number	%	Number	%	Number	%
Under 40	5	10	5	12	10	11
40-49	7	14	14	33	21	23
50-59	20	39	12	29	32	34
60+	15	29	11	26	26	28
Never worked	2	4	0	0	2	2
Not known	2	4	0	0	2	2
Total	51	100	42	100	93	100

Thompson Goodall (1998) examined ways to prevent homelessness amongst veterans. The study found that aged care homeless services were likely to have around 10% veterans in their client mix. These figures are consistent with the experience of Wintringham workers. However, 24% of the respondents in this study stated that their work history had been employment in the armed forces.

The reasons for stopping work are varied, with the largest number of respondents (33%) leaving their last place of employment for health reasons, while 17% were made redundant. Of the respondents who left their last job for family commitments,

the majority were women who had left the workforce at an early age to have children or because they could not continue to support the family after a marriage separation.

Table 5: Reasons for ceasing work

Reason for stopping work	Men %	Women %	Total %
Retired	15	6	13
Redundancy	20	6	17
Health Problems	38	19	33
Job dissatisfaction	8	22	11
Family commitments	3	35	11
Other	4	3	4
Never worked	2	0	1
Working when homeless	10	9	10

When the respondents were asked how work problems and the cessation of work triggered their homelessness, 10 subjects stated that they could no longer afford the bills and rent after they ceased working and three stated that they were living in accommodation attached to a job and that they lost their home when the job ended. One respondent stated that he ceased work due to a work related injury and that he had never received any compensation for his injury. Another man stated that the nature of his work, meant that he spent little time with his family and this contributed to his marriage breakdown.

All the respondents in this study were in receipt of some form of income. Of those receiving benefits, 42% were receiving a disability pension, 29% an aged pension and the remainder were receiving a range of unemployment benefits. Whilst all of the respondents were receiving their pensions, 11% stated that they were not in receipt of Commonwealth Rent Assistance or aware that they were entitled to it. Case worker reports indicated that in at least 34% of cases, the respondents would have difficultly in accessing these social security benefits on their own.

3.4 Housing History

The housing history as reported by the respondents yielded interesting results. Prior to becoming homeless 54% of respondents lived in private rental, 19 % in public housing and 6% in the not-for-profit sector. It is of some interest that 19% of the participants reported that they were owner/occupiers immediately before becoming homeless. There were marked differences between the subjects' most recent

accommodation and that of the elderly population in Victoria (Table 6) with study subjects more likely to be in private rental or public housing prior to becoming homeless.

Table 6 Housing Tenure Of The Subjects And Older People In Victoria

Tenure	**Study Subjects[1] (%)**	**Population In Victoria[2] (%)**
Owner Occupier	19	78
Rented Public Sector	19	4
Rented Not For Profit	6	3
Rented Private Sector	54	5
Other	2	9
Total Number	125	577,600

Notes: 1. Their most recent accommodation. 2. People aged 65 years and over in Victoria In 1999 (Ronaldson, 1999)

The large numbers of study subjects in private rental compared to public housing can be explained by the Federal government's significant shift in policy which took place in the mid 1980s. At this time, greater emphasis was placed on the provision of income support in the form of Commonwealth Rental Assistance, rather than the development of additional public housing. The result is that while CRA to private tenants now exceeds $1.6 billion per annum, waiting lists for public housing continue to increase past their already high previous levels.

72% of respondents lived in a house or self-contained apartments and 14% lived in rooming house accommodation. The remaining respondents reported living in shared houses and housing "attached to job".

The majority of subjects reported 1-3 years as being the length of stay in their housing. However, 31% reported staying 3-10 years and 21% reported that they had lived in their former home for more than 10 years.

Prior to becoming homeless over half of the respondents lived on their own, 22% had lived with a spouse, 10% with children and 10% with other friends or relatives. 66% of women reported that they had lived with a spouse, children, friends or relatives compared to 66% of the male respondents who lived on their own prior to becoming homeless.

When the number of dwellings that the subjects had lived in the three years before they became homeless is examined, it shows that those who had previously been

homeless, were more likely to have moved from one address to another (Table 7). Only 44% of formerly homeless subjects had stayed at one address, and 32% had lived in three or more places with the majority of all respondents (29 out of 47) living in private rental.

The degree of housing instability leading to regular episodes of homelessness corresponds to Wintringham's experience where we have noticed that the breakdown of formal or informal support services greatly contributes to the loss of housing. Yet even with these supports, many older tenants of inner Urban or CBD boarding houses and hotels are vulnerable to eviction following sale or redevelopment (Lipmann, 2002).

Case Study

Shirley is a seventy-seven year old lady living in a low cost city hotel which she moved to 5 years ago when the neighbouring hotel she had lived in, closed down. She has lived in the city ever since she split up from her husband 20 years ago.

Her room at the hotel is small and unable to cope with Shirley's lifetime of belongings. Shirley has no kitchen facilities and because she cannot afford to eat out, her nutrition is poor. She shares communal showers and toilets, and because she is starting to show signs of dementia, her personal hygiene is poor. Yet she remains very independent and resistant to receiving any sort of assistance. Shirley has now received a notice to vacate and has 120 days to find herself a new home in a city where affordable single room accommodation is very difficult to find.

74% of those who had not previously been homeless had stayed in one location for the past three years, while just 8% had lived in three or more places.

Table 7 Number of homes during the three years preceding homelessness (all subjects)

Number of homes	Not formerly homeless		Formerly homeless		Total	
	Number	%	Number	%	Number	%
One	55	74	22	44	77	62
Two	13	18	12	24	25	20

Three	2	3	8	16	10	8
Four or more	4	5	8	16	12	10
Not known	1		0		1	
Total	75	100	50	100	125	100

3.5 Previous Homelessness

Data and information contained in this study lend weight to the theories of Hock and Slayton (1989) and Keigher (1991) who talk of the emergence of "New" homeless people who defy all of the negative stereotypes of the Old homeless.

Their writings talk of the New homeless being people who have had no previous experiences of homelessness, who lived fairly normal lives on low incomes, but who defy the images of unemployable hard drinking loners. Their homelessness is seen as a product of events largely out of their control, where there is little evidence of personal blame.

Only 40% of respondents had been homeless prior to this current episode. There was a significant gender difference with more men (45%) than women (25%) having been previously homeless.

The age when respondents experienced their first episodes of homelessness varies. 12 people first became homeless before 30 years of age, nine people became homeless between 40- 49 years, four aged 50 - 59 years and six when they were over the age of 60 years.

The data also showed that those between 50 – 59 years (52%) were more likely than those aged 60+ years (30%) to have been homeless before. Of particular interest however, is that 70% of those aged 60 years and over and 48% of those aged 50-59 years have never experienced homelessness prior to this current episode.

This result, rather than corroborating the stereotypical image of a lifetime of homelessness, shows that for many elderly homeless people the experience of homelessness is a new one.

The research also shows that once the respondents became homeless the experience was not quickly resolved. Those aged between 50-59 years of age were often homeless for more than two years, and those older than 60 were more likely to have

been homeless for two years or less. These figures are of some concern considering the well developed homeless services available in Melbourne.

Table 8 Duration of homelessness (latest and former episodes) by sex

Duration	Men	Women	Total
number of months	%	%	%
Up to 24	67	94	74
25-60	16	3	12
61-120	3	3	3
121+	14	0	11
Number of subjects	91	32	123

Details not available for two men.

Table 8 demonstrates that the total length of time that the respondents had been homeless (both current and past episodes) varied from one month up to 40 years. While only one woman reported to have been homeless for more than five years, men were more likely to be homeless for longer periods of time, with nine men having been homeless for more than 20 years.

It is commonly accepted that the longer people remain homeless, the more difficult it is to find pathways out of homelessness. Particularly this is the case for the elderly homeless who often adopt a reclusive and mistrustful approach to survival which makes them reluctant to seek out assistance and unlikely to come into contact with mainstream aged care, housing or health workers.

The role of Outreach workers becomes essential in these circumstances and has led to the formation of the Assistance with Care and Housing for the Aged (ACHA) program. With funding from this program, outreach workers can spend time with elderly homeless developing a sense of trust and rapport that can result in accessing appropriate services. (For a description of the ACHA program see Alt, Statis 1996).

Table 9 Reasons for the first episode of homelessness

Reason for *first* homeless episode	**Men**	**Women**	**Total**	
	%	**%**	**Number**	**%**
Marital/ Relationship breakdown	11.8	15.6	16	12.8
Other family problems	11.8	0	11	8.8
Housing sold/ end of tenure	1.1	0	1	0.8

End of tenure/ arrangement to stay	2.2	0	2	1.6
Financial problems	1.1	0	1	0.8
Unable to manage in housing	2.2	3.1	3	2.4
Moved to another area	6.5	3.1	7	5.6
Alcohol /drug problems	7.5	3.1	8	6.4
Other reason	1.1	0	1	0.8
Never been homeless before	54.8	75	75	60.0

When asked what the trigger to their first episode of homelessness was, 22% of respondents described marital/ relationship problems and other family problems. While 6% stated that alcohol or drug problems were a factor, it can be seen from Table 9 that other triggers were also reported. What these figures do not show is that homelessness amongst the elderly is usually not a product of a single factor but more likely to have been the result of a number of compounding issues.

The end result leaves the newly homeless aged person confused, isolated and depressed. These underlying factors are discussed in section 4.

4. Proximate Reasons for homelessness

This next section looks at the reasons nominated by the respondents for their most recent episode of homelessness. The causes of homelessness can often be identified either as issues which directly trigger homelessness, or underlying risk factors that create the vulnerability. Those that have recently become homeless are often able to nominate the common triggers that lead to their situation.

The reasons given by the respondents were varied (Table 10) with most of the respondents nominating more than one contributing factor. The following section of the report discusses each of the reported factors in further detail.

Table 10 Reasons for leaving or losing the last accommodation

Problem	**Number**	**%[1]**
Accommodation sold/converted/needed repair	35	28
Unable to maintain/look after housing	16	13
Financial problems and rent arrears	32	26
Breakdown of a marital or cohabitating relationship	18	14
Problems with other tenants/ neighbours/ locals	25	20
Problems with the landlord	9	7
Other problems with relatives	33	26
Death of a Relative or friend	13	10
Number of subjects	125	

Note[1] most subjects described multiple reasons

4.1 Housing: physical condition and tenure

Overall 50% of the respondents stated that the physical conditions of their housing or the ending of a tenure directly contributed to their homelessness. 13% stated that they had problems with maintaining their housing and 28% stated that they had to leave because their housing was to be sold, converted or was to undergo major repairs. These people often were given illegally short notice periods, and many reported that once they left their home they could not get back into the private rental market primarily because of the large bond required, prohibitive rental costs and the requirement of advance rental payments. Others cited discriminatory practices by real estate agents as being a factor preventing them from entering the private rental market.

In some cases the notice of eviction is the catalyst for connecting vulnerable and isolated aged people with the wider service system. The following case study is illustrative of how a supportive (or intimidated) partner unwittingly prevents her husband from accessing appropriate psychiatric care. In this case it is the notice of eviction which leads to a Wintringham worker ensuring that care is received.

Case Study

Wintringham outreach workers were informed of 60 day eviction notices given to residents of a 6 story dilapidated rooming house that was due to be redeveloped. In the process of visiting the building they hear of George and Petra who live on the top floor which is only accessible via a narrow steep set of stairs. George and Petra have been living in the rooming house for the past 10 years and are refusing to discuss moving.

They have been married for approximately 20 years, and both are in their sixties and immigrated from Ukraine. Petra has 5 adult children from a previous marriage, whom she has no contact with.

When the caseworker visited Petra, she greeted them outside her apartment. She was a quiet frail and nervous woman. On this and all subsequent visits only Petra was seen. While she insisted that she did have a husband, it was initially doubted that this was the case. Over time Petra began to confide in the caseworker and she told her that her husband had not left the bedsit for at least four years. He has not showered and uses a bucket for a toilet which she then cleans when he is finished.

George spends his days sitting on the bed which was separated from the rest of the room by a curtain. For years they have been eating boiled potatoes which Petra has been preparing in the bedsit. They can't afford much more because George refuses to sign any paperwork and as a consequence he has no pension.

For a period of time there were doubts over George's existence, as no one in the building had seen him for a number of years. One day as the eviction day drew near, Petra eventually allowed the caseworker into the room and started to talk to George who was behind the curtain facing the wall. As the case worker approached, George became very distressed and started shouting for the workers to leave.

George was subsequently moved against his will into a hospital where he received medical assistance. Petra and George are now living in public housing, where George is receiving outreach support from a local psychiatric clinic.

Data from the study demonstrates that a high proportion (58%) of those who experienced tenure or housing problems (Table 11) were living in private rental, 24% were in public housing at the time and 16% were in owner occupied homes. The commonly reported tenure issues included the ending of a tenancy because the lease was held by another person who left or died. Others reported losing the family home following the breakdown of a marriage or relationship. Four people stated that they had difficulty accessing their home once their health deteriorated, while others stated that the location of the housing was unsuitable because they were too far from medical services.

Table 11 Problems with the housing's physical conditions or tenure

Housing tenure	Housing problems		No housing problems		Total	
	Number	%	Number	%	Number	%
Owner-occupier	10	16	14	22	24	19
Rented: private landlord	36	58	32	51	68	54
Rented: public sector	15	24	9	14	24	19
Rented: voluntary sector	1	2	6	10	7	6
Other	0	0	2	3	2	2
Total	62	100	63	100	125	100

When data concerning those who experienced housing or tenure problems was further analysed, and compared to the sex of the respondents or previous episodes of homelessness, no significant differences were found. However, when the data was analysed against age, it was disturbing to find that 13 people became homeless when they were aged 75 + years and that 10 of these people associated their homelessness with housing and tenure problems. There is little doubt that the principle cause of housing related homelessness amongst the aged is a direct result of changes occurring to the housing market in Melbourne. In common with most major cities in industrialised countries, over the last 10 years the inner city area of Melbourne, where the largest concentration of low cost accommodation was located, has undergone gentrification, with the result being a significant decrease in available affordable housing stock.

This has been further compounded by an increase in the number of low and moderate income households seeking private rental accommodation. The overall result of these factors is that rent prices for both small and large dwellings increased at a much faster rate than real household income (Housing Assistance Act, Annual Report 2001 - 2002). The CRA payment has not kept up with the rapid rental increases, and as a consequence, a large number of people in Victoria are now paying more than 30% of their income on rent (Berry, MacKenzie, Briskman, & Mgwenya, 2001). An immediate outcome is that many older people who live in insecure private rental accommodation are at risk of becoming homeless.

It is interesting to note that only 18% of subjects reported that they were evicted or asked to leave. The very low eviction percentage is surprising and at odds with the experiences of other homeless people now living at Wintringham, and with the experiences of our outreach workers.

4.2 Financial Problems

All of the respondents who participated in this study have Government funded aged or veterans' pensions or disability or New Start benefits. As these pensions are set at a minimum level income, many older people face severe financial difficulties if there is an adverse change in circumstances, such as a gambling debt or rental increase.

Accordingly, it is not surprising to find that 26% of respondents stated that financial problems led them to becoming homeless, with more men (29%) than women (16%) likely to report financial problems. A total of 24% of respondents reported rental arrears or debts and 10% reported affordability issues with no arrears. Of those who reported arrears only eight were evicted.

17 people stated that they did not receive sufficient income to enable them to pay their rent. When this data was further analysed it was found that 35% of these respondents were heavy drinkers and that 10 (60%) of these respondents admitted to being problem gamblers.

In some cases the financial problems were related to income deficiencies caused through the cessation of employment, or through social security issues. A lack of knowledge of their rights and entitlements was noticeable, with some respondents unaware that they were eligible for Commonwealth Rent Assistance to help with their rental payments. Three of the respondents stated that they were unaware that they were in rental arrears until they were evicted.

Case Study

While visiting a resident in a rooming house, a worker was approached by an elderly man who complained that his pension had not been paid into his account. Investigations with Social Security revealed that they had been trying to contact him for 6 months and with no response being received, they ceased payment. The worker went back to the gentleman, who at first denied that he had received any mail from the Department, but after some prompting, gave the worker a bundle of unopened letters from the Department that had been neatly tied together with string. The worker then learnt that the man was illiterate and terrified of notices from the Government.

4.3 Problems with Tenants or Neighbours

27% of respondents reported that arguments and problems with their co-tenants including relatives other than marital partners, neighbours or landlords, led to their homelessness. 7% of the respondent stated that they had problems with their landlord and some of the respondents stated that they found the tenants in the building noisy.

These results must be interpreted carefully given that the only information available is that of the subjects, and it is unknown how much of their own personal problems affected the situation. Further analysis of the data shows that 23% of respondents who reported problems with tenants were suffering from depression and 19 had alcohol problems.

13 of the respondents were victims of, or were frightened by the petty crime and violence taking place around them. One client who resided in a rooming house prior to leaving, stated that the drug use and consequent crime that comes with it, often left him too frightened to leave his room.

Case Study

Fred has been homeless and a heavy drinker most of his adult life. After leaving home at the age of 20, he worked intermittently in the merchant navy, eventually leaving and returning to Melbourne when he was 45. After living transiently for a number of years, Fred finally moved into a rooming house, where he continued to drink heavily.

Fred's friends would visit and drink with him, using the communal facilities and frequently being aggressive to his neighbours. The other tenants would often complain about the noise and threatening behaviour, and one night after drinking heavily, Fred was evicted after getting into a fist fight with one of the neighbours over the use of the pool table.

4.4 Breakdown of Marital or Co-habitating Relationships

11% of those seeking support from SAAP services in the 2002- 2003 were doing so as a result of relationship or marital breakdown, while a further 22% were seeking assistance as a result of domestic violence (Chung D et al 2000). Our research produced similar results, finding that 21% (26) of respondents (25% of women and 11% men) attributed their homelessness to the breakdown of a marriage or co-habitating relationship. In 12 cases domestic violence was cited as the reason for leaving the relationship.

The breakdown of a marriage or co-habitating relationship was reported predominately (30%) by those who were 50-59 years of age. 12% of those aged over 60 also reported that a relationship breakdown was a trigger to their homelessness. When questioned further about how the breakdown of their marriage contributed to homelessness, 20 stated that they left and their partner stayed in the accommodation. One man stated that on leaving the marital home *"I lost my support base and things are inclined to go wrong when you lose that support"*. Most of the men reported entering the homeless system fairly quickly after the breakup of their marriage.

The story is slightly different for women. Several of the women went to stay with friends or relatives after the breakup and only became homeless when this relationship broke down. As one woman explains "*I moved in with my son and his girlfriend, after I split up with my boyfriend. Things were OK for a short time, but I didn't really get on with the girlfriend…..It wasn't long before my son asked me to leave*"

Some people reported that the combination of the breakdown in their relationship and the resultant depression that this caused, severely effected their ability to maintain their accommodation. These respondents stated that they felt lethargic and tired and could not be bothered doing anything around the house. A further five stated that after their partner left they could not afford to pay the bills or the rent. One lady stated that she moved to Australia to marry her husband and now that they were separated she felt displaced as she had no family support.

4.5 Death of a Friend or Relative

10% of the respondents stated that the death of a relative or friend triggered their homelessness with six people stating that the death of their mother contributed significantly to their homelessness. One of the respondents stated that his mother's long illness had led to high medical bills with the family home being sold to pay for them. This same person stated that once his mother died his relationship with his brother also broke down, leaving him with no supports. Another stated that he was going to move in with his mother once he got out of prison, however, as she died while he was in jail, he had no where to go once released.

Three respondents stated that the death of their spouse had a direct impact upon their ability to maintain their housing. These people found it difficult to cope on their own, undertake household tasks or pay the bills. One woman stated that her life was empty without her husband and as a result she could no longer settle down. Another stated "*He cared for me, the house and the finances. When he died I could no longer look after myself and the house*".

Three of the respondents stated that as a result of the death, they had to leave the tenancy as it was not in their name. Four stated that once they had lost the second income, or the combined pension, they could no longer afford to pay the rent. One woman stated that her husband, who was an alcoholic, left her with huge debts when he died. She felt that her inability to pay the debts had directly contributed to her becoming homeless.

Nor is it only a marriage breakdown which can result in homelessness. In the following case study, it is the death of a close friend and flat mate.

Case Study

John was a fascinating small and wiry 75 year old man, someone who had never married and who had lived in boarding houses or homeless shelters since he was 15 years old. Self educated, he would be found reading eclectically anything from politics to gardening. On one occasion when I visited with a politician who had wanted a tour of the shelters, we came across John lying on his bed reading a book on breast surgery.

John's life long friend was Mick, a man about 5 years older. Mick was everything that John wasn't. A tough, streetfighting man who had none of John's kindness or gentleness. Mick made all the decisions and for whom John could never do enough for. Every morning, John would slowly walk down to the shops on his wobbly legs, to get Mick the newspaper and a cream cake! After many years Mick and John were assisted to rent a unit together.

Although John was very frail, Mick was much sicker and periodically had hospital stays. On one visit, he was told that he had cancer and very soon after that visit, Mick's health began to deteriorate rapidly. As he was moved from one hospital to another, John would slowly travel over Melbourne on public transport tracking him down. Hospital staff would invariably not inform John where Mick was moved to, which would mean that John would sometimes arrive at the hospital only to find that Mick had been transferred.

Eventually, Mick was moved to a hospice in Caulfield. John would travel down every day from South Melbourne to sit by Mick's bed. The sight of these two frail old friends sitting together greatly moved the staff who began to adopt John – probably the first homeless man that many of the younger staff had met.

When Mick finally died, John held his hand while the nurses and staff stood at the end of the bed, many crying. Unfortunately, John was not able to cope in the unit on his own anymore and he went back to living in the shelters.

4.6 Problems with other relatives

A total of 33 respondents stated that problems with other friends or relatives triggered their homelessness. 13 of these people were living with their children when problems or arguments occurred which resulted in them losing their accommodation. One woman moved in with her daughter to escape her violent husband. *"He kept coming round and frightening us and eventually I had to leave again to protect my daughter and her kids."*

Others stated that their children's drug problems made staying with them intolerable, while others stated that the children of their defacto partner caused problems for their relationship. Others related how the interference of their in-law's led to the breakdown of their marriage and eventually to homelessness. One woman, Sarah, stated that she moved out of her secure accommodation to help her daughter with her children. When this did not work out, Sarah became homeless as she lacked the money to re-enter the private rental market.

4.7 Summary

The previous section discussed the events or triggers that respondents identified as the reason why they lost their most recent accommodation. In most cases the triggering event was not enough on its own to cause homelessness. The reaction to the incident is dependent on each person's personal circumstances and their abilities to cope with changes to these circumstances. Importantly, it is also the interaction with the external environment, such as the availability of low cost housing, which significantly impacts upon the likelihood of these elderly people becoming homeless.

In some circumstances however, it was found that homelessness was less a factor of external factors and more a direct result of the actions of the respondents.

The following chapter will look at the underlying factors contributing to vulnerability and how these factors contributed to the respondent becoming homeless.

5.0 Health and Addiction Problems

The study enquired into the health and addiction problems facing many of the elderly homeless participants and found a clear link between their capacity to manage these issues and their ability to maintain their housing.

5.1 Physical Health Problems

While the aged population is generally defined as people over the age of 65 years, it is generally accepted in both Australian and international literature that homelessness prematurely ages people (Cohen and Sokolovsky,1989; Purdon 1991). Using this data, and the experiences gained through working with older homeless people in the night shelters of Melbourne, Wintringham was able to gain Commonwealth acceptance to lower the admissible age to 50 years, for entrance to its aged care residential services (Lipmann, 1989).

The data obtained during this present study was able to confirm the effects of premature ageing on the respondents. Physical health problems were the most commonly reported complaint with 78% of all respondents reporting to have problems prior to becoming homeless. When asked to describe how this had affected their life, 50% stated that their health problems left them with decreased mobility which made day to day tasks difficult. 26% stated that because of their physical problems they were no longer able to work and 21% stated that their problems led to depression and decreased motivation making the respondents unwilling or unable to look after their physical needs.

When the data was further examined it was found that there was no noticeable difference between men and women or between those aged 50-59 years and 60+ years.

Musculo-skeletal (49%) and cardiovascular problems (42%) were the most commonly reported complaints. Women tended to report digestive and neurological disorders less frequently than men although no significant gender differences were demonstrated. The following case study demonstrates how changes to physical health factors can lead to homelessness.

Case Study

Bill 65, was born in England and came to Australia when he was 28 with his younger brother. While his brother soon found work, married and raised a family, Bill drifted between jobs before heading into the country where he worked as a shearer and general hand on a number of stations. Bill took little care of himself and while his strength held out, he was able to earn enough money to support himself.

Gradually however, his lifestyle led to a number of ailments leading him to move into a local country town where he lived in a boarding house. Years later when he returned to Melbourne, he was in poor physical health and unable to support himself and moved into a homeless persons shelter.

When Wintringham workers placed him in a low care residential facility and were able to contact his brother, it was noticeable the marked difference in the two men. Bill's brother was clearly distressed at the frailty and poor health of his brother.

When comparing the research data with estimations based on age-matched general population data, the homeless people in this study were marginally more likely to have reported musculo- skeletal problems or cardiovascular problems and twice as likely to have reported endocrine disorders (especially diabetes). The study subjects were six times more likely to have reported neurological disorders (including epilepsy and alcohol related acquired brain injury). The likelihood of genito-urinary problems was also slightly higher, yet digestive problems, sensory problems and the presence of tumour were reported less frequently. It is possible that the latter three conditions were reported less frequently because the associated symptoms are either accepted as an unavoidable consequence of a homeless lifestyle, considered to be minor or unimportant relative to other, more serious health issues, or are only recognized and diagnosed at a more advanced stage of disease development.

33 (30%) of the respondents stated that their physical health problems contributed to their homelessness a lot and 10% of subjects stated that it contributed a little. The reasons they gave were that the housing they were residing in was no longer suitable to their needs (30 respondents). Problems with getting up and down stairs were the major problem for most of the respondents. Eight of the respondents stated that because of the physical health problems they had to cease working. This then led to financial problems and homelessness. Others described how their physical health problems put a strain on their relationships and how they subsequently broke down under the pressure.

Whilst for some, these health problems may have triggered homelessness, it is clear that the interconnectedness between housing and health greatly impacted upon the severity of their problems. While people need housing to maintain their health, they also need housing so that they can recover from illness. In this respect, it is worth noting the positive impact that hospital after-care such as the Chicago Interfaith Hospice Program and Melbourne's Cottage Program can have on the recuperation for homeless people after severe illness or surgery. Wintringham has itself noted the improved health outcomes after hospitalisation for previously homeless residents of its various housing programs.

Table 12 Physical problems prior to homelessness (subjects' reports).

Physical Health Problems	**Men**	**Women**	**Total**	
	%	**%**	**Number**	**%**
Musculo-skeletal problems	47.3	53.1	61	48.8
Respiratory problems	9.7	12.5	13	10.4
Cardiovascular problems	43.0	40.6	53	42.4
Neurological disorders	20.4	15.6	24	19.2
Endocrine disorders	11.8	21.9	18	14.4
Digestive system problems	12.9	9.4	15	12.0
Tumor	3.2	18.8	9	7.2

56 respondents reported that their main source of medical assistance was the local hospital where free medical care is provided and 39 stated that they received services from medical practitioners. While non-elective acute hospital services are free, they are an expensive drain on hospital resources and as a consequence are not always easy to access. Wintringham has been able to demonstrate that by providing a homeless person with a safe and secure home, support services and home based community services, the use of medical resources rapidly diminishes. Through the use of innovative and carefully co-ordinated services, Wintringham has built housing where formerly homeless aged people have been able to live their final years in comfort. This has been a positive result for both the resident who has been able to return to a familiar environment surrounded by their friends, and for the hospital and health care system where equivalent services would have cost many hundreds of dollars a day more than home based services (Wintringham submission to the Victorian Homelessness Strategy, 2002).

5.2 Mental Health Issues

An inner Sydney study conducted in 1998 found that 75% of the homeless people using inner city hostels and refuges had at least one mental health issue (Hodder et al 1998). Our findings show that 66% of respondents were suffering from some sort of mental health problem.

The most commonly reported mental health problem was depression. 62% of respondents reported being depressed prior to becoming homeless, with women more likely than men to report mental health problems (84% compared to 60%). This finding supports other research which shows that even though one in six men experience depression, men are less likely to report that they are depressed or seek assistance for their depression (Better Health Channel, 2001). Often depression in men is easily misinterpreted or dismissed as age related changes (The American Association for the Advancement of Science, 2001).

Those aged 50-59 years were more likely than those aged 60+ to report depression, while those who had previously been homeless were more likely than those who had never been homeless before to report being depressed (69% compared to 57%). Surprisingly, the data obtained from the interviews found that there was no significant relationship between depression and alcohol problems or depression and gambling problems.

As depression can be triggered by a range of stressful situations, it is of no surprise that 19 of the respondents attributed their depression to a marital or relationship breakdown. 31 of the respondents further reported that their underlying physical or mental health problems were the cause of their depression. A further 22% of respondents reported having other mental health problems either in conjunction with their depression or in isolation. The conditions reported included anxiety and schizophrenia.

Caseworkers reported that in their opinion 84% of subjects were suffering from depression. When comparing case worker reports to self reports it appears that men were less inclined to admit or recognize that they were suffering from depression (84% compared to 56%). To compound this issue only 56% of men who reported that they had mental health problems had received treatment for it as compared to 78% of women. 5% of those who had been offered treatment had refused it.

The case workers also reported that respondents suffered from various combinations of the following mental health issues; hallucinations (29%) memory problems (63%) or other mental health disorders (58%).

Case Study

Jeff, who is now 61, had his first psychotic episode when he was 22. He has spent many years in and out of institutions, boarding houses and sleeping rough. Jeff has no family supports. His fixation with locating his daughter sees him travelling to areas where he thinks she might be, frequently stopping people on the street to ask them if they know her or might have seen her.

He begs on the street for money and puts himself at risk of physical harm, arrest and jail by stealing food and clothes. His speech is abstract and rapid fire, and often threatening while his quirky dress sense inevitably draws attention, as does his lack of personal hygiene.

Jeff has almost no ability to comply with a medication regime, and as a consequence has regular admittances to both general and psychiatric hospitals.

It is generally acknowledged that the elderly homeless do not seek medical services and are invariably non compliant with their treatment. Our research found that 63% of those with mental health disorders stated that they had received some assistance, 27% stated that they had not asked for it and 5% were offered assistance and had rejected it. The services received were varied and often respondents nominated more than one type of service. Treatment from psychiatrists or other mental health services were commonly reported with medication and counselling being the most commonly reported method of treatment. Unfortunately, while we know the respondents did seek treatment, it is not clear how often the treatment was received. It is both possible and likely that once the respondents became homeless, assistance with their mental health problems could have ceased.

5.3 Alcohol

Alcohol abuse effects all sections of society including the elderly homeless.

43% of respondents reported issues with alcohol with nearly one fifth saying that their alcohol problems had stemmed from drinking with workmates or socially, whilst others stated that personal problems and marital problems (12 respondents) had contributed to their alcohol problems.

Problems were more commonly reported by men (48%) than women (28%) with nearly one half of the men admitting to heavy drinking or alcohol dependence. When asked how the heavy drinking affected the respondent, 22% stated that it led to physical and mental health problems and others stated that it had led to family and marital problems. Alcohol abuse can lead to or exacerbate behavioural problems.

Case Study

Joe started drinking when he was 12 years old. While his family refuse to have any contact with him while he is drinking, the absence of family support and familiarity from Joe's everyday life makes it all the harder for him to abstain from alcohol.

Joe's days are consumed with finding alcohol, often putting himself at risk. If he can't find alcohol his addiction is so strong that he will drink petrol from the bowsers at service stations. Two years ago, Joe's malnutrition and continual presentations at emergency wards at general hospitals, led the Office of the Public Advocate to be appointed as his Guardian.

Multiple assessments to determine his ability to make rational decisions and live and care for himself independently have been inconclusive. It was eventually decided that there had been a level of permanent brain damage associated with long-term alcohol use which impacted on Joe's ability to make decisions and to plan everyday activities. At no stage in his life has Joe ever considered abstinence; the addiction to alcohol for him is too strong. Joe's long term prospects look bleak in a health system that is not designed to care long-term for people with his particular needs.

The reporting of alcohol problems differed amongst the age groups. Those respondents aged 50-59 years (58%) when they became homeless were more likely than those aged 60+ years (30%) to report alcohol problems. A likely reason is that the level of acquired brain injury can get progressively worse as a heavy drinker ages which will limit their ability to have insight into their problem.

Case Study

Dean was referred to Wintringham after he was evicted from his housing. Suffering from an alcohol related brain injury, Dean's gas had been cut off after the landlord found out that he frequently left it on after cooking. Dean responded by lighting fires in his kitchen sink to cook his meals, prompting the landlord to evict him.

While at the boarding house, Dean had obviously struck up a friendship with a young woman who lived nearby, and who amazingly, used to ask Dean to look after her young child when she went out. The woman eventually left the boarding house about the same time that Dean was evicted, but in his confused state, Dean became convinced that she was his wife and that the child was theirs.

For the first month or so at Wintringham, staff spent much time with Dean who had become increasingly frantic as he wandered the streets trying to find his 'wife and child'.

It was also found that those who had been previously homeless (60%) were more likely than those who had never been homeless (32%) before to report alcohol problems. This possibly demonstrates that unresolved alcohol problems can be linked to incidents of recurring homelessness. The destructive behaviours linked to excess alcohol consumption can also make it difficult for people to maintain their tenancies.

The case workers reports show that there was significant under-reporting of alcohol problems. They stated that in their opinion 77% of men and 44% of women had alcohol problems that were either evident or suspected by the workers.
67% of respondents stated that they had received assistance for their alcohol problems from self-help groups such as Alcoholics Anonymous and from professional counselling. 28% stated they had not asked for assistance and 4% stated that they had been offered assistance but had refused the treatment.

The research also found that 32% of the respondents had both mental health and alcohol problems. There was little difference between men and women (33% and 38%). Those aged between 50 – 59 years were more likely than those aged 60+ years to report combined mental health and alcohol problems (48% compared to 17%), but as noted earlier, there may have been under-reporting for those aged 60+ over.

The study also found that those who had previously been homeless were more likely than those who had never been homeless to report mental health and alcohol problems (44% compared to 24%).

Table 13 Substance misuse and personal problems prior to homelessness

Problems	**Men**	**Women**	**Total**		
	%	**%**	**Number**	**%**	**%UK**
Alcohol problems					
Reported by subjects	43.2	28.1	54	43.2	36
Evident or suspected by staff	77.5	43.8	81	64.8	43
Drug misuse problems					
Reported by subjects	12.9	12.5	16	12.8	6
Evident or suspected by staff	11.8	25.0	19	15.2	3
Gambling problems					
Reported by subjects	37.6	12.6	36	28.8	5
Evident or suspected by staff	53.8	6.2	52	41.6	5

5.4 Drug Problems

Contrary to the culture surrounding youth homelessness, the aged homeless participants in this study reported only a small incidence (13%) of problems with illicit drugs. All respondents who reported drug issues were aged between 50-59 years, and there was no gender imbalance in their responses. It was also found that those who had previously been homeless were more likely to report using illegal drugs (24% compared to 5%) than those who had never been homeless before. Of those who reported drug problems, 13% had received assistance and 87% stated that they had not sought assistance for their habit.

These figures are consistent with current experiences of Wintringham workers who report that the primary concern of older homeless people is not personal drug use but is more one of fear of the young drug users and pushers, particularly in boarding houses. Lipmann (1995) reported similar concerns in Denmark where Sonderskov Hjmmet tried unsuccessfully to combine services to elderly homeless men and young men with drug addiction problems.

The relatively low numbers of drug users amongst the elderly homeless population in Australia is not likely to remain at these levels if we continue to follow the American

experience where survivors of heavy drug use are now themselves ageing and presenting with a number of drug related ailments.

Case Study

Fifty year old Richard says that he had never been able to cope well with pressure so he began to turn to cocaine as a way of escaping. As his life began to spiral out of control Richard became addicted to heroin. He lost his job and when his wife eventually left him, he lost his home. Richard continued using, although he tried to go to rehab but it didn't work. Richard is now living on the streets and he says "there is no place in the drug world for an old man."

5.4 Gambling Problems

Gambling in Australia is big business. There are over 7 000 businesses providing gambling services with a net revenue of more than $11 billion annually (Commonwealth of Australia, 1999). Gambling has the potential to considerably increase the risk of homelessness for low income elderly people.

It is of some concern therefore that 38% of participants in the study self-identified gambling problems, a figure that was second only to alcohol. When these results are compared to those of our UK study partner, where only 5% of the respondents reported a gambling problem, the extent of problem gambling amongst the homeless in Melbourne becomes clearer.

Even in spite of these high figures, the caseworkers reported that they considered that there was still some under-reporting amongst the men. In their opinion, 54% of the men who participated in this study had evident or suspected gambling problems.

Further analysis showed that men (46%) were more likely than women (16%) to self-report their gambling, and were more likely to spend more than women on gambling each week ($25 compared with $14) (Victorian Casino & Gambling Authority, 1997).

It was found that there was no relationship between the age people became homeless and gambling and there was also no difference according to whether people had or had not been previously homeless.

It was expected that a significant relationship would be found between gambling and alcohol, however whilst 41% of those with alcohol problems had gambling problems, the relationship was not found to be statistically significant. Reasons for this could be the underreporting of alcohol and gambling problems as reported by the caseworker. Further research would need to be conducted into these factors to determine the extent to which they relate to each other.

However, a significant relationship was found between those living alone and gambling. 46% of those living alone compared to 28% of those who lived with others had a gambling problem. Elderly people are often isolated and the clubs provide a safe venue for socialising as evidenced by the following case study.

Case Study

Mary was 53 when her husband died of cancer. Her three children were no longer living at home, one was in the United States and the others were living on the other side of town. Having spent the last three years of her life caring for her husband, Mary had given up most of her social contacts and now she felt lonely and isolated.

Her loneliness was initially relieved by gambling at the local RSL club where she was befriended by Betty, but eventually her gambling started to consume most of her pension until she was forced to borrow money off her children and friends. It was not long before Mary was in considerable debt and behind in her rent. Mary was eventually sent an eviction notice.

It was striking to note that despite the public anti-gambling campaigns and the numerous support agencies available to assist problem gamblers, 85% of those who reported gambling issues did not seek assistance for their problem.

5.5 Supports Access Prior to Homelessness

While there are numerous formal support networks available to elderly people in Australia, USA and Europe, it is well documented that the elderly homeless people often struggle to access these services (Crane 2001, Judd et al 2003). Many are fiercely independent and may be sceptical of the services being offered. Alternatively they may not have any understanding of the services available or how to access them or they may simply feel that they are undeserving of help (CACH, 1997). This next

section looks at the support services the respondents access prior to becoming homeless, both informal and formal, and those they tried to access once homelessness was imminent.

Informal Supports

More than four fifths of the subjects (86%) were in contact with relatives or friends prior to becoming homeless. This applied to 84% of the men and 94% of the women, and these proportions were similar for those with and without previous histories of homelessness. When the frequency of their contact is examined however, the isolation of the study participants is striking, with 34% seeing a relative or friend less than once a month. The women tended to be more isolated than the men with 41% of women and 31% of men having less than monthly contact with relatives or friends.

Table 14 Support Networks Prior To Homelessness

Contacts	Men %	Women %	Total %
Contact With Relatives And Friends	84	94	86
Saw Relative Or Friend At Least Monthly	69	59	66
Help From Relatives Or Friends[1]	43	66	49
Formal Support Services[2]	47	55	49
Number Of Subjects	93	32	125

Notes: 1. Given Financial Assistance Or Help With Household Tasks. 2. Home Support Or Social Services Or At A Day Centre.

Only 61 of the respondents (49%) received help from relatives and friends prior to becoming homeless. Those who had not been previously homeless (55%) were more likely than those who had been homeless (40%) to receive this assistance. 50 respondents reported receiving help with household tasks, while 20 respondents were assisted with budgeting and paying bills and 26 respondents were given money by their relatives or friends. Often more than one type of support was received.

Table 15 Source of help from relatives and friends by sex

Source of help	*Men* %[1]	Women %[1]	Total %[1]
Spouse / cohabiting partner	16	22	18
Mother	4	3	4
Father	0	3	1
Daughter	3	22	8
Son	6	16	9

Sister	3	9	5
Brother	4	0	3
Friend	10	12	10
No help	57	34	51
Number of subjects	91	32	123

Note 1. The proportion who received the help. Some people received help from more than one source so the column does not add up to 100%.

Further examination of the data found that those who had previously been homeless were slightly less likely to report informal help (40% compared to 55% with no previous history of homelessness). Similar proportions of people aged 50- 59 years and 60+ years received informal assistance and support.

It was noted earlier that the study found that women were more likely to be isolated prior to becoming homeless, however, the reverse was found when it came to receiving assistance. Women (66%) were more likely than men (43%) to receive informal help, as demonstrated in Table 15. The main source of help received by the women who participated in this study was from spouses or cohabitating partners. The other principle source of assistance came from sons and daughters. In most cases the reason for this help ceasing, was a breakdown in their relationship and arguments and problems with their children.

Social Services and Community Support Services

Even though Australia has well developed aged care and community services it was disappointing to find that 51% of respondents received no formal assistance from professional staff prior to becoming homeless, and that this figure did not differ between those who had and those who had not been previously homeless.

Case Study

Barry is a 60-year-old gentleman diagnosed with schizophrenia and depression who has been living in Wintringham housing for two years. Prior to coming to Wintringham he had a long history of housing breakdown and recurring homelessness.

In the past Barry has had difficulty in maintaining his home and caring for himself,

which resulted in repeated hospitalisation and regular periods of homelessness following housing eviction. When Wintringham outreach workers convinced Barry to move to one of our housing services, he was initially difficult to engage, and reluctant to accept services. After much coaxing, he finally agreed to be assessed for home care with the local council, but received these services for only a few months before the arrangement broke down. The council staff struggled to provide services to Barry and found his behaviours unacceptable.

The housing support worker was able to repair the damaged relationship and negotiate with the council for a male worker to provide the services to Barry. Barry and the male council worker have began to develop a rapport with each other and the services are currently continuing.

When examining the results further it was found that those who had not previously been homeless were more likely to access a housing support worker or social worker to assist them than those who had been homeless (30% compared to 14%), yet those who had been previously homeless were more likely to attend a day centre for meals.

Why this would be the case is not known, but it is difficult to escape the conclusion that people who had previously been homeless appear to be more resigned to their homelessness than those who had no previous experience. Recently homeless people appear more willing to try to access or accept supports than people whose prior experience has demonstrated that these services are frequently unwelcoming and inappropriate.

Lipmann (2003) suggests that agency hesitation to take on potentially challenging clients is some of the reasons why this client group finds it difficult to obtain services.

36% of respondents reported that they received assistance with household tasks and assistance with personal and medical care (21%). Even so, the caseworkers reported that in their opinion, poor daily living skills had contributed to homelessness for 60% of the respondents.

According to caseworker reports, 34% of the subjects had known or suspected reading problems because of literacy or language difficulties and 73% had difficulty with budgeting and managing money. Even though the needs of the clients were obvious,

only 4% of respondents received assistance with managing their money and none received assistance for their literacy or language problems.

Table 16 Social services & community support prior to homelessness (all subjects)

Agency	Not formerly homeless		Formerly homeless		Total	
	Number	%[1]	Number	%[1]	Number	%[1]
Social services worker	15	20	10	20	25	20
Housing support worker	22	30	7	14	29	24
Personal care staff	14	19	8	16	22	18
Day centre / meals program	6	8	12	24	18	15
No formal help	37	51	26	52	63	51
Not known	2		0		2	
Total	75		50		125	

Note 1. The proportion who received the various forms of help. Some people received help from more than one agency so the column does not add up to 100%.

6. Service and Policy Gaps

The aims of the three-nation study were: (i) to increase understanding of the causes of homelessness among older people, by examining the biographies of recently homeless people and the policy and service context in which they became homeless; and (ii) to inform the debate about prevention practice, by identifying the sequence of events that precede homelessness, and the risk factors and 'early warning' indicators of serious difficulties.

The tragedy of elderly homelessness is as much a blight on Australian society as it is in the other nation members of this study. The study highlighted and reinforced many of the experiences that Wintringham has gained over the past 15 years of working with aged homeless men and women, but also drew attention to causative factors which have not in the past been as widely acknowledged as perhaps they should be.

While the linkages between psychiatric disorders, ABI and depression with homelessness are well known, the study revealed new linkages with what has been described in the American literature as New Homeless: people who would normally have appeared to be unlikely candidates for homelessness, but whose changed circumstances have been sufficiently severe to culminate in the elderly person becoming homeless. Similarly, the linkages between gambling and aged homelessness is an area that needs further research if an effective preventative model is to be developed.

The study has demonstrated that the longer a person had been homeless, the less likely that they retained a belief that there were supports and services in the community that could assist them. This conclusion is entirely consistent with the experience of Wintringham which has found that it is invariably the most recently homeless of our clients who retain a positive outlook and optimistic view of the future.

The results of this study provide clear guidelines to potential improvements in policy and service delivery.

The study demonstrates once again, that perhaps more so than with any other homeless group, the role of the outreach worker is absolutely critical. It appears to be

within the nature of elderly homelessness, that the aged person withdraws, can at times be reclusive, and rarely if ever, goes searching for services. Compared to the relative assertiveness of many of the young homeless, aged people live and die often in the most appalling circumstances, unable or afraid to seek help.

An effective outreach worker can, through a variety of informants and established linkages with local services, find these aged people and begin to broker services for them. In Australia, the nationally funded program Assistance with Care and Housing for the Aged (ACHA) resources such services, and has made one of the most effective and productive impacts on the steady recruitment into the homeless world of elderly and financially vulnerable people. Unfortunately however, the program is tiny and severely under-resourced. A clear recommendation arising out of this study, is that the ACHA program be expanded and refocused towards the most vulnerable of the impoverished aged. ACHA remains one of the most cost-effective services in the country.

The other clear outcome of this research is the need for specialised services to be developed or improved so that the aged homeless can gain access to them. There is in Australia, no clear Department or policy area that has responsibility for the aged homeless. Elderly homeless people have a variety of needs, the responsibility for which falls across Housing, Health and Aged Care as well as Social Security for income support and Veterans' Affairs for income and specialised support services.

The inevitable result is that the lack of services can be attributable to a variety of different jurisdictions and portfolio responsibilities. Wintringham has argued since its creation in 1989, that for the purposes of program responsibility, the elderly homeless should be considered to be aged and as such entitled to the same suite of services that mainstream elderly people are entitled to. By considering them as primarily homeless, departments are inevitably consigning the elderly homeless to a poorly resourced program area that has no experience or expertise in providing aged care services.

With regard to aged care services, it is clear that the elderly homeless need access to quality high and low care residential services. The responsibility of the Commonwealth Department of Ageing is to resource the capital construction of such services, for it is clear that the poverty of the homeless themselves prevents any organisation such as Wintringham from earning enough surplus income to finance the construction of additional services.

A further recommendation arising from this research is the clear and undeniable need for an increase in the provision of affordable housing for the aged homeless and for those at risk of becoming homeless. While it is apparent from the study that many of the respondents were unable to live independently and as a consequence, lost their housing, it is Wintringham's experience that the levels of support required is often quite low and able to be provided within the program parameters of the Community Aged Care Package Program. The lesson from our practical experience and from the results of this study is that the provision of affordable housing and the existence of low and medium levels of support can prevent vulnerable aged people from becoming homeless.

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