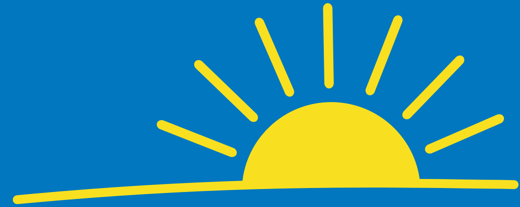
Journeys out of loneliness:

The views of older homeless people

A report for Help the Aged by Kim Willcock



Help the Aged

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Acknowledgements

I would firstly like to thank the many older people who shared their thoughts and experiences with us. Their insights and opinions have directed the course of the research and the writing of this report. I was touched by their warmth and humour and their willingness to share often very personal feelings and painful memories with us. This was often with the hope that the information they provided could be used to improve services and benefit others.

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About the author

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The views expressed in this report are those of the author and not necessarily those of Help the Aged or of other organisations involved in the research.

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Summary

Introduction

Isolation and loneliness are common among older people who are homeless. Social isolation often precedes homelessness and homelessness may exacerbate and intensify isolation. Isolation and loneliness are also commonly experienced after people have been rehoused into permanent housing and are sometimes linked to tenancy breakdown and repeated episodes of homelessness. Yet there has been little research investigating ways of alleviating social isolation and loneliness among homeless or former homeless people, and older people may receive little support in enabling them to build the kinds of social relationships that may reduce loneliness.

Overview

This report is based on research involving interviews and small group discussions with 160 homeless and ex-homeless older people in London. The purpose of interviews was to ascertain older people's perceptions of their situation and their solutions to the difficulties they experienced.

Social isolation and loneliness featured strongly in interviews. Common themes were the absence of social networks and of social relationships, estranged relationships with family and particularly the absence of a close or meaningful relationship.

The report explores:

- older people's experiences of social isolation and loneliness;
- states and events throughout the life course that may contribute to loneliness;
- older people's perceptions of solutions to isolation and loneliness; and
- barriers to alleviating isolation and loneliness.

Pathways into loneliness

Loneliness is complex and is associated with multiple, inter-related factors. For the older people interviewed for this research, its origins can be traced to experiences throughout the life course. For some people, loneliness may be linked to recent events (such as widowhood, homelessness or moving home), while for others the causes of loneliness may be rooted in earlier experiences that accompanied them into later life.

Factors linked to loneliness

Older people identified a number of distinct yet interrelated factors that seemed to be linked to loneliness.

Social network deficits

Social isolation was associated with the lack or loss of social networks, arising not only from experiences of homelessness but from family breakdown, which often preceded homelessness. Some older people attributed isolation to the exclusion associated with being homeless and, conversely, with being rehoused. After people had been rehoused, isolation was associated with the loss of existing social networks without having new ones to replace them. Isolation was also linked to retirement or cessation of work and subsequent lack of meaningful activity, where new social networks might be developed.

Life events

For some individuals, loneliness may be rooted in earlier experiences of loss, abuse and other traumatic experiences, often preceding homelessness, which can affect the ability to form close relationships. Participants had often experienced multiple losses, sometimes within a relatively short period of time. A common link was lack of social support at the time of, and following, a loss or other stressful life event. These factors are associated with the aetiology of depression, which can contribute to or maintain loneliness.

Health factors

Isolation and loneliness were linked to poor physical and mental health, alcohol misuse and mobility problems.

Psychological factors

Loneliness may be maintained by an individual's behaviour, thoughts or beliefs, including lost social skills, anxiety and low self-esteem, in some instances arising from experiences of loss and abuse or as a consequence of severe and prolonged isolation.

Barriers created by isolation

The research identified a number of physical barriers to alleviating social isolation and loneliness. These include:

- inappropriate housing and poor housing conditions;
- lack of accessible transport;
- ineffective information and ignorance of services and community facilities; and
- low income.

Pathways out of loneliness

Older people identified a range of interventions to alleviate isolation and loneliness and to enable them to rebuild their lives after homelessness, develop new roles and promote psychological well-being. The types of interventions wanted by older people were:

- psychosocial interventions;
- meaningful activities; and
- one-to-one company and informal support.

Psychosocial approaches to loneliness

For many older people, developing social networks may be effective for reducing isolation but for those who are depressed, have alcohol problems or experience difficulties forming relationships with others, expanding their social networks may have a limited impact on alleviating feelings of loneliness.

Psychosocial approaches address the factors contributing to or maintaining loneliness and aim to build self-esteem, develop skills and promote psychological well-being.

Many participants had not accessed psychosocial interventions such as counselling, occupational therapy or psychology services. Older people said they wanted support and advice with cutting down on alcohol intake, counselling and emotional support, therapeutic group activities, skill-based groups (including social skills training and anxiety management) and information and advice about mental health and alcohol issues.

The meaning of activity

Lack of meaningful activity was a strong theme in interviews with older people. Regular engagement in activity is vital for psychological well-being and quality of life in later life. Meaningful activities can provide a sense of purpose and a continued role in life. Participation in activities can reduce isolation and loneliness, develop interpersonal and social skills, build confidence and self-esteem, boost morale and improve motivation. Engagement in physical or mental activity can help to alleviate anxiety and depression and distract from drinking.

Older people who had engaged in activities at day centres valued these highly. However, participants were not always interested in the kinds of activities available at day centres or felt these were inappropriate to their needs. Many participants wanted to access activities within the wider community and to expand their social networks outside homelessness provision.

Participants were interested in a wide range of activities, including social, leisure, physical and educational activities and volunteering. Older people wanted to participate in meaningful activities, where they would have opportunities to share their skills with others and feel valued.

Older homeless people have diverse needs, aspirations, capabilities and expectations. The research indicates that a 'one size fits all' service response is inappropriate. This calls for a more individualised approach to enable older people to access activities that are meaningful to them.

One-to-one support

Older people valued one-to-one social contact and informal support, including befriending, telephone contact and home visits. Volunteers can play a valuable role in alleviating isolation by providing social interaction and engaging an older person in one-to-one activities. Volunteers can support an older person in widening their social networks and building links with the local community. One-to-one support is important to reduce isolation after being rehoused, particularly for older people with physical health and mobility problems, and for people who do not want to join a group or attend a day centre or other facility.

Involving older people in finding solutions

Older homeless people are a group whose voices are rarely heard and seldom listened to. Older people interviewed for this research felt it was important for services to consult them about their views on their needs and services requirements as this would enable them to exercise greater control over their lives and ensure that services were geared to their needs. They also said that agencies could use this information to improve services and, potentially, to guide the development of new projects.

This research was the first stage of an action research project, which involved developing services in response to feedback from older people. There are numerous examples of how the views of older people directly influenced service development, including developing day centre activities, setting up new groups and organising outings, and recruiting volunteers to provide one-to-one informal support to homeless and resettled older people.

The research has informed the development of two new projects for homeless and former homeless older people, to address some of the gaps identified by the older people who participated in the research, in relation to isolation and loneliness, meaningful activity and emotional well-being.

1 Background and methodology

Overview

This report is the first of five, all based on research taking place over seven years (1998–2005). This first report provides an overview of the themes arising from exploratory research based on interviews with 160 homeless and former homeless older people contacted through five homelessness agencies in London.

The aims of the research are to:

- explore older people's perceptions of their needs and circumstances;
- identify gaps or weaknesses in current service provision;
- investigate the kinds of support or interventions perceived as appropriate by older people; and
- identify barriers to accessing services.

Social isolation and loneliness emerged strongly in interviews with older people. These and associated areas became the focus of the research and the subject of this report.

The report explores older people's experiences of social isolation and loneliness; factors linked to loneliness; older people's solutions to isolation and loneliness and promoting psychological well-being; and barriers to alleviating isolation and loneliness.

Intended to be practical, the report is targeted mainly at agencies working directly with older people, in the hope that it will support their work with older people who are socially isolated and who have experienced homelessness.

Background

During the 1990s Help the Aged became increasingly aware of the problems faced by older people who are homeless. In 1997 Help the Aged and Crisis commissioned a study to advise on the circumstances, problems and needs of older homeless people and to make recommendations as to the types of services that are needed. The report (Crane, 1997) draws heavily on the author's doctoral thesis, which found that many older homeless people are isolated and have little contact with their families or with services. The study indicated that some older homeless people do not use hostels and day centres for homeless people because they fear intimidation from younger service users. The research also found that many older people sleeping rough have unmet health and social problems and a high proportion have mental health problems, yet are not accessing mental health services. The report highlighted the lack of policies and homelessness services targeting older people.

In September 1997, building on the recommendations of this report and following consultation with a number of homelessness agencies in London, Help the Aged drafted a homelessness strategy. The strategy combines several distinct elements in one integrated campaign:

- research into the needs of older homeless people;
- action research within individual projects to improve services;
- project development;
- raising funds through several targeted appeals;
- campaigning for changes in policy and practice; and

- developing partnerships with other agencies.

In 1998 Help the Aged joined forces with two other national charities, hact (the Housing Associations Charitable Trust) and Crisis, to launch a partnership, 'Action for Older Homeless People', to support the development of projects for older people. Help the Aged and hact made funding available for 17 projects over three years. Projects funded by the Partnership Programme were required to supply information for an evaluation of the programme by the University of the West of England, Bristol, commissioned by the partnership and funded jointly by Crisis and Help the Aged.

The three charities initiated a new UK lobby group – the UK Coalition on Older Homelessness – to work with and on behalf of older homeless people. Membership of the UK Coalition now includes national and local agencies concerned with tackling homelessness among older people.

In addition to projects funded by the Partnership Programme, Help the Aged funded an additional 23 projects between 1998 and 2002. Six organisations supported by the Help the Aged grant programme participated in a programme of action research, developed as part of the homelessness strategy.

Help the Aged wanted to develop a programme of action research to enhance the work within individual projects supported by the Charity. In November 1997 the Charity commissioned a brief study to assess the monitoring systems employed by a number of homelessness agencies, to advise on the best approach to take to measure outcomes from services and to develop an effective action research programme. The proposal (Willcock, 1997) recommended a qualitative, user-centred evaluation of services and a user-focused approach to action research, which would aim to improve services by developing practice in response to feedback from older users. A researcher was appointed to undertake the research, in collaboration with homelessness organisations. Following the original recommendations of the proposal, the research programme was developed over four years (1998–2002).

There are three interrelated parts to the research:

- an exploratory study, which explores older people's perceptions of their circumstances, needs and services;
- qualitative, user-centred evaluation of projects; and
- action research, which involves making changes in practice and monitoring the impact of action taken.

Practitioners and managers were involved throughout the research process and in discussing the research findings. The action research involved incorporating into practice the findings from the research, so that services were developed in accordance with older people's perceptions of needs.

Methodology

The fieldwork for the exploratory study took place over four years (1998–2002). In order to provide a broad and in-depth understanding of older people's needs, methods included a combination of questionnaires, in-depth interviews and small group discussions with older people and observation. Partial life histories were collected, from a combination of interviews with older people, questionnaires and information provided by project staff.

The researcher spent considerable time at day centres, hostels and shelters and other schemes, talking with staff and 'sitting around' at day centres, talking to older people. The research began with a broad area of study. Using a grounded theory approach, data was gathered and analysed throughout the research process. A qualitative approach allowed topics to be added as they arose and themes emerging from interviews to be pursued. The data guided the course and direction of the research and the research focus narrowed as the research progressed.

As is the nature of qualitative research, not all areas were covered in all interviews. The purpose of the study was to enhance understanding of how older people perceive their circumstances, to attempt to gain a degree of insight into their thoughts and feelings, and neither to try to establish prevalence of need nor to produce statistical generalisations.

Altogether, 160 older people participated in the research. Although some participants were interviewed only once, the majority of participants were interviewed three or four times, using a combination of semi-structured questionnaires and in-depth interviews. A few participants provided little information, due to long-term memory loss or because they were confused or disoriented. Some older people with severe memory loss were, however, able to participate in the research, by commenting on their current needs and on support or services they wanted.

There were three stages to the interviews with older people:

- Unstructured interviews with 20 older people, with the broad aim of exploring their perceptions of their circumstances, needs and views on service provision. Semi-structured questionnaires were designed, based on themes emerging from the interviews.
- Questionnaires were completed by 140 older people, in one-to-one interviews or self-completed, according to the preferences of older people. Questions were open-ended and explored older people's needs, their views on current service provision, the kind of support and interventions perceived as appropriate, and barriers to accessing services. Experienced front-line staff from homelessness agencies (hostel workers, day-centre workers and support workers) administered the questionnaires, with guidance and support from the researcher throughout the process.
- Themes emerging from the second stage of the research were further explored in in-depth interviews with 40 older people and small group discussions with 38 people, with a sample of older people who had participated in the second stage of the research.

Interview procedure

Before the interview, the older person was given verbal and written information about the research. The purpose of the interview/questionnaire was explained, including how the information would be used (including anticipated publications). Anonymity and confidentiality were assured. Interviews were not taped, as earlier research suggests that older homeless people are often suspicious of taped interviews (Crane, 1999). Older people were asked if notes could be taken, which was considered acceptable to the older people interviewed. Interviews lasted between 30 minutes and 2 hours, allowing time for an informal chat or for the interviewee to talk further on issues raised in the interview.

Following the interview, participants were given the opportunity to ask questions about the research and to read (or have read to them) the notes taken and were informed that they could comment on these. A few older people chose to read the notes. Participants could also opt to be sent (via project staff) a copy of the typed transcript of the interview.

At the end of the interview, the interviewees were asked for their consent to use the information they had provided for the purposes of the research. Older people were asked if they would sign a written consent form, although reassured that they could choose not to. On the consent forms, participants were asked to give consent to various uses of the information they had provided, for example use of direct quotations in publications. Just a few older people preferred not to sign forms and in such instances verbal consent was taken, provided the researcher was satisfied that informed consent had been given.

The researcher had familiarised herself with local support and advice services and after the interviews she gave older people information about services available, where relevant. A small number of participants were referred directly to project staff, where this was felt to be appropriate.

Sampling

Participants were people aged 50 and over who use homelessness day centres, short-stay hostels and night shelters or who were in touch with other support services. They were therefore older people who had engaged with staff on at least some level. The research does not include rough sleepers who had no contact with services. However, many participants were among those considered 'hard to engage with' and sometimes had little more than cursory contact with agency staff and often refused support with problems. It is possible, though, that the research does not include arguably the most severely isolated older people who have no contact with services. These might be more likely to come from specific groups, such as older women, or older people from black minority ethnic groups.

Interviews took place at day centres, hostels and in some cases (with resettled older people) in older people's own homes. Some resettled older people who were not using day centres were contacted through other support services, to ensure that such people were represented.

Older people were contacted through five homelessness agencies in London, although many use and move between various other services. Some older people were approached for an interview by the researcher and informal group discussions were held in which older people who approached the group could participate. Many older people were invited to participate by agency staff, who introduced them to the researcher. Where possible (that is, with settled participants), older people were sent a letter by the researcher to explain the purpose of the interview. For many, however, this was not an option, so these people were interviewed at day centres or hostels as and when they were around.

A 'snowballing' technique was also used, whereby older people who had participated in an interview volunteered to introduce the researcher to another older person. Personal recommendation by a peer can increase the likelihood of including those who are more isolated, distrustful or alienated from services and generally hard to reach.

Some 15 older people, having heard about the research from others who had been interviewed, had approached project staff or the researcher (at two agencies), asking if they too could participate in the research. While it is acknowledged that allowing these volunteers to take part could have introduced bias into the

research, a basic principle of the research process from its inception had been that it would endeavour to be an empowering experience for the participants. Interestingly, staff were surprised to see that often the individuals who had asked to participate in the research were people who did not normally ask to be involved in any activity and, in some cases, had not asked for support or services either.

As with other research about older people and homelessness, the sample is one of convenience and no claims are made that the research is generalisable to all 'older homeless people'.

2 Characteristics and circumstances of participants

Participants were people aged 50 and over who were or had been homeless (sleeping rough or staying in short-stay hostels or shelters). Participants were contacted through five homelessness agencies in London. Altogether, 160 older people participated in the research.

Age, gender and ethnicity

The research includes people aged 50 and over. While there is no consensus as to the age at which older homelessness begins, research about older people and homelessness tends to involve people aged 50 and over, owing to the accelerated ageing associated with sleeping rough and lower life expectancy. People with a history of street homelessness are thought to be comparable to people who are 10–20 years older, not only in terms of their health characteristics but also their self-perceptions.

In line with other research among older homeless people, participants were mainly the 'young old' (table 1). Eighty-three participants (52 per cent) were aged 50–59; and 77 participants (48 per cent) were aged 60 or over, of whom 18 (11 per cent of the total) were aged 70 or over.

Table 1: Age and gender of participants

Age	Men	Women	Total	%
50–59	74	9	**83**	52
60–69	52	7	**59**	37
70+	15	3	**18**	11
Total	**141**	**19**	**160**	100
%	**88**	**12**	**100**	

Most participants (88 per cent) were men. The gender ratio is consistent with that of estimates of single homeless people in London (see Crane and Warnes, 2001a). However, the research did not include older people who were not in contact with homelessness services and previous research has suggested that older women may be less likely to use day centres and hostels.

The majority of participants were white male (table 2). Similar to other research about older people and homelessness, a high proportion of participants (29 per cent) were Irish or Scottish. The research included a small number of older people from black minority ethnic groups. It may be that older people from black minority ethnic groups are less likely to use services dominated by young white men.

Table 2: Ethnic group of participants

	Number of people	%
White English	93	58
Irish	32	20
Scottish	14	9
Welsh	2	1
Other European	5	3
Asian	3	2
Black African	3	2
Black Caribbean	6	4
Other	2	1
Total	**160**	**100**

Health, disability and substance misuse

Participants had complex needs and multiple disabilities. The health characteristics of participants are presented in table 3. This information was collected from a combination of self-reports, information from agency staff and observation.

Physical health and disability

Eighty-seven participants (54 per cent) reported having one or more chronic physical health problems and in many cases these were severe. Many participants had mobility problems and a number of participants had partial or total loss of sight or hearing.

Health conditions included:

- respiratory diseases, including asthma, chronic bronchitis, emphysema and lung cancer;
- cardiovascular disorders, such as angina and coronary heart disease;
- alcohol-related diseases, including cirrhosis of the liver and chronic pancreatitis;
- neurological conditions, including epilepsy or seizures, recent history of brain haemorrhage, recent stroke and partial paralysis; and
- arthritis and diabetes.

Table 3: Health, disability and substance misuse

	Number of People	%
Physical illness or disability	87	54
Learning disability	17 [1]	11
Mental health problem	74 [2]	46
Depression	65	41
Anxiety	51	32
Psychotic symptoms	15	9
Memory loss [3]	13	8
Alcohol problem	83	52
Mental health and alcohol problem	36	23
Either a mental health or alcohol problem (or both)	111	69
Other substance misuse	7	4

Notes:

1. Includes three people observed or reported but undiagnosed.
2. The total is not the sum of the symptoms reported, as some participants reported more than one type of problem.
3. Memory loss is not included in the number of participants with mental health problems.

Although the majority of participants were registered with a GP, many did not visit their GP or seek medical help with health problems. Some participants were terminally ill; a number of these were alienated from statutory services and had refused treatment. Chronic back pain and joint pain were commonly reported.

A small number of older people experienced chronic pain from (unhealed) fractures acquired on the street or in a hostel (from assault by other homeless people/hostel residents) and some had not accessed health care while on the street or had refused health care when they entered a hostel. Some people were self-medicating with alcohol in an attempt to cope with chronic pain.

Learning disability

Eleven per cent of participants had mild to moderate learning difficulties. Most had been formally assessed at some point in their lives and had a diagnosed learning disability, although none were currently in contact with learning disability services. Three had a self-reported and/or observed learning disability but were undiagnosed.

Older people with learning disabilities may be especially isolated and vulnerable using homelessness facilities and can experience particular difficulties in accessing services. Some of those with learning disabilities had lived with their parents throughout their lives. They had become homeless later in life, after their last remaining parent had died. Without adequate support, they struggled to cope with living independently and had accumulated rent arrears, sometimes resulting in them being evicted from their tenancies. A number of older people with learning disabilities had spent years living in institutions and had become homeless at some time following discharge from hospital. Of this group, some had returned to their families after being discharged from hospital and had become homeless after this support broke down; others had lived alone since leaving hospital.

Mental health problems

In line with other research, a high proportion of participants (46 per cent) reported, or were observed to have, mental health problems. According to the self-reports of participants, mental health problems often preceded and contributed to homelessness. It is believed that poor mental health is one of many interrelated factors that leads to and perpetuates homelessness (Marshall and Bhugra, 1996). The experience of homelessness may exacerbate pre-existing mental health problems (eg Crane, 1999).

Fifteen participants (9 per cent) exhibited or reported psychotic symptoms (auditory hallucinations, paranoid ideas or delusional thoughts). Some had a formal diagnosis of schizophrenia or bipolar disorder; others had not had a formal assessment. In some cases observed or reported psychotic symptoms may be alcohol induced. Many participants with mental health problems were not using mental health services or receiving specialist support with these difficulties, although many participants had earlier experiences of using mental health services and admissions to psychiatric hospitals or acute psychiatric wards.

Many older people had poor short-term memory and a number of people were disoriented and confused. Thirteen participants (8 per cent) had experienced long-term memory loss and in some cases this was marked. Two men had virtually no memory of their lives. Many had not been formally assessed and the causes of memory loss were not ascertained.

Depression and demoralisation

A high proportion of older people (41 per cent) reported feeling depressed and symptoms of depression were observed in interviews. Some had a formal diagnosis of depressive disorder or 'clinical depression', although many had not been assessed. Many were demoralised and reported feelings of worthlessness, low self-esteem and poor self-images. Other research has reported high rates of demoralisation, low self-esteem and feelings of hopelessness among older rough sleepers, which may be a consequence of the experience of being homeless and may also serve to prolong homelessness (Crane, 1999).

Demoralisation is often distinguished from depression among older people. Gurland and Toner (1982) estimate that rates of demoralisation among older people in the general population are at least double that of clinical depression (cited in Coleman, 1993). Self-reports of depression (while not diagnosed) in some cases suggested dysthymia, which is generally considered distinct from major depressive disorder or 'depressive syndrome'. Dysthymic disorder is a mild but chronic form of depression (as distinct from the depressive episodes characteristic of major depressive disorder) and is characterised by depressed mood, low energy, low self-esteem, poor concentration or difficulty making decisions and feelings of hopelessness. This form of depression is more common among older people in the general population than is major depression (Blazer, 1990).

There is evidence from British epidemiological surveys that prevalence of depression among older people in the general population is high, affecting one in seven people aged 65 and over. However, while depressive symptoms are prevalent among older people, Coleman (1993) points out that epidemiological studies suggest that severe depression is more common among younger groups in the population (eg Henderson, 1989). When studies use stricter diagnostic criteria for depression such as DSM criteria (American Psychiatric Association, 1994) – as opposed to measuring the occurrence of depressive symptoms – lower rates of depression are found. It should be noted, however, that some commentators have suggested that these diagnostic criteria may not necessarily apply to older people.

Definitions of depression in ordinary usage differ from psychiatric definitions. Many more older people among the general population are troubled by depressing thoughts and feelings than actually develop full-blown levels of clinical depression (Coleman, 1993). The form and severity of depression may indicate a different type of intervention.

Anxiety

Fifty-one participants (32 per cent) reported problems with anxiety. Self-reports of anxiety referred mainly to generalised anxiety and occasionally to panic attacks or specific phobias. A few participants reported debilitating anxiety disorders, including agoraphobia.

Suicidal ideation

A number of participants had attempted to commit suicide in the preceding few years, sometimes on more than one occasion. Some expressed present or past suicidal thoughts. Suicidal ideation and previous suicidal attempts were more common among heavy drinkers and those with self-reported alcohol problems.

Alcohol problems and substance misuse

A high proportion of participants (52 per cent) had alcohol problems. This proportion is similar to other research with older homeless people (eg Crane, 1999; Crane and Warnes, 2001a). Alcohol problems sometimes preceded homelessness, sometimes along with other addictions such as gambling. For many, it seemed that heavy drinking was exacerbated by the experience of homelessness, low self-esteem, demoralisation and feelings of hopelessness.

The majority of those with alcohol problems were heavy drinkers. Some drank every day and were rarely sober. Others were 'binge drinkers', drinking heavily for a few days followed by a period of abstinence after their money ran out. This statistic also includes a number of older people who did not drink 'heavily' but reported having an alcohol problem. Drinking was perceived as a problem to the individuals and the alcohol consumption affected their physical or mental health. This was considered significant as tolerance of alcohol is lowered in older people (see, for example, Institute of Alcohol Studies, 1999).

These figures should not be statistically extended to all 'older homeless people', although they are similar to those found in other research. The fact that some participants (albeit a small proportion of the total sample) were contacted through an agency that targets homeless people with complex needs and challenging behaviours could have inflated the proportion of alcohol problems in the sample. Almost all the older people contacted through this agency were heavy drinkers and many had co-existing (though perhaps sometimes alcohol-related) mental health difficulties.

In line with other research, only a small proportion of older people reported taking drugs other than alcohol. Drug use (including heroin, cocaine and LSD) was reported by seven participants, all aged in their fifties.

Dual problems

The majority of people with learning disabilities had mental health problems and some had concurrent mental health difficulties and alcohol dependency.

Over two-thirds (69 per cent) of participants had either an alcohol problem or a mental health problem or both. Almost a quarter of the sample (23 per cent) had both an alcohol problem and poor mental health. However, it should be noted that this statistic is unreliable, as it is difficult to gauge mental health problems among people who drink heavily and who may not have been clinically assessed.

It is therefore problematic to establish the number of people with dual problems. In some cases (among those with apparent co-existing mental health and alcohol problems), observed or reported depressive (or psychotic) symptoms may be alcohol-induced symptoms, rather than indications of an underlying mental illness. Among people who exhibit co-existing depression and an alcohol addiction, alcohol is often the primary diagnosis, not affective disorder. People dependent on alcohol are prone to depression and the depression is often secondary to excessive alcohol intake (Institute of Alcohol Studies, 1999). Research has found that for 90 per cent of people who have both an alcohol dependency and depression, the diagnosis is alcohol dependency, not affective disorder (Madden, 1994).

Definitions of what constitutes a mental health problem or an alcohol problem are likely to vary between studies (and in practice).

Housing and homelessness

Homelessness covers a broad spectrum of housing need:

- being literally roofless and without any accommodation (sleeping rough or street homeless);
- living in short-stay hostels and night shelters or other temporary accommodation, such as bed and breakfast hotels;
- having permanent accommodation that is deemed uninhabitable, either due to unsanitary or otherwise poor housing conditions, or for other reasons such as risk of violence or abuse in the home.

Current housing situation

A summary of the participants' current housing situation is presented in table 4.

Table 4: Older people's current housing situation[1]

	Number	%
Street homeless/sleeping rough	24	15
Temporary accommodation Short-stay hostel/shelter: 46 Other temporary accommodation: 5	51	32
Permanent Housing Independent tenancies, flat/bedsit (LA/HA/private): 66 Supported/shared housing: 11 Sheltered housing: 5 Registered care homes/ residential care: 3	85	53
Total	160	100

Note:
1. Some older people moved between hostels and the street, between different hostels and between different types of accommodation. A number of older people were rehoused during the four years of the fieldwork for the research. Some experienced repeated attempts at resettlement, with intermittent periods on the street. Current housing situation refers to participants' accommodation when first interviewed.

Street homeless

Twenty-four participants (15 per cent) were sleeping rough. Of these, seven participants never used a hostel or shelter and 17 occasionally used a hostel or shelter (eg for a few days at a time or during the winter).

Temporary accommodation

Fifty-one participants (32 per cent) were living or staying in temporary accommodation, although sometimes spending intermittent spells on the street. Forty-six participants in this group were staying in short-stay hostels or shelters for homeless people.

The sub-group includes:

- ten participants who moved in and out of different hostels, spending intermittent periods on the street; and
- thirty-six participants who were 'settled' in a hostel or shelter, many of whom had been living in a hostel/shelter for a long time – sometimes many years – and were previously street homeless.

A small number of older people (five) were living in other temporary accommodation: squatting, staying with a friend or (former rough sleepers) living in rehabilitation units, preparing to move into permanent housing and having no permanent accommodation.

Permanent housing

Eighty-five participants (53 per cent) were living in permanent housing, the majority in independent tenancies (flat or bedsit). Of these, the majority (75) were former street homeless older people. They were mainly recently rehoused, although a small proportion had been housed for up to two years or longer. A number of people in this group slept out on occasion, often to escape loneliness. The high proportion of participants who were living in permanent accommodation in part reflects the high proportion of older people using homelessness day centres (or living a 'homeless lifestyle') who are no longer homeless but are in need of continuing support to remain housed. Most were considered to be at risk of losing their accommodation without the continued support of voluntary homelessness agencies. This group also includes a small number of resettled older people who were not using day centres but were using other support services.

Many older people in this group may be considered to fall within the group that Crane (1999) terms the 'symptomatically homeless': older people, often previously homeless, who have permanent

accommodation but display 'homelessness behaviours', such as regularly using homelessness day centres and soup kitchens and 'congregating on the streets with homeless people'.

This group also includes 14 older people (aged 60 or over) living in independent tenancies, who did not have histories of rough sleeping but were using homelessness day centres. They were vulnerable and isolated and were considered to be at risk of losing their home, through landlord action/rent arrears, or because they were experiencing difficulty in coping with living alone with inadequate support.

Histories of homelessness

The majority of participants (both those who were currently homeless and those who were housed) had experiences of sleeping rough. However, participants' backgrounds and experiences of homelessness are as diverse as their needs. The age at which participants first experienced homelessness ranged from 13 to 78 years and the length of time spent sleeping rough varied from one night to over 30 years. In line with other research (eg Crane, 1999), the majority (85 per cent) became homeless for the first time before they were 60. Fifteen per cent experienced a first episode of homelessness aged 60 or over; a small number became homeless for the first time when they were aged 70 or over; and five became homeless at 19 or younger.

A high proportion of participants had long histories of sleeping rough (over 10 years and in many cases over 20 or 30 years). Some had been continuously homeless, while others had been homeless on and off for a number of years, with intermittent periods of being housed, sometimes for several years or sometimes for a few days or weeks at a time. The majority of participants could be described as 'chronically homeless' (Crane, 1999): people who generally become homeless earlier in life and who often experience repeated cycles of homelessness and being housed.

3 Social isolation and loneliness in later life

Introduction and literature review

Isolation and loneliness are distinct but interrelated concepts. Various definitions of the two terms have been proposed to distinguish between them. It is generally accepted that social isolation refers to an objective, measurable state of having minimal contact with other people such as family, friends or the wider community (Wenger et al, 1996; Victor et al, 2000). Loneliness, or 'emotional isolation', has been defined as the subjective feeling associated with perceived social isolation or the absence of a specific desired companion (Weiss, 1982). Distinguishing between the two concepts can help us to understand why some older people, as was the case in this research, say they are lonely even though they do not appear to be isolated. It can also help us (as suggested by Cattan, 2002) to appreciate that isolation and loneliness may require different service responses.

Contrary to popular stereotypes of old age, the majority of housed older people, unlike their homeless counterparts, do not report being isolated or lonely. A major national survey by Tunstall in 1963 found that approximately 10 per cent of older people were lonely and 20 per cent were isolated (Tunstall, 1966). Since this early research, studies have reported rates of loneliness in people aged 65 and over ranging from 5 per cent to 16 per cent with a median of approximately 9–10 per cent (Victor et al, 2000). It has been estimated that about 10 per cent of older people in the UK are socially isolated (Victor et al, 2000). Loneliness is often thought of as a problem of old age, despite the evidence that other groups within the population are also more likely to experience this state (Victor, 2002).

Loneliness is experienced by people of all ages. Cramer reports the findings of a survey based on a representative sample of 9,003 British adults. Twenty-seven per cent of respondents admitted to feeling lonely sometimes and 5 per cent reported that they are often lonely (Cramer, 1992). These figures probably underestimate the actual number of people who are lonely, as people being interviewed may be reluctant to admit to feeling lonely.

Nonetheless, social isolation and loneliness are associated with age and are more common among people aged 75 and over (Victor, 2002). In real terms, experiences of isolation and loneliness may have a significant impact on the quality of life of at least 10 per cent of older people in the UK.

Research in North America and the UK has found isolation to be prevalent among older people who are homeless. Crane, from her ethnographic study of 225 older homeless people, found that many older people are isolated. The majority in the sample were estranged from their relatives and had no friends:

Most older people either lacked family or had had no contact with relatives for years. Estranged family relationships often dated back more than 20 years and several were unaware if their family were still alive. Only 27 per cent had seen a family member (parent, child or sibling) during the five years before being interviewed [and] over half of the homeless subjects had had no family contact for more than five years. (Crane, 1999)

Only 19 per cent of older people interviewed had had contact with a relative within the past year (Crane, 1999; table 8.5). The paucity of family contact among homeless older people contrasts sharply with the frequency of family contacts for the majority of housed older people in the UK. Only 2 per cent of all older people do not see relatives or friends (ONS, 1998) and few are

estranged from their families (Wenger, 1994). According to Hunt (1978), the vast majority of older people (97 per cent) have relatives they describe as 'close' and more than 70 per cent of older people see a relative at least once a week (Jerrome, 1993).

This report explores the experiences of a group of older people who may be seen to represent one extreme of the spectrum of social isolation in later life.

Factors associated with isolation and loneliness

Research has established a range of factors linked to isolation and loneliness in later life. Many of these factors were relevant to homeless and former homeless older people interviewed for this research.

Associated factors include:

- Amount of time spent alone (Victor, 2002)
- Living alone: research has found that, among older people, social isolation is associated with living alone, although the link between loneliness and living alone is often thought to be tenuous (Cattan, 2002). However, a recent major study of loneliness among older people found a statistically significant association between living alone and loneliness (Victor, 2002)
- Age: isolation and loneliness are more common among the very old (aged 75 and over) (Tijhuis et al, 1999; Victor, 2002)
- Marital status has been found to be related to loneliness among older people (Victor, 2002)
- Gender: women are more likely to experience social isolation and loneliness than men (Victor, 2002), although (and with particular relevance to many older people who are homeless) some studies have shown that non-married men feel more lonely than non-married women or married men or women (Andersson, 1998)
- Poverty and low income are associated with isolation and loneliness (Victor, 2002)
- Recent bereavement (Victor, 2002) and widowhood are linked to isolation and loneliness: recently widowed men and women report the highest levels of loneliness (Andersson, 1998; Victor et al, 2000; Victor, 2002)
- Isolation and loneliness are linked to chronic health problems, loss of mobility, sight or hearing problems, and loneliness is significantly higher among older people with depression or poor mental health (Victor, 2002)
- Other major life events, such as retirement, moving home or moving into residential or nursing homes, are associated with social isolation and loneliness among older people (Cattan, 2002)

From a recent major study of loneliness among older people across Great Britain, Victor (2002) defines loneliness as deriving from three sets of factors which, she suggests, might indicate the need for different interventions:

1. Impaired social networks: loneliness is linked to the number and closeness of relationships with friends and with relations;

2. 'Functional/environmental' impairments: this relates to the loss of a range of abilities and the loss of practical aspects of daily life (particularly among men); and

3. The individual's state of mind: loneliness is 'caused' solely by an individual's personal state of mind. This includes 'the ability to find ways of filling time, happiness at spending time alone, self-motivation and the ability to

go out and meet new people and make new friends'. (Victor, 2002)

It is suggested that, in later life, loneliness may be triggered by a recent event or series of events (such as a bereavement or moving home) or may be a continuum from previous phases in the life course:

...we can differentiate between those whose experiences of loneliness emerged gradually over the course of time and those whose emerged following a single, specific event (usually bereavement) or a series of events which acted as a trigger (such as friends moving away or dying, changing neighbourhoods, retirement and children moving away) leading either directly or indirectly to a reduction in the social interaction available to that person. (Victor, 2002)

Thus, loneliness among older people may be associated with recent states and events or it may be rooted in earlier experiences that individuals take with them into later life.

The impact of isolation and loneliness

The quality of relationships, especially close ties with important others, are critical to quality of life in later life (Kelly, 1993). Studies have consistently demonstrated a relationship between social engagement and participation, 'quality of life' and physical and mental health in old age (Victor, 2002).

Social isolation and loneliness are strongly associated with poor psychological health:

- Isolation and loneliness among older people are linked to psychosomatic or stress-related physical illness, poor mental health, anxiety and depression (Murphy, 1982; Peplau and Perlman, 1982; Wenger et al, 1996). An association between two variables does not necessarily indicate a causal relationship. However, longitudinal research has found that loneliness sometimes precedes psychological ill health (eg Broadhead et al, 1983).
- Lack of social support following major life events is a risk factor for depression in old age (Murphy, 1982). Godfrey (1999) explains that a number of studies (Green et al, 1992; Roberts et al, 1997) have demonstrated a relationship between social isolation and the onset of depression in older people.
- Research has found that social isolation and loneliness are linked to use of alcohol among older people. Loneliness, retirement and decreased social activity are thought to be reasons for increased drinking among housed older people, along with coping with illness and pain (Institute of Alcohol Studies, 1999). Among older people who are homeless, loneliness has been found to be more common among heavy drinkers (Crane and Warnes, 2000).
- Social isolation and loneliness (associated with widowhood, lack of social support, poor physical health and especially pain) are associated with suicide among older people (Cattell, 1988; Loebel et al, 1991), particularly among older men (Dennis and Lindesay, 1995). Isolation and loneliness are also precipitants of suicide attempts and deliberate self-harm among older people (Pierce, 1987).

Isolation, loneliness and homelessness

Isolation and entry into homelessness

Social isolation (or lack of social support) associated with bereavement and relationship breakdown often precedes homelessness. Crane's study of pathways into homelessness among 'unofficially homeless' older people (1999) identified a number of states and events that precede homelessness. Those states and events occurring in later life include the following:

- Marital or relationship breakdown is a commonly reported reason for homelessness (Crane, 1999).
- Widowhood is an important contributory factor to homelessness, particularly among men (Crane, 1999).
- Retirement followed by loneliness (Crane, 1999) or the cessation of work is associated with homelessness, particularly those with weak or no family support (Crane and Warnes, 2001b).
- The onset or increased severity of a mental illness is a contributory factor to homelessness among older people. In Crane's research, of those who became homeless following the onset, or increased severity, of a mental illness, all were living alone at the time and had no support from their families or friends throughout their difficulties (Crane and Warnes, 2001b).

Crane and Warnes suggest that when people experienced these and other difficulties, homelessness arose when support networks broke down (Crane and Warnes, 2001b). A common link was social isolation or lack of social support at the time of, and following, a loss or other stressful life event. The apparent link between isolation and homelessness (in relation to relationship breakdown, mental illness and lack of social support) does not necessarily pertain specifically to isolation in later life, but among people of all ages, as the majority in Crane's sample, as with the study under discussion, became homeless when they were aged under 60 years.

Other research among 'officially' homeless older people (older people presenting as homeless aged 60 or over and who are registered in local authority housing statistics) found that relationship breakdown contributes to homelessness in later life. Hawes' analysis of local authority statistics by applicants for rehousing found that 65 per cent of cases of loss of home in later life were related to various kinds of relationship breakdown within families (Hawes, 1997; Hawes, 1999).

Loneliness prolonging homelessness

Social isolation and loneliness are also common among former homeless older people after they are rehoused.

Research has found a high rate of tenancy breakdown in the first two years after moving into accommodation, particularly in the first six months (Warnes and Crane, 2000). In Crane's study, loneliness and boredom were among the three main difficulties reported by older people when they are resettled, along with difficulties adjusting to living in accommodation and managing household chores and finances (Crane, 1999). Warnes and Crane explain that:

Rehousing often involves moving to a new area and losing social and support networks (however tenuous) at hostels and on the streets. Many homeless people have minimal contact with relatives and have few friends and their isolation is commonly compounded when they move because they find it difficult to socialise and are unlikely to become acquainted with neighbours or to access community facilities. (Warnes and Crane, 2000)

Loneliness and boredom are reasons why some older people cede their tenancies or continue to live the 'homeless lifestyle' after they have been rehoused (Crane, 1999).

Lemos explains the paradox:

...the breakdown of social networks is a cause of homelessness... The continuing absence of social networks is also a barrier to escaping homelessness Staying homeless provides a way to avoid being alone. (Lemos, 2000)

4 Pathways into loneliness

Introduction

Social isolation and loneliness featured strongly in interviews. Common themes were the absence of social networks and of social relationships, estranged relationships with family and particularly the absence of a close or meaningful relationship. There were differences between groups, depending on the participants' housing situation. Isolation was common among those sleeping rough, but less common among hostel residents, who often socialised with other residents. Isolation was a strong theme among those living in independent tenancies, including those who were resettled, and vulnerable older people considered at risk of becoming homeless. Loneliness, however, was a strong theme among all groups.

Perceptions of isolation and loneliness

Older people distinguished between isolation and loneliness. Isolation was perceived in terms of the amount of contact they had with other people, with peers, friends and the wider community. This was without reference to the quality of social contacts, but largely referred to as 'being in the company of other people'. Loneliness was associated with the quality of social contacts, the absence of a close relationship and the lack of or loss of familial relationships. In accordance with this distinction, a number of participants reported being lonely though not isolated.

Some participants isolated themselves, describing themselves as loners or saying they did not mix well with people. However, many wanted support in trying to come to terms with their loneliness.

Factors linked to loneliness

Loneliness is complex and is associated with multiple, interrelated factors. For some people, loneliness may be linked to recent states (such as poor physical or mental health) or events (such as widowhood, the exclusion associated with being homeless or moving home/being rehoused), while for others the causes of loneliness may be rooted in earlier experiences that accompanied them into later life.

Older people identified a number of distinct yet interrelated factors that seemed to be linked to loneliness. These are discussed in this chapter and summarised below.

Factors linked to loneliness

i Social network deficits: linked to experiences of homelessness and being rehoused, family breakdown preceding homelessness, and loss of occupation and lack of meaningful activity.

ii Life events: childhood experiences of loss, abuse and neglect; experiences of loss and trauma in adulthood; and the effects of these experiences in relation to mental health and intimate and/or social relationships.

iii Health factors: poor physical health and mobility problems, mental health difficulties and alcohol problems.

iv Psychological factors: behaviour (eg social skills) and thoughts (eg anxiety-provoking thoughts and low self-esteem).

i Social network deficits

Loneliness was associated with the lack or loss of social networks and the quality of social contacts.

Older people's social networks

'I have no friends or family.'

The social networks of participants focused largely on the homeless circuit. Social contacts tended to be limited to other homeless or formerly homeless people in hostels, day centres or on the street. A few participants had contact with people at places of worship and these contacts were valued highly. One man frequently went on day trips with people from a local church. Another man who regularly attended a mosque had friends there. Three participants did voluntary work and a few others held part-time jobs, such as selling the *Big Issue*. However, for the majority of participants, contact with people in the wider community was minimal.

While some participants preferred to mix with other people who had shared experiences of homelessness, with 'everyone in the same situation', which could be mutually supportive, others were keen to develop social networks outside homelessness provision. Some participants related their isolation and loneliness to the exclusion associated with being homeless and the limits this placed on social networks. One man explained, for example:

'Sometimes I feel lonely. Even though there are people around I feel lonely. Other people seem to want to be on their own. I only meet people who have been in a similar position. I need to make friends and join outside clubs at day centres.'

However, participants valued hostels and homelessness day centres for company and for advice and advocacy with housing, benefits and other practical matters. For many older people, these facilities were their only source of social contact and support.

Loneliness was associated with the isolation associated not only with homelessness, but with relationship and family breakdown prior to becoming homeless.

Contacts with family

Some participants cited estrangement from the family as a reason for loneliness. Some participants had never had a close family and some had no living relatives. In line with other research, the majority of participants were found to be single. Some had never married or been in a long-term relationship; however, many had been married, some with children, but had separated from their spouse. Many had become estranged from their families, often losing contact with their children following marital separation. For many participants this had preceded homelessness, while others had lost contact with their family after, or at the time of, becoming homeless. Some participants had a limited amount of contact with their family, such as by telephone, although many had had no family contact for years.

Reminiscing about their past, participants recounted with sadness the broken relationships in their lives and how they had lost contact with their families. Some participants wanted to re-establish relationships with family, with their children, parents, siblings and extended family, and if not rebuild broken relations, at least have some level of contact. Sometimes feelings of worthlessness and shame about their present situation prevented them from doing so. They did not want people they had been close to in the past to see them in their current situation, feeling that their family would be ashamed of them because of their housing situation or their use of alcohol or other addictions.

'I was married, a long time ago. It broke up because of the gambling. I lost my wife to gambling... There were times when I had no money, walking the streets because of gambling, drinking from 10 o'clock in the morning. I'd like to win that much money and go home to [country] for good. Not a million pounds, just enough. My mother's still alive, but I don't think they're too fond of me. I'm too far gone, drinking, and I've gambled. I have a brother in [country], and a sister. She has children, I've never seen them. What I want most is to go home. But not like this [pointing to his clothes] – people will think I'm a tramp. I will go home one day, but when I go home it'll be in a box, I suppose.'

Some participants had re-established some degree of contact with their family after they had become more settled or had regained control over their drinking (in other words, when they felt they were ready to) and self-reports of loneliness were less common among this group. However, ties had often been severed many years previously and for some older people broken familial relationships were perceived as irreparable.

Friendships

'Not a real friend. I only have associates who I drink with.'

Some participants socialised with others on the street or in hostels (particularly long-stay hostel residents and heavy drinkers) and a number of participants had made friends at a day centre or a hostel. For many, however, social ties were not strong and participants reported being lonely even if, as with some hostel residents, they did not necessarily perceive themselves as being isolated. While having social contacts, they lacked meaningful contact with others. Participants distinguished between 'peer-contact' and 'friendship', often referring to their peers as 'acquaintances' or 'associates' rather than friends. Some participants were extremely isolated and had little more than cursory contact with their peers.

Many said they had no friends. This was a reason for continuing to use homelessness day centres after being resettled. One man commented, for example:

'I haven't got any friends, that's the reason I come here. I live alone, come here for the company, people about. I don't talk to anyone, only people who talk to me. I can't talk to other people.'

ii Life events

The origins of loneliness can be traced to experiences throughout the life course. For many of the older people interviewed for this research, it seemed that loneliness was rooted in earlier life events preceding homelessness, including experiences of loss and trauma, and the consequences of these events in relation to mental health (particularly depression and anxiety) and social relationships later in life.

Loss and trauma can lead to psychological problems including depression, anxiety disorders (Parkes, 1996), post-traumatic stress disorder (Resick, 2001) and suicide (Stroebe and Stroebe, 1993). For some people, stressful life events may contribute to homelessness.

Participants encountered difficulties coping with stressful events, sometimes exacerbated by increased severity of mental health problems or increased use of alcohol or other addictions (such as gambling). These problems sometimes contributed to relationship conflict, marital or family breakdown and, ultimately, homelessness.

However, not all people respond pathologically to such events. Given that people respond differently to stressful life events, it is therefore likely that the event itself is not solely responsible for a pathological response. There is a considerable body of research that has investigated the variables that may influence a person's reaction to and recovery from loss and trauma. Parkes

(1996) suggests that there may be one chief determinant or a number of circumstances that contribute to the outcome from loss. These may occur prior to, at the time of or after an event. The accumulative effect of a number of factors may increase the likelihood of a pathological response to a stressful life event.

Contributory factors that seemed to apply to older people in this research were:

- the multiplicity of events and their close proximity;
- type of loss (sudden and untimely losses and severely disturbing types of loss);
- experiences of abuse and other traumas;
- additional or secondary stresses; and
- lack of social support at the time of a major life event.

For many participants, these experiences were set within a background context of disturbed childhoods and early life experiences of loss, neglect and abuse, which may affect a person's ability to cope with events later in life.

Broken and disturbed childhoods

In line with other recent research (Crane, 1999), many older people had experienced broken and disturbed childhoods and lack of or loss of an attachment figure during childhood.

Participants had sometimes experienced deeply traumatising experiences in childhood, including:

- loss of one or both parents by death;
- parental separation and abandonment by one or both parents, often resulting in lack of contact with one parent, and sometimes inadequate or insecure relationship with the remaining parent;
- childhood experiences of physical, sexual and psychological abuse and neglect, among men and women participants;
- violence within the home and witnessing an abusive relationship between parents and between step-parents;
- being placed in care (sometimes directly leading to a first episode of homelessness in early life, eg running away from a care home); and
- being institutionalised at an early age, by being admitted to psychiatric and learning disability hospitals in childhood (into adulthood).

Childhood experiences can influence how a person responds to stressful life events later in life, especially the loss of a parent by death, physical or sexual abuse or an insecure relationship with parents (Bowlby, 1969; Parkes, 1996; Parkes, 1999; Resick, 2001). This can in some instances apply also to the loss of a parent through early parental separation (ie under 12 years), where a child has no contact with the parent who left the home or contact stops after some time. A number of studies have shown that when children lose contact with the departed parent (usually the father), this often intensifies the original loss and feelings of rejection and the child experiences a second loss (Kroll, 2002).

Other influential factors in relation to early family environment include parental poverty and familial psychiatric illness (Resick, 2001). The early family environment may influence later reactions to loss and trauma by the failure to learn coping skills that are normally acquired through modelling. If a person has an unsupportive or dysfunctional family at the time of stressful events in early life, when they encounter stress later in life they may

not seek support from others or may refuse offers of assistance (Resick, 2001).

Loss of attachment in childhood

The lack of an attachment figure can arise from actual loss of a parent (by death) or from emotional neglect, repeated rejection or insecure relationship with parents (Bowlby, 1969). Attachment refers not only to physical proximity to an attachment figure, but also to the child's sense of emotional closeness to a caregiver. Caregivers who are emotionally unresponsive to a child are just as likely to cause anxiety and distress as those who are physically absent (Howe et al, 1999).

Bowlby (1969; 1973; 1980) suggests there is a strong causal relationship between an individual's experiences with their parents and their later capacity to form affectional bonds. The experience of losing a caregiver more than once (eg following the break-up of a second marriage or by repeated care home and foster care placements) may seriously affect the capacity for trust and forming new attachments (Kroll, 2002; Romaine, 2002).

Disturbances in attachment in early life are seen to underlie a variety of psychological problems later in life, including anxiety, anger and depression. Depression arises from unwanted disconnectedness from others. Loneliness might arise when an individual, in adult life, is unable to form close attachments with others.

Since Bowlby's pioneering work, a body of research has grown, providing empirical support for Bowlby's attachment theory, not only in childhood but throughout the life course (see, for example, Parkes et al, 1991).

Childhood abuse

Experiences of childhood sexual and physical abuse are associated with poor mental health in adult life. Research has found that experiences of abuse by a parent or other relative, or systematic abuse in an institution, are associated with depression, low self-esteem, guilt, poor self-image, sexual difficulties, alcohol misuse, social anxiety and self-harm. Such experiences are strongly linked to a disturbance in the capacity for interpersonal relationships in adulthood (Gilbert, 1992; Jehu, 1989; Alter-Reid et al, 1986; Ammerman et al, 1986; Rohner, 1986). Thus for some individuals, loneliness in adult life may be linked to early experiences of abuse, where a person withdraws from intimate relationships and self-isolates.

Early life events may have long-term consequences for people's psychological well-being. Research has found that early experiences of abuse are associated with depression in old age. For example, from a community sample of 194 older people, Kraaij and de Wilde (2001) found that depressed mood at old age was related to sexual abuse and emotional abuse and neglect during childhood.

Childhood sexual or physical abuse may influence how a person responds to stressful events later in life. Research suggests that such experiences predict worse reactions to adult traumas (Davidson et al, 1991; Breslau et al, 1991). Resick explains that people who were abused as children might never fully recover psychologically prior to the subsequent events; they might develop psychological problems which affect how they respond to later traumas; and/or they might develop poor coping skills with which to handle later traumas. Repeated abuse, especially while young, may lead to more extensive patterns of avoidance and poor coping styles for stressful events (Resick, 2001).

Institutional life

A number of participants (14 per cent) had spent many years living in psychiatric and learning disability institutions, often from an early age. They were among some of the 'long-stay patients' who had been admitted to hospital, sometimes during their childhood, prior to the deinstitutionalisation policies of the 1950s and 1960s. This group was particularly alienated from services and distrustful of other people and tended to self-isolate. They sometimes feared being placed in an institution if they agreed to 'come in'.

While few were discharged without accommodation being in place, they had become institutionalised and, often in the absence of the informal support of family and friends, they experienced difficulties in coping with living independently. Others returned to their family on discharge from hospital but family support had subsequently broken down and homelessness resulted.

One woman had spent 20 years in a psychiatric hospital, having been admitted at the age of 14 after running away from a children's home. A man in his early sixties had spent 38 years in a hospital for people with learning disabilities. He was admitted to hospital when he was five years old. After his discharge from hospital, he stayed with family members for several years, but his family had found it difficult to cope. He had left home and become homeless. He slept rough for a number of years, spending intermittent periods in various hostels. Another man appeared confused and disoriented and had severe mental health problems. He had been admitted to a psychiatric hospital when he was 14 and had stayed there until he was in his late twenties. After being discharged from hospital, he had slept rough for many years.

Loss and bereavement

'Loneliness. Because I miss my wife.'

The loss of one or both parents in early adulthood sometimes directly triggered a first episode of homelessness. One man became homeless when he was 16 years old after the death of his mother. He did not get on with his father, his siblings had left home and he left home and ended up on the street. Another man, following the death of both parents, with whom he had had a close relationship, left home and became homeless aged 19. Among those who became homeless in middle or later life, homelessness was often preceded by the loss of a spouse by death or partnership breakdown. Participants sometimes referred to a bereavement, particularly the loss of spouse or a child, to explain why they felt lonely.

Multiple losses

While everyone experiences loss at some point in their lives, especially later in life, participants had sometimes experienced multiple losses, often earlier rather than later in life and sometimes within a relatively short period of time. These included the loss of spouse at an early age and the loss of a child or children. Parkes (1996) suggests these two types of loss are more likely to result in psychological problems than are other losses. More recent losses included the death of close friends and of adult children. Additional stresses included loss of occupation, loss of income, health losses and the loss of their home.

Losses that were experienced by participants in adult life included:

- widowhood;
- the loss of a child or children;
- the loss of extended family through partnership separation;

- loss of roles, associated with retirement or cessation of work and also linked to family breakdown;
- loss of home and personal possessions;
- losses associated with poor physical health and reduced mobility, poor mental health and cognitive decline, terminal illness and awareness of their own mortality;
- loss of independence (through chronic ill health) or perceived threat to independence (eg in relation to resettlement or fear of being placed in residential care); and
- loss of social networks and friends, associated with moving home or being rehoused.

The development of psychopathology is more likely in the event of multiple concurrent stressors, including losses, family conflict, threats of loss, chronic illness, loss of job or retirement, poor housing or loss of home (Parkes, 1996).

The accumulative effect of multiple stresses may give rise to depression. From their community sample of 194 older people, Kraaij and de Wilde (2001) found that depression scores were especially high when subjects reported the experience of many events during adulthood and late adulthood. With reference to Murphy's study of depression and older people (1982), Coleman describes the 'addictive effect' of a number of stresses contributing to depression among older people:

Data from Murphy's study indicate that as the types or numbers of stress present increase so does the risk of developing depression. For her community subjects the risk of developing depression was 25 per cent following one severe event, 44 per cent when a severe event occurred in the context of a marked personal health difficulty, and 50 per cent when a severe event was combined with a major social difficulty. Of those subjects with all three risk factors, 80 per cent developed depression. (Coleman, 1993).

Bereavement may be linked to depression in later life, because of the increased occurrence of losses in old age, and also because of other stresses triggered by a bereavement, such as loss of income, moving house or losing friends (Parkes, 1996).

However, although depression among older people is often attributed to the increased losses associated with later life, in some instances depression in later life may be triggered by a more recent loss but may stem from losses experienced much earlier in life. Coleman (1993) suggests that depression often seems to occur when the losses of old age reawaken earlier losses that have never properly healed.

Trauma

Participants had sometimes experienced violent and horrific types of loss, including by suicide, familial violence and deaths by fatal accidents or disaster (eg car accident, fire). These events had sometimes resulted in multiple deaths and, in a few cases, the deaths of the entire family. One man had, in early adulthood, lost his wife and two children in a fatal car accident. Another man had witnessed, as a young adult, the fatal stabbing of his stepfather. A woman participant, at a young age, lost her only child and six months later her partner was killed in a car accident.

According to Parkes (1996), an atypical (or pathological) reaction to a bereavement is more likely:

- when the death is unexpected, sudden and without warning (eg through an accident);
- when the death is untimely (eg the loss of a young spouse or a child); or

- with particularly traumatic kinds of bereavement (eg murder or suicide).

Survivors of traumatic losses, Parkes suggests, are likely to experience high levels of anxiety, which might be perceived as a form of post-traumatic stress disorder.

Many participants had survived other traumas, such as wartime experiences; physical assault on the street or in a hostel; and harassment in later life (eg by young people in the neighbourhood), sometimes after being rehoused and sometimes directly triggering a first episode of homelessness in later life. Some participants, particularly among those with learning disabilities, had been abused by a carer and/or while living in an institution. Women participants often had experiences of childhood abuse and violent relationships in adult life. Domestic violence sometimes directly triggered homelessness among women participants in middle and later life.

A high proportion of participants had served in the armed forces and some in this group had experiences of combat or military conflict. In addition to those who had served in the armed forces, a number of participants had survived other forms of disturbing wartime experiences. In interviews, some men talked about wartime experiences as if they were the present day.

Research suggests that the type of trauma is a consistent predictor of reactions to, and recovery from, a trauma (Resick, 2001). Among men, experience of combat is associated with post-traumatic stress disorder (Kessler et al, 1995). Intimate traumas, such as domestic violence, assault, childhood physical and sexual abuse and childhood neglect, are associated with psychological problems, more so than other traumas such as accident or natural disaster (Kessler et al, 1995).

Similar to bereavement, traumatic stress appears to be accumulative. Studies have found a greater trauma response with people who had experience of other stressful events during the year preceding the trauma, such as loss of spouse, marital separation, death of a close friend, or major illness (eg Ruch et al, 1980; Wirtz and Harrell, 1987). Research also indicates that traumas in adulthood affect reactions to subsequent events. Experiences may have a cumulative effect that may serve as risk factors for the development of psychopathology (Resick, 2001).

Unresolved trauma

It was apparent in interviews that some participants were still deeply traumatised by past experiences and feelings had sometimes been buried for many years. Some participants were upset and tearful when recalling past events; many others talked of past traumatic events and more recent losses, in a detached manner, displaying a lack of emotional responsiveness. Both these types of response may indicate that they had not come to terms with past experiences (see, for example, Hallam, 1992).

How people respond cognitively and emotionally to the event is likely to affect their recovery (Resick, 2001). The more an individual attributes blame to him/herself and feels guilt (eg because of marital dysfunction or conflict or for an accident, for example where a child was killed), the greater the distress and symptoms are likely to be. Extreme and prolonged feelings of guilt may give rise to depressive symptoms (Parkes, 1999). Feelings of guilt and self-blame were common among participants, such as in relation to marital difficulties brought about by their own behaviour, especially drinking and gambling, and these self-attributions persisted many years after these events. The influence of self-blame also applies to reactions to other losses. For example, participants sometimes blamed themselves for poor physical and mental health because of

their drinking behaviour and general lifestyle. Such an attribution of self-blame to health losses may contribute to anxiety or depression (Katz, 2002).

Recovery from a loss or trauma will also be influenced by individual responses to events and coping styles, particularly attempts at avoidance. An individual's response may be influenced by social and cultural influences, where difficulties expressing feelings reflect a family system (Resick, 2001).

A pathological response to bereavement is more likely when grief takes an unusual form, such as when it is more severe or prolonged than usual, or when it is delayed, or when a person fails to express grief, or does not talk about the loss (Parkes, 1996; 1998). It is believed that delayed grief (eg when the person acts as if nothing has happened) may be associated with depressive illness, anxiety problems and suicidal thoughts (Parkes, 1996).

When an individual avoids thinking about or talking about a trauma, while reducing symptoms in the short run, this avoidance strategy may prolong recovery by interfering with emotional processing of the event (Resick, 2001).

Alcohol or other substances may sometimes be used in an attempt to reduce distress and to avoid distressing thoughts. This was a reason given by some participants for heavy drinking, many of whom had been drinking heavily for many years. However, even if the person is successful in avoiding the memory of the traumatic event, even for years, eventually when reminded of the trauma or when vulnerable, 'the memory and effect will come back with full force because nothing has really changed or been resolved about the incident' (Resick, 2001). They may have merely delayed the full impact of its effects and it may come back to haunt them later in life.

It may be that earlier experiences were so deeply disturbing that later in life the person distances themselves from other people, as a kind of 'defence mechanism' for avoiding further pain. An individual may avoid intimacy or feel unable to form close relationships with others and the consequence of this, in adult life, may be loneliness.

Lack of social support

A common link was isolation or lack of social support at the time of, and following, a major life event, sometimes related to family breakdown. Older people commonly cited relationship and family breakdown as reasons for becoming homeless.

When participants had experienced losses and other stressful events, they had lacked the social support that is known to moderate the impact of stressful events. The relationship between lack of social support (particularly lack of a close, confiding relationship) and depression is well established in the social model of depression. Brown and Harris's famous (1978) study of depression among young widows found that the absence of a close and confiding relationship is one of a number of vulnerability factors predisposing an individual to depression following a major life event.

Many studies since the early study by Brown and Harris have supported the findings of their work (eg Flannery, 1990). These studies suggest it is not the actual amount of social support received but the perceived adequacy of social support that affects recovery, although those without any family support are particularly vulnerable (Parkes, 1996).

Murphy replicated the work of Brown and Harris with older people and confirmed the importance of lack of social support as a vulnerability factor for depression in old age following a major life event. Older people who reported a lack of a confiding

relationship were more prone to depression following a stressful life event (Murphy, 1982).

Similar to the research on general stress, research on traumatic stress (eg assault, rape, domestic violence and abuse) has demonstrated a relationship between perceived adequacy of social support and trauma outcomes (Resick, 2001). How others respond after a traumatic event may affect whether they share their experiences with others or withdraw and isolate themselves (Resick, 2001).

iii Health factors

Isolation and loneliness were linked to poor physical and mental health, loss of mobility and alcohol misuse.

Physical health problems and loss of mobility

For both homeless and resettled older people, isolation was often related to poor physical health, reduced mobility and increased frailty, which (combined with a lack of access to transport assistance) restricted their access to day centres and leisure facilities and prevented participants from visiting friends after they are rehoused. Fifty-four per cent of participants reported having one or more chronic physical health problems and these were often severe. Many participants had mobility problems. A number of participants were incontinent and some had become unnecessarily housebound. A few had stopped attending day centres for this reason.

Mental health difficulties

Forty-seven per cent of participants reported, or were observed to have, mental health problems.

As outlined in the introductory chapter, research has found that social isolation and loneliness can contribute to poor mental health in later life. Conversely, mental health problems can also contribute to or maintain isolation and loneliness.

Paranoid ideas or delusional thoughts prevented some participants from accessing services and from building trusting relationships with other people. This was especially true for older women, who sometimes isolated themselves from people and avoided closeness, as they were often paranoid about services and suspicious of the motives of other people. Their isolation may stem from experiences of abuse earlier in life.

Depression is characterised by loss of interest, poor motivation, low self-esteem, reduced concentration and social withdrawal. Depression reduces the ability to manage day-to-day tasks and to engage in activities. Poor motivation and feelings of worthlessness may inhibit a person from asking for help or from making their needs known. People sometimes cut themselves off from friends and relationships when they are depressed. Depressed people who were previously sociable may become withdrawn and uncommunicative and distance themselves from social interaction. In some cases they can become reclusive and isolated.

People who are depressed often report being lonely. However, in some instances, the feelings of loneliness and low mood may be so closely linked that the individual is unaware that loneliness is a problem to them:

People seeking help through counsellors or similar helpers rarely report that they feel lonely. Instead, they tend to present with the symptoms of loneliness. For instance, they may ask for help with a drink problem, stress, mild depression, or anxiety. They do not include comments about their loneliness because they rarely realise its involvement. (Murphy and Kupshik, 1992)

The cycle of loneliness, heavy drinking and depression

The social networks of many participants focused on the homeless circuit and a drinking culture and, for many, social ties were not strong. Heavy drinking was exacerbated by environmental influences and participants' social networks revolving around other drinkers. Depression associated with heavy drinking can affect the individual's ability to engage in meaningful social interaction, thereby exacerbating isolation. Breaking out of this lifestyle can mean losing existing social networks, making it very difficult to break the cycle unless opportunities exist for developing new social networks in a non-drinking environment.

A hostel resident, homeless for over 25 years, described how he perceived the cyclical relationship between loneliness, heavy drinking and isolation:

'Loneliness – I think everyone suffers from it. [It's] why I drink. I need advice about what I can do and what lies ahead. I need to be dry and then with others who are dry so I can get some sense out of them. I'm a chronic alcoholic. I want to pack it in. I need to be somewhere dry now... Only minor detail, depression after drink makes it hard to explain yourself and communicate. I need help with communicating with people, don't know what sort of help I need someone to talk to, to sort myself out. Probably need to see a psychiatrist.'

iv Psychological factors

Loneliness may be maintained by an individual's behaviour (eg interpersonal and social skills) or thoughts and beliefs (eg negative expectations, low self-esteem and thoughts triggering anxiety). While perhaps not causing loneliness, which may be rooted in much earlier experiences, according to many older people interviewed for this research, these factors contributed to loneliness.

Behavioural approaches to loneliness

For some people the key to loneliness may be at a behavioural level, where loneliness is maintained by the individual's behaviour, such as latent social skills, inappropriate expressions of anger or overt hostility. An individual may have lost the skills necessary to interact meaningfully with people or to form intimate relationships, sometimes arising as a consequence of early experiences of loss or abuse or from experiences of extreme isolation.

Interpersonal, social and relationship skills

Loneliness is associated with relationship deficits. A number of participants attributed loneliness, at least in part, to lost social and communication skills and interpersonal difficulties.

'I need help with social and relationship aspects – avoiding loneliness.'

Apparent social skill deficits can also be associated with anxiety or with depression, where these occur alongside a depressive episode.

A high proportion of participants reported difficulty communicating or interacting comfortably with people, problems empathising with other people, and difficulties forming relationships.

Many participants said they wanted to relearn the skills they had forgotten, to enable them to interact meaningfully with other people and to form friendships and relationships. Sometimes older people had become more aware of these issues after participating in small group discussions where they reflected on group processes and how they interacted with others.

Participants pointed out that to them, these skills were not 'new' skills but 'forgotten' skills: skills they had once had but had lost through experiences of homelessness and isolation. Some participants had been isolated for many

years and had become unaccustomed to interacting with other people and as a consequence had lost skills and confidence. Skills may remain 'dormant' because they have not been practised for some time, as one participant explained:

'Not new skills, but skills I'd forgotten I had.'

Controlling feelings

A number of participants acknowledged that they found it difficult to control anger. Anger, irritability and mood swings are indicators of excessive use of alcohol and are also associated with grief and depression. Overt hostility may alienate other people and prevent the development of relationships, thereby intensifying feelings of loneliness. A number of participants said they wanted help with learning how to manage feelings of anger.

'I get mad sometimes. I used to control anger myself – I want to be able to do that again. I want to be able to sit and listen and talk rather than be mad about things.'

Cognitive theory of loneliness

A number of participants attributed loneliness to latent social skills. However, in interviews with older people it sometimes appeared that self-reported interpersonal difficulties could stem from lack of confidence or anxiety, rather than poor skills (ie where an individual has the necessary skills but anxiety prevents them from using their skills in social situations). Inhibitory anxiety can block the skills required for competent social interaction (Murphy and Kupshik, 1992).

Loneliness may be maintained by an individual's thoughts and beliefs about him/herself or the world. Cognitive theory proposes that loneliness arises when the individual compares him/herself in a negative light to others. The individual anticipates negative outcomes from social interaction and worries about unlikely outcomes (for example, with reference to comments made by participants, that in a group he or she will be left out or will not 'fit in'). Thoughts may be exaggerated, the individual anticipates the worst and focuses on the negative side of things. Positive information is ignored and the individual creates obstacles by concentrating on their weaknesses and ignoring their strengths. This leads to excessive self-questioning and self-doubt, which, in turn, generates further anxiety (Murphy and Kupshik, 1992).

Anxiety-provoking thoughts can either trigger feelings of loneliness or prevent people from confronting appropriately the social situations that could serve to ease loneliness (Murphy and Kupshik, 1992). They may quite literally talk themselves out of engaging in the very situations that could help to alleviate their loneliness.

One man, talking about the idea of joining a new group activity, explained:

'It'd do me good, but it'd be embarrassing. I'd sit there by myself not talking to anyone. I find it difficult talking to people, and I wouldn't be able to keep up with the others, I always forget things. And anyway, it'd be a problem getting there and back...'

The natural response to anxiety is to avoid the situations (such as social interaction) which evoke anxiety. Avoidance of situations can reduce confidence further (Butler, 1985). A cycle of anxiety, low self-esteem and loneliness may then develop.

5 Barriers created by isolation

This chapter considers some of the factors that contributed to social isolation after people moved into permanent housing. These include:

- the loss of social and support networks arising from moving home;
- moving away from a local community;
- proximity to community facilities;
- inappropriate housing; and
- poor housing conditions.

The research indicates a number of related triggers that exacerbate isolation, creating barriers for older people. Barriers identified by older people were:

- lack of access to transport;
- low income;
- ineffective information; and
- poor accessibility.

Resettlement and isolation

'No company, no support, being on my own.'

Some participants associated social isolation with homelessness, especially those who were sleeping rough or recently homeless. Many, however, associated isolation with resettlement rather than being homeless. This was particularly the case for long-stay hostel residents. Isolation was related to the experience of moving home (or being rehoused), which involved breaking existing social and support networks without any means of replacing them.

Participants felt they had inadequate opportunities to meet other people and to make friends and were often unaware of places they could go to meet other people. They often lacked the confidence to build new social networks and, through experiences of severe and prolonged isolation, had sometimes lost the skills to enable them to develop new relationships.

Participants cited loneliness as one of the main reasons for resettlement breakdown and for repeated episodes of homelessness. Other, often related, reasons given by older people included:

- difficulties coping with living independently and managing the home, without adequate support;
- difficulties in budgeting and paying bills;
- problems adjusting to the change in daily routine (associated with moving into supported housing from a hostel);
- lack of social support and company;
- the loss of existing social networks;
- mental health difficulties; and
- heavy drinking, which sometimes led to self-neglect and poor motivation to maintain their home.

The vast majority of participants wanted to be resettled. Many had settled in permanent accommodation and, with the continued support of homelessness agencies, had successfully adapted to life after homelessness. However, others, without adequate preparation and with inadequate support, returned repeatedly to a hostel or the street after moving into accommodation, because they were lonely and lacked social support.

Some participants spoke fondly of the hostel where they had stayed, sometimes for a number of years, and reminisced about the homeless people they had known over the years, with a sense of affiliation and comradeship. They talked with affection of the hostel staff with whom they had built relationships. For some older people, the experience of resettlement had been one of loss: the loss of their friends, their 'family' and their home. Those who had settled in a hostel often found it hard to break ties. This group had become institutionalised by hostel life and, even when they wanted to move into permanent housing (and kept trying time and time again), the threat of breaking these social and support networks was an obstacle that was difficult to overcome. However tenuous these relationships might be, they were for many all they had.

One man, who had been homeless for over 20 years, was staying at a shelter he had used on and off for over 10 years. He had attempted to be resettled a number of times over the previous few years. On each occasion he had returned to the street within a few days of moving in. He said he experienced difficulties coping with the change in daily routine associated with moving into supported housing. Each time he panicked and walked out. He slept out rather than returning to the shelter because he said he felt ashamed about having 'failed again' and was then picked up by an outreach worker and returned to the shelter. Talking about the most recent attempt at being rehoused, he said:

'I wasn't happy about moving there. I was scared to break ties with [agency]. I was also worried that once I had moved, [hostel worker] would forget me. I've built up a lot of friends here, I know everybody. I didn't want to go back the second time. I was aware that I didn't like the first time so I knew it wouldn't be any better. I was worried that once I moved, [hostel worker] would forget about me. I can't really remember what I was thinking when I walked out. I felt ashamed. What would everybody think of me?'

And yet, despite a number of unsuccessful attempts at resettlement, and the impact of each perceived 'failure' on his morale, he was determined to succeed the next time:

'This is only a short-term place. What they're trying to do is get me into a shared home, with my own room. I don't want my own place – I've tried that before. I'd like to live with other people but with my own room where I have privacy.'

After being rehoused, for some older people the consequence of loneliness and lack of social support is to abandon their home and return to the street or a hostel. Others continue to display what Crane has termed 'homelessness behaviours' after they have moved into permanent housing and continue to spend time on the street as a way of coping with loneliness:

Loneliness and boredom were commonly reported reasons why some rehoused older people ceded tenancies and others continued to use soup kitchens and linger on the streets with homeless people. They said that they stayed on the streets and used day centres because they were lonely and needed company; they had nothing to do during the day; and they were finding it difficult to manage at home. (Crane, 1999)

The majority of housed older people do not abandon their home because they are lonely, but for older people who have histories of sleeping rough, this is for them returning to a familiar environment. Some housed older people may nonetheless go to extraordinary lengths to combat feelings of loneliness.

Cattan (2002) includes some personal accounts of how (housed) older people cope with loneliness, which, she suggests, 'highlight the sometimes desperate measures that older people will go to in order to alleviate their feelings of

loneliness', as the following comments illustrate:

'When I feel lonely I go out to make myself feel better. I go in the car and sit in the supermarket car park where there are lots of people about and lots of traffic and that helps.'

'I try not to get lonely but I do. I go out to try to stop being lonely. I sit and talk to people in the park. I get lonely a lot that's why I go out a lot.' (Cattan, 2002)

A similar pattern of behaviour can be observed among older people who have experienced homelessness, although their behaviour may be interpreted quite differently.

One man, who had formerly slept rough for over 30 years before moving into supported housing, explained how he coped with loneliness:

'I'm much better off here, it's far better than the shelter, but I feel lonely sometimes. I like to go out sometimes. I like going to the park. I sit on the bench and have a couple of cans while I'm there. I love the gardens. I like looking at the flowers... Sometimes they let you sit there and they let you be, but other times they ask you to move on. They don't like you cluttering up the place.'

Moving home

'Sometimes I feel lonely as I have moved to another area.'

Loneliness was associated with physical isolation arising from moving to an unfamiliar neighbourhood, away from their local community, and also related to their proximity to community facilities and places where they could meet other people. For example, one man commented:

'I am an old man. I needed to be closer to community centres where I can meet people and make friends.'

Those who reported not being lonely observed that they had remained within their local community, had established links with the area prior to resettlement or had moved to an area where they had previously held strong links. One man, who had formerly slept rough for over ten years, commented:

'It is close to my place of worship and friends. My friends from the mosque live around and also my mosque is close to me.'

In some respects, and especially in relation to the loss of social networks and moving to an unfamiliar neighbourhood, the experience of resettlement for homeless older people is not dissimilar to the experience of moving home among housed older people or of moving into residential homes. Both these experiences are linked to social isolation among older people (Cattan, 2002).

Living alone

A 67-year-old former homeless woman, living in own tenancy:

'I live alone. I feel lonely most of the time.'

A 54-year-old former homeless woman, living in supported housing:

'I'm not isolated – I live with 20 people. But I do feel lonely sometimes.'

Isolation was a common theme among those living alone (after being rehoused) but generally not among those living in hostels or in shared housing. All groups reported loneliness, however. This apparent difference was related to the way participants distinguished between isolation and loneliness. As outlined earlier in the report, isolation was perceived in terms of the level of social contacts, whereas loneliness was perceived in terms of the quality of those contacts.

Loneliness was a strong theme among participants living alone, who sometimes related their loneliness to living alone. Loneliness was also a common theme among hostel residents, which they related to the lack of meaningful contacts with other residents, sometimes associated with heavy drinking. Among (rehoused) participants living in shared housing, responses were mixed. One group reported not being lonely: they said they were happy where they were living; they had made friends and sometimes had trips and social activities organised by staff. A second group, however, reported being lonely: they were unhappy where they were living, as they were not living with people they had chosen to live with, and had not made friends with other residents.

Isolation was associated with living alone, but the link between loneliness and living alone is less clear. Many older people reported feeling especially lonely when they were at home, but this applied to those living with others as well as those who lived alone. It seemed that loneliness was associated with the perception of 'being alone', rather than 'living alone', and this may be more likely to be experienced by those who live alone.

Deprived neighbourhoods and poor housing

When older homeless people are rehoused, they often move into deprived neighbourhoods, which raises a number of issues in relation not only to isolation but also to tenancy sustainment. Many older people lived in poor housing conditions and they sometimes lived in fear of crime and harassment.

Isolation was related to inappropriate housing, poor housing conditions and disrepair, often in relation to age, poor health and mobility problems. Because of the need to move in quickly when accommodation became available, participants had sometimes moved into unsuitable accommodation and, in some cases, into conditions damaging to their health. A number of older people lived in a flat or bedsit without heating or with damp or leaks; many had sparse furniture and kitchen appliances that did not work; and a few (mainly those who had been rehoused by local authority housing departments) had no electricity connection. One particular concern to participants was living above the ground floor and having to rely on lifts which frequently broke down and where repairs were slow to be implemented (again, in local authority housing). Some older people became housebound for periods of time for this reason. A number of participants felt their accommodation was inappropriate for a person of their age and that their age and physical health should have been taken into consideration by local authorities when the housing was being allocated.

A 65-year-old man, who had multiple disabilities, was rehoused by his local authority into a seventh-floor flat. His health had deteriorated significantly since moving in:

'I am presently seeking a transfer because my flat is not suitable for my health. My flat is damp due to roof leakage. My lift is not working regularly and this is not at all good for my health problems. The lift has broken down over 50 times in the past year. I would want to move into a ground floor flat that will be suitable for someone of my age and especially my health problem. I want to be listened to and my physical health condition considered.'

Another man in his sixties, formerly homeless but now settled in his flat, explained:

'I need a ground-floor flat. I don't like climbing stairs... I think it is wrong to allocate a higher-floor flat to an older person like myself when I should have been allocated a ground-floor flat. It is difficult climbing when the lift breaks down.'

During the course of the research, some resettled older people had had to move again, as they could no longer cope living in a higher-floor flat without a reliable lift. Unlike young homeless people who may view a bedsit or flat they move into as a temporary measure, older people may perceive their new home as a home for life. Although participants had been involved in choosing their accommodation at the time of housing allocation, the health of some had deteriorated since they moved in. In retrospect, they felt that their likely future needs should have been anticipated to prevent them from becoming isolated and to avoid the upheaval of having to move again. This also applies to moving into supported housing schemes (where rooms are above the ground floor), where an individual may need to move again if their health deteriorates and they become less mobile.

Harassment and fear of crime

Some resettled older people lived in fear of crime. After they were rehoused, a number of participants had been a victim of burglary. One woman, aged 57, who had previously slept rough for many years, was settled in her flat but had been burgled three times in the two years since she had moved in. She said she sometimes feared going out because she needed to 'look after' her home as she anticipated being broken into again.

A 64-year-old man was rehoused by his local authority in a flat. Over a year later, the flat was bare; there was no furniture apart from a bed that he said 'dipped' in the middle and was heavily soiled, a fridge and two cookers (neither of which worked). His flat had recently been broken into and he had lost the few personal possessions he owned: his television that had kept him company and, most importantly, the precious belongings of his son who had died. He was distressed and upset and fearful of his flat being broken into again.

In line with other recent research (Pannell et al, 2002), a number of older people had been subjected to harassment and sometimes physical assault by other tenants or young people in the neighbourhood. In a few cases, this had led to the abandonment of their tenancies after they had been rehoused.

Harassment sometimes stemmed from prejudice. One man, aged 68, had a long history of sleeping rough, with intermittent periods being housed. He said his previous attempts at resettlement had broken down because of his drinking and getting behind with rent payments. However, at the age of 60, he settled in a private tenancy for a number of years. While living in the flat he was mocked and taunted by neighbours, who called him a 'tramp'. One day he felt he could no longer cope with the intimidation and he walked out of his flat and returned to the street. At the time of the interview he had been sleeping rough for three years.

In some instances, harassment had also directly triggered a first episode of homelessness in later life, where older people had, in fear, abandoned their tenancies. A 70-year-old man had lived alone for a number of years after his wife had died. He had suffered many months of harassment from young people in the neighbourhood, until one day he found his dog with its throat cut, lying on his doorstep. He fled from his home and slept rough for a few nights before he was picked up by an outreach worker and taken to a hostel. He refused to return to his home because he was terrified.

Another man had befriended a younger tenant. She had repeatedly stolen money and possessions from him to feed a drug addiction and with a group of friends had physically assaulted him in his home when he had refused to give her more money. After being robbed repeatedly over many months, finally he was unable to pay his rent. He walked out of his home and ended up on the street for a few weeks before moving into a hostel.

Physical barriers to alleviating isolation

Isolation was exacerbated by a number of physical barriers to accessing services and facilities, including transport issues, low income, lack of information and poor accessibility.

Lack of access to transport

Transport was a strong theme among all groups participating in the research, including those who were sleeping rough or living in hostels, as well as those who were resettled. Participants often had not asked for help with transport and sometimes reported that they did not know they could ask for help with such issues, which may not be perceived as a 'necessity'. Some said they wanted help making applications to obtain a travel pass so they could get out more. Transport issues were related to uptake of benefit entitlements.

One man, through deteriorating health, had become increasingly less mobile. Whereas in the past he had always kept occupied, now he rarely stepped outside the hostel where he had been living for some time:

'I don't have a bus pass but I want one. Would get about more if had one. I should be on DLA (Disability Living Allowance), was on it before but it stopped because no fixed abode. I want to go back on DLA. I need help to fill in the form.'

When planning activities, consideration also needs to be given to the time restrictions of freedom passes for those who have them and the difficulties for (or time taken by) some older people with health and mobility problems in getting to a facility, as explained by a hostel resident:

'I've got a freedom pass, I got mine on medical grounds... You can't use a freedom pass until 9am on buses and tubes, 9.30 British Rail. It's no good starting the class at 9 o'clock. Not many places take that into account, do they? Even if they start later, like at 10am, you'd be really pushed for time.'

Some participants were unable to use public transport independently because of ill health, disability and increased frailty. They said they needed transport assistance so they could access services and attend appointments, as well as attend day centres and other facilities. A long-stay hostel resident, previously active and sociable, had become increasingly withdrawn following a decline in his health and had become virtually housebound. He explained:

'I find it difficult to get around. I want help to get around. I don't trust myself on a bus because of my [disability]. I need transport to go to DSS and appointments. It's difficult on buses and people don't understand how it affects me.'

Income

Some participants linked isolation to low income. Participants were not always aware of their benefit entitlements and needed advice to help them navigate through the complex benefits system and to ensure they accessed their full entitlements.

Some participants felt let down because, having previously worked and paid their National Insurance contributions and taxes and perhaps served their country in the armed forces, they now had to jump through hoops to 'prove' their entitlement to benefits. Repeated applications and

re-assessments made them feel anxious and unsettled.

'I was in the British Army for five years, and in the Irish Guards. I done my time. When I first came here things were cheap, money was good and there was plenty of work. I was a good worker, building motorways and we built tunnels. Then the work ran out. They want to get rid of us, the Government. They don't care about us now, now all the roads and motorways are done. When I was working I thought that once I'd reached a certain age everything would be OK. Then along came Maggie Thatcher and took it all away. I swore I'd never pay taxes again. The present Government's no better. All the taxes I've paid, thousands of pounds, and not just 20 pounds a week we paid but hundreds of pounds [he had worked for 35 years]... I have to see the doctor, not a health doctor but a government doctor. I have to keep having assessments. They might cut my benefits, I don't know.'

Of particular concern to participants were debts and rent arrears they had incurred prior to becoming homeless. Some participants feared that action would be taken against them if their debts became known to their local authority and as a consequence had not accessed their benefit entitlements. It was of some concern that some resettled older people living alone were unable to have a telephone because of previous debts. This not only contributed to their isolation, but it was also a cause of worry to some participants (especially those with significant health problems) who could not telephone a support agency for help in times of emergency.

Lack of effective information and ignorance of services

Participants were not always aware of activities and services available, including those organised by hostels and day centres they used regularly. Participants commented on the lack of accessible information. They were often unaware of facilities in the wider community or the availability of leisure passes and concessionary rates for pensioners and people with disabilities. One woman, for example, was interested in taking up swimming but had not been aware that she could go for free. After she had gone swimming with a group from a day centre a few times, she started going regularly by herself, which she said boosted her confidence and improved her mobility.

Participants wanted information about:

- cheap, free or subsidised activities;
- community facilities, including libraries, community centres and other social and leisure facilities;
- concessions, entitlements and subsidies for pensioners and people with disabilities; and
- how to get leisure and travel passes.

Accessible information

Conversely, too much information was confusing. Participants said it was difficult to remember what was on, when and where, and on what days various centres were open or closed. This was especially a problem for participants with memory problems and those who led 'chaotic' lifestyles, with their characteristic lack of routine and structure to their lives. Some participants frequently forgot to attend appointments or turned up on the wrong day or at the wrong time. This was of concern to some participants as they found it embarrassing and they reproached themselves for 'always turning up on the wrong day' and for 'always forgetting everything'.

Many participants simply had not seen or read posters or leaflets promoting projects or community resources. One man suggested having 'a larger notice-board displaying services' at day centres (and hostels perhaps), with explanations of

different services and activities available and who to contact for information.

It would also be useful if project literature could be made available in a number of different languages, in large print and preferably with symbols and images. A number of participants did not speak English as their first language; some participants were blind or partially sighted; many had literacy problems; and 11 per cent had learning disabilities.

It might be helpful to synthesise information: for example, producing a single brochure covering a wide range of activities provided by different agencies, to make it easier to find out what is available in the area. One man said he thought it would be a good idea to have a local timetable of activities, so that people would know what was available on each day of the week.

Another man, a hostel resident and homeless for 25 years, said he wanted to expand his social network outside homelessness provision, but said it was difficult to know where to go. He suggested publishing a directory of services and facilities:

'I have problems finding something to do in the day. There are a lot of things I don't know, things for people over 50. Has anyone ever thought of publishing a manual? It would be helpful to know what sort of services are available to people over 50. It's hard to know about places to go. There are a lot of different organisations that deal with people over 50. It's a job finding where they are. A lot of people don't know about these places if they're not advertised.'

This indicates how agencies working with and for older people may not always reach the most severely isolated groups of older people.

Being proactive

While project promotional literature is important to inform service providers – making them aware of where they can refer people and giving information to potential users – written information alone may have limited impact on the uptake of services by older people. Face-to-face information is likely to be more effective. One man, for example, suggested presentations and demonstrations at day centres (and perhaps also at hostels and other facilities) about local activities and facilities.

Accessibility

When planning activities for older people, consideration needs to be given to the locality and accessibility of venues, especially for older people with health or mobility issues. If an activity is held above the ground floor where there is no lift, older people will be excluded if they cannot climb the stairs. The same issues apply to some hostels and supported housing projects, which are inaccessible to people with disabilities. Instances arose in the research of older people who had encountered difficulties in being resettled because supported housing projects could not accept people with disabilities unless they could climb stairs.

Although this is a difficult issue to raise with voluntary homelessness agencies, whose resources are already stretched to the limit, it needs to be addressed (not only by provider agencies, but also by national organisations and funders) if the principle of 'equal opportunities' is to be taken seriously.

6 Pathways out of loneliness

Finding solutions to social isolation and loneliness

The Government's new approach to tackling homelessness recognises that following resettlement one of the most commonly reported factors in tenancy breakdown is isolation and loneliness (DTLR, 2002). The Rough Sleepers' Unit emphasised the need to support people in developing social networks away from the streets and to tackle the loneliness and boredom that can sometimes lead people back to them:

...resettlement support alone is not enough to help people back into mainstream society. We need to find ways to help people build self-esteem, develop their skills, and reconnect into social networks away from the streets. (DETR, 1999)

However, despite growing recognition of the relationship between isolation, loneliness and homelessness, little research has investigated ways of alleviating social isolation and loneliness among people who are, or who have been, homeless. Homeless and ex-homeless older people may receive little support in building social networks or in addressing the factors that contribute to loneliness.

Lemos mapped existing homelessness provision aimed at reducing isolation (including family mediation, befriending and mentoring schemes) and identified 25 projects in England. This review found that few services currently provided to homeless people help them re-establish old social networks or forge new ones. Of services purporting to be aimed at tackling isolation, often 'practical support was the top priority, followed by personal development'. In contrast, 'the fundamentals of conviviality – making friends and re-establishing social networks – if featuring at all, were low on the priority list' (Lemos, 2000).

On the other hand, some volunteer schemes providing practical support may help to reduce social isolation. Among older people, the social contact arising as a 'by-product' of receiving one-to-one practical support is often valued by older people as an acceptable way of alleviating isolation and is important for some older people where other interventions (eg 'befriending') may not be accepted (eg Cattan, 2002).

However, of the homelessness services surveyed by Lemos, few are provided for older people. Lemos found that much of what is available is targeted at under-25s (often care-leavers) who are homeless or at risk of becoming homeless (Lemos, 2000).

In addition to one-to-one approaches surveyed by Lemos, group approaches can be (perhaps more) effective in alleviating isolation and loneliness. Research has found that group approaches, including group activities, group counselling and support groups, are effective in alleviating social isolation and loneliness among older people (see below). Some homelessness day centres organise group activities on a regular basis, although many older people who were interviewed for this research had not engaged in activities available at day centres or in the wider community, and some hostels provide little meaningful activity.

Among housed older people, there has been considerable attention paid to the causes of social isolation in later life, mainly because of the strong relationship between social isolation and quality of life. However, despite concern over the impact of social isolation on quality of life and psychological well-being in later life, there have been relatively few studies evaluating the impact of interventions for reducing isolation and loneliness among older people. From a systematic literature

review, Cattan identified 22 studies (of which only two were from the UK) evaluating the effectiveness of health promotion interventions to alleviate social isolation and loneliness among older people (Cattan, 2002).

Studies identified by Cattan evaluated group activities and one-to-one interventions, including befriending and home visiting schemes. Group activities, such as discussion and self-help groups, bereavement support and counselling groups, were all found to be effective in alleviating isolation and loneliness among older people. Cattan notes that group activities, such as exercise groups and groups set up by therapists to create friendships, can also be effective in reducing feelings of loneliness among older people (eg Minkler, 1981; Rook, 1984; Jerrome, 1991). The effectiveness of one-to-one interventions was less clear.

Help the Aged commissioned a qualitative study to identify (housed) older people's views on solutions to alleviating social isolation (Cattan, 2002). Cattan concludes from the research that social isolation and loneliness may require different service responses:

There was an inference that loneliness and social isolation might in some cases require different inputs. Older people indicated that people who are isolated are often in need of practical support or resources, for example, ramps, transport and volunteer help, whereas the main need of older people who are lonely is social support and improved social networks. However, there is often a link and an overlap between the need for practical and social support. (Cattan, 2002)

Older interviewees in Cattan's study valued group activities, including exercise, cooking classes and outings. Contrary to findings from other research, older people also valued one-to-one interventions, including befriending, home visits and practical support. The report highlights the importance of purposeful activity, where older people have the opportunity to share skills and knowledge, and of involving older people in planning and delivering activities. While there are differences in emphasis between Cattan's study and the current study (perhaps related to specific issues arising from participants' particular experiences and needs, including homelessness, mental health problems and alcohol issues), there are notable similarities in terms of the characteristics of interventions valued by older people.

Choice of intervention(s) will depend on the factors contributing to, or maintaining, loneliness for an individual. The types of interventions identified by older people interviewed for this study were:

- a range of therapeutic interventions, especially group approaches;
- meaningful activities; and
- one-to-one support.

In line with Cattan's research, participants highlighted the value of purposeful activity and their involvement in planning activities appropriate to their needs. Many were interested in group activities, while others preferred one-to-one or solitary activities.

Older people valued one-to-one interventions for reducing social isolation, but emphasised the importance of group interventions (social, leisure, educational, creative and therapeutic activities) for alleviating loneliness. This was related to the perceived role of groups for providing opportunities for mutual support and for developing the skills necessary to form friendships with other group members.

In addition to those interventions identified in Cattan's study, older people interviewed for this research emphasised the need to address the underlying issues contributing to, or maintaining, loneliness,

including interpersonal and social skills, anxiety and low self-esteem, depression and alcohol problems. Some older people said they needed to begin to address these issues before they would feel ready to expand their social networks outside the homeless circuit.

Psychosocial approaches to loneliness

This section looks at some of the psychosocial approaches to loneliness that aim to:

- tackle the individual or psychological barriers to alleviating loneliness;
- build the confidence and skills to enable people to engage in social interaction and form relationships; and
- enhance self-esteem and emotional well-being.

The discussions in this section should not be interpreted as a blanket recommendation for the use of any therapeutic approach with older homeless people. Attention is drawn to some of the possible contraindications of some approaches with some individuals. Any form of therapy must be undertaken by an experienced and trained therapist.

The following section considers the role of activity for alleviating isolation and loneliness and for promoting well-being.

Support with problem drinking

Over half of the participants (52 per cent) had alcohol problems. The majority of these were heavy drinkers.

Reasons given by older people for drinking were:

- loneliness;
- feeling depressed;
- to cope with persistent and disturbing thoughts and memories of trauma;
- to cope with chronic pain;
- inactivity and boredom, sometimes associated with loss of mobility and poor physical health; and
- social networks comprising mainly alcohol-using social contacts.

Some participants wanted to stop drinking, but many had been drinking heavily for a number of years and felt it would be unrealistic to stop drinking altogether. The emphasis by many participants was on harm minimisation: to minimise the damage caused by alcohol, to promote a healthier lifestyle and to increase control over their drinking. Many participants said they wanted support and advice with cutting down on alcohol intake:

'Last four or five months I've been like this, drinking. Before that, social drinking. I want to get back into just social drinking – to be able to drink socially, but not like this.'

Many older people had attempted detoxification on numerous occasions, but had started drinking again immediately afterwards (on returning to a wet environment). They found it difficult to stop drinking because of loneliness, inactivity and boredom and where their social networks revolved around drinking. The majority of participants who drank heavily (including those who had been drinking heavily for a number of years) said they wanted to change their drinking behaviour. But they needed something to stop for. They wanted meaningful ways to occupy their time and to find a sense of purpose to their lives. A number of participants felt they would be able to cut down on their drinking if they had more

activities to get involved in at hostels and day centres. Some participants reported drinking less when engaged in an activity or going out for the day on outings organised by staff.

A number of participants (mainly those who were resettled but also some hostel residents) wanted one-to-one counselling in relation to alcohol issues.

'I could do with counselling, or a psychiatrist. Someone to speak to every now and then, because of the drinking.'

There was an indication from participants of the need to address the underlying problems associated with alcohol use and not just their behaviour:

'Why would I want an alcohol worker? I drink because I'm depressed. I need a mental health worker, not an alcohol worker.'

One man suggested the need for a mental health worker to provide a peripatetic service to older people at homelessness facilities (in relation to both mental health and alcohol issues).

Support with mental health and emotional needs

Among participants there was a perceived lack of focus on mental health by homelessness services and reference was made to the need for a proactive and assertive approach to needs assessment. For example, one man, talking about a day centre he used, commented:

'Pretty good on the whole. I just wish they had more sessions like on mental health, which I think is very important. That sort of session is sadly lacking. Should be a lot more as regards mental health – that's important... There's no counselling as such in this place. People can come and go without speaking to anyone.'

Mainstream homelessness services may not be able to provide the specialist support that is necessary to provide an effective service to older people with enduring mental health problems and multiple needs. Homelessness workers, without specialist training, may be expected to provide a service to a group of people who present with complex and challenging needs, with limited input from mental health, learning disability and older persons' services. Many older homeless people receive no specialist support with mental health problems but sleep rough or stay in general needs hostels which may not have the support of mental health workers (Warnes and Crane, 2000). Those with dual problems may encounter particular problems in accessing specialist mental health and alcohol services.

Very few older people in this research had accessed psychosocial interventions such as counselling, occupational therapy or clinical psychology services. In the UK, counselling is little used with older people and rarely with older homeless people (Warnes and Crane, 2000). Thompson (2002) suggests that this is related to an ageist ideology that assumes that older people are less affected by loss than younger people. This is based on the assumption that because of the increased losses encountered in later life they should be 'used to it' and therefore feel the emotions less keenly, even in the face of devastating losses. Thompson asks us to consider, for example, how seldom counselling is offered to older people who acquire a disability through strokes or falls. Yet counselling is often seen as an important part of the rehabilitation of younger people who acquire a disability as a result of accidents (Scrutton, 1992). Other psychological interventions, such as cognitive-behavioural therapies may be even less accessible to older people and especially to homeless older people.

Counselling may help to address the underlying issues associated with loneliness, including loss and bereavement, relationship difficulties and low self-esteem. Some older homeless people may benefit from counselling. Others may be unable to commit to formal counselling or they may not be at a stage where they might benefit from counselling (eg while they are drinking heavily). In these instances people may benefit from informal counselling and emotional support.

A number of participants wanted support and advice with emotional and sexual relationships. Many participants simply wanted someone to talk to, either individually or in groups, because they were lonely or needed emotional support. After engaging in informal counselling or group work, some people, where appropriate, may then move on to more formal counselling. They may also benefit from other approaches, including support groups, skill-based groups, cognitive-behavioural interventions, complementary therapies, and creative and expressive approaches.

Group counselling, self-help and support groups

Group approaches were popular among participants. Suggestions by older people included:

- group counselling;
- alcohol support groups; and
- discussion-based groups for the exchange of information and advice.

Participants wanted information and advice about:

- how to cut down on alcohol intake;
- the effects of alcohol on the body;
- promoting mental health; and
- medication they had been prescribed (psychotropic drugs and their side effects).

Participants emphasised the importance of groups that would encourage mutual support. The focus was on promoting inter-dependence, learning self-help strategies and building skills (eg learning how to manage anxiety, exercise to reduce anxiety and enhance mood, peer support groups and access to information about health, nutrition, mental health and alcohol issues).

Cognitive and behavioural approaches to loneliness

Cognitive and behavioural approaches may be useful where an individual's behaviour (eg social skills or anger) or thoughts (eg anxiety-provoking thoughts) maintain loneliness, depressed mood or anxiety. Cognitive and behavioural approaches have been applied to a range of difficulties including interpersonal difficulties, behavioural problems and challenging behaviours, addiction, anxiety and depression. The potential value of psychological interventions for homeless older people needs further investigation.

Challenging thoughts

Behavioural techniques are sometimes used to increase day-to-day activity levels, which can build confidence and increase motivation. These techniques can help to break the routines characteristic of depression (eg inactivity and social withdrawal) and enable an individual to benefit from other interventions such as cognitive therapy.

Cognitive therapy is a short-term, problem-solving approach to therapy, focused on current problems and the factors that maintain them. The aim is for people to develop the skills necessary to help themselves. Cognitive therapies aim to challenge and adapt the negative thoughts that can maintain loneliness, low self-esteem or anxiety.

Depression is characterised by persistent negative thoughts and beliefs about the self, the world and the future. These negative thoughts lead to hopelessness, helplessness, pessimism and self-blame. Cognitive therapy challenges the negative cognitive reasoning that gives rise to depressive symptoms.

Substantial empirical evidence exists of the efficacy of cognitive-behavioural approaches to therapy with people of all ages, including older people. Cognitive therapy has been used effectively with older people both individually (eg Gallagher and Thompson, 1982) and in groups (Yost et al, 1986). Some psychologists recommend making some adaptations for the use of these approaches with older people, to acknowledge the need for greater flexibility and longer therapy duration that may be required with older people and to take into account physical health problems or disabilities.

Building skills

Social and communication skills may be developed through one-to-one social interaction (eg with a volunteer) and this can help to build confidence. However, it is often felt that social skills can be more effectively developed in groups. This is because skills can be practised with other group members, people can learn how their behaviour affects others in a group, and group members may also learn from observing other people's behaviour.

Participation in group activity can help build social skills and confidence in social situations. Structured groups may also incorporate an element of social skills training. Many participants said they wanted to improve social or communication skills and to learn how to interact with others more effectively. A number of participants said they wanted to join a skill-based group for this purpose.

Social skills training is a behavioural approach: it is structured and task-related and involves exploring and practising skills through skills modelling, role play and rehearsing skills in a safe and supportive setting. Social skills training may also include anxiety management, assertiveness skills training and anger management. A number of participants suggested the need for assertiveness skills training sessions and some wanted to learn how to control feelings of anger.

Using a cognitive-behavioural approach to anger management, people are taught to identify situations that trigger anger responses and then practise using more appropriate responses, sometimes using self-talking strategies. They may also learn relaxation techniques. Through their interaction with others in the group, people learn how to negotiate and deal with conflict.

Managing anxiety and learning to relax

Almost a third of participants reported problems with anxiety.

'Life gets so stressful sometimes, you feel you want to explode. Life goes so fast, your nerves get jangled up sometimes.'

Anxiety states may stem from unresolved trauma, such as the death of a loved one, childhood abuse or wartime experiences (Hallam, 1992). Anxiety may be the main presenting problem; it often accompanies depression and is also associated with heavy drinking. Alcohol use may have an immediate effect of alleviating anxiety but can exacerbate feelings of anxiety and restlessness that can last for days and sometimes weeks (Hallam, 1992).

Anxiety states may be maintained by the individual's thoughts – their 'anxiety about anxiety'. By focusing on, and worrying about, the distressing symptoms of anxiety (eg feeling of tightness in the chest, palpitations, dizziness or feeling faint, difficulty in breathing or of feeling 'unreal'), a 'vicious cycle' may be created that escalates and perpetuates the problem.

Many participants said they wanted help with managing anxiety. Some suggested the need for anxiety management and relaxation groups. People can learn self-help techniques (derived from cognitive therapy) to manage anxiety, either on a one-to-one basis or in groups. Anxiety management involves learning how to relax mentally and physically, distracting the mind from anxiety-provoking thoughts (eg through engaging in physical or mental activity), and learning how to identify the thoughts that cause anxiety. Clients are then taught how to 'catch' the thoughts that trigger anxiety, to prevent anxiety spiralling out of control.

Participants were enthusiastic about trying different approaches and complementary therapies. Some suggestions from participants were:

- relaxation exercises, including meditation;
- exercise classes;
- reflexology for relieving tension;
- yoga; and
- aromatherapy and massage.

'New techniques for relaxation, for example putting in earplugs to hear birdsong.'

'Exercise – more for relaxation than anything else. A fitness thing – I don't know if they do fitness? That could be possibly arranged, hopefully. Yoga might be all right for some people, though not for everyone. If we had relaxation it would be helpful. Quite a few people would benefit from it.'

The role of creative and expressive approaches for alleviating loneliness

Art, literature, drama, poetry and other forms of creative expression can all help in the understanding and alleviation of human distress. Creative and expressive ways of working are aimed at empowering, enhancing self-esteem and making interpersonal communication more meaningful (Simms, 1993).

A number of participants expressed interest in art, creative writing or drama. Music and dance were more popular among older people.

Art work

Art therapy uses a range of art and creative techniques to improve self-esteem, develop skills, improve self-awareness and express feelings. Art therapy can help people to act out complex feelings and gain a greater self-knowledge and can be a powerful means of expressing ideas and emotions (Simms, 1993). Landgarten (1981) suggests that the 'expression of pain and the accompanying feelings of anger, rage, guilt or sorrow through art work permits catharsis and leads to successful management of the feeling'. Artwork is a social activity and can provide an opportunity for group members to interact with each other.

Generally, art was perceived by older people in terms of its therapeutic benefits – as a form of distraction from upsetting thoughts; and, within a group, for developing interpersonal skills. One man, who had been sleeping rough on and off for over 20 years, spoke about an art class he attended at a day centre:

'I'm a bit of a loner, I find it hard to mix with people. This has helped. It has been good, mixing with people. I enjoyed it. For someone like me, staying on my own, it help, occupy my mind. I love painting. It help me, the painting classes, it help me a lot, revive

myself. You need more activities, because some of the things, can I put it...I enjoy myself – that's why I came back, because I'm a loner, so a group like that [is] good for my mind, worrying about unnecessary thoughts, all these thoughts, things you don't need to think about.'

Creative writing

Writing is a way of discovering and communicating feelings, values and ideas in order to help clarify, analyse and synthesise life experiences (Simms, 1993). A number of participants were interested in writing poetry and prose, although not necessarily in groups, but sometimes on an individual or one-to-one basis. One man, for example, said he was interested in writing articles for a magazine and suggested creating a newsletter that people could contribute to.

Writing can be used in a variety of ways to enable people to understand and explore thoughts and feelings: for example, through writing letters, keeping diaries or a personal journal to record thoughts and feelings and writing autobiographical material. These may help people to understand events more clearly and increase self-awareness. With older people, an autobiography may help make sense of the past by re-evaluating past experiences and giving their life meaning (Simms, 1993).

In some respects autobiography is similar to reminiscence. Reminiscence can be a positive experience for many older people, although it is not appropriate for every individual. From the findings of a longitudinal study of 50 older people living in sheltered housing, Coleman suggests that reminiscence can indeed be an 'encouraging and comforting activity', but he warns that it can also be a 'worrying or a disturbing experience' (Coleman, 1993).

Reminiscence may not be appropriate for those individuals who are likely to become depressed when thinking about past experiences and regrets or (with obvious implications for older homeless people) who may compare their current situation unfavourably to their past. Within this context, reminiscence can in some cases evoke persistent feelings of depression and guilt (Coleman, 1993). Coleman suggests that 'whether people stand to gain from reminiscence will depend on their past histories as well as their present needs'. It should therefore not be assumed that the writing of autobiographical accounts (or life stories) is beneficial to all older adults; rather, the potential benefit of this approach needs to be assessed on an individual basis.

Drama and drama therapy

Derived from psychodynamic principles, drama therapy uses role play, dance, movement, storytelling, mime and acting to work through issues people bring to the group. Drama therapy, or psychodrama, can work towards specific goals, including rehabilitation, social skills and overcoming anxieties. Use of drama in therapy examines experiences, situations and conflicts and considers alternative ways of looking at them. People can gain greater insight through drama, which can help them to see more clearly. By working through defences dramatically it is possible to uncover the problems involved (Langley and Langley, 1983).

While some older people may benefit from drama therapy, it is not appropriate for all. As emphasised by Simms (1993), it is essential that drama therapy (as with any psychoanalytical therapy) is undertaken by a trained and experienced therapist, with specialist supervision.

Through exposure to role-play situations, drama therapy can evoke deep-rooted feelings and emotions, in some cases uncovering disturbing memories that have been buried for many years. Several older people interviewed for this study had previously participated in drama groups and some had found the experience

painful and distressing. Their involvement in drama had in some instances brought back memories of institutional life where they felt they had been 'made to do' drama therapy.

Nonetheless, some participants said they were interested in drama, acting, play production or play reading. Drama can be used for fun, as well as for therapy. It is essential to distinguish clearly between drama and drama therapy when developing drama-based activities.

The healing power of music

Music therapy uses music to enhance emotional and psychological well-being. Music can change mood and emotional states and encourages people to explore feelings and emotions. People can also develop interpersonal and communication skills by playing music together.

A number of participants were keen to participate in music workshops and some wanted to learn to play a musical instrument, such as the guitar, piano or harmonica. Many participants said they would like to listen to music (in groups) or sing or dance to music. Singing can enable people who find it difficult to express their feelings to do so in song (Yon, 1984) and encourages the sharing of fears, worries and experiences with other group members (Short, 1992). The use of music therapy can help individuals to relive positive experiences and can alleviate anxiety (Blumenthal and Kupfer, 1990).

Music can have a powerful effect on mood:

Musical participation evokes powerful associations and moods and encourages expression of thought, feelings and emotions. Music...can aid in combatting feelings of loneliness, fear, helplessness, depression, and despair... Music naturally encourages group participation and verbal and nonverbal social interactions and communication. (Osgood, 1993)

Self-expression through dance

Many participants said they wanted to dance. Among the suggestions were disco, rock 'n' roll, jive, country & western, Irish dancing, salsa and the Cuban rumba. Dance can be a way of enabling people to communicate and express their feelings with other people. Dance can improve physical co-ordination, reduce feelings of depression and anxiety, and build confidence:

Participation in dance activities offers many benefits to older adults...[including] greater confidence and greater feelings of power and mastery... Like other forms of physical exercise, dance decreases depression and anxiety and improves memory and alertness. Dance is an excellent way to release tension and stress and relax. Dance is a social activity. Through dance, older adults explore, express, and share feelings with others. (Osgood, 1993)

The value of group approaches

Group approaches can have a particular benefit to those participating in them. Through their interaction with others in the group, people can develop social skills and learn how to interact meaningfully with other people.

Group members may benefit from the reactions of others to their views and concerns, and experience belongingness through sharing experiences with others. Older people may benefit from the support and encouragement of other group members and from helping other people in the group. The acts of sharing and being of assistance to others in the group are well documented as giving real benefit to the participants (Yalom, 1985).

An evaluation of group activities for homeless and former homeless older people (Willcock, forthcoming) found that:

- participating in group activities helped to develop interpersonal and social skills;
- structured groups provided a context for friendships by facilitating communication; and
- participation in a group gave older people a sense of belonging and an awareness that they were not alone.

Older people emphasised the context of activity for the development of meaningful social engagement. The kinds of groups valued by older people were those that:

- facilitated the sharing of skills;
- fostered the sharing of experiences and personal difficulties with other group members;
- encouraged peer support and interdependence; and
- provided opportunities for group members to help one another and to give to others, which made them feel valued, perhaps indicative of the relationships missing from people's lives.

The particular benefits of group approaches were emphasised by older people interviewed for this research. The meaning of activity is discussed in the next chapter.

7 The meaning of activity

This chapter examines the crucial role of activity in alleviating social isolation and loneliness and for promoting psychological well-being. It offers practical suggestions on how activities and groups can be made more responsive to the needs and aspirations of older people. The chapter concludes with a synopsis of the views of older people on age-specific service provision.

Activity and ageing

Kelly suggests that some combination of two dimensions of life are critical for quality ageing: the quality of relationships, especially close ties with important others; and regular engagement in activity. He suggests that the two are usually associated when activity is the context of the relationships; and communication and sharing with others are a central component of the meaning of the activity (Kelly, 1993).

Engagement in meaningful activity can help to maintain a continued role in life and provide a sense of purpose. Regular engagement in activity is vital for psychological well-being and quality of life in later years:

- Participation in leisure activities is associated with quality of life among older people (Cutler Riddick, 1993); leisure constraints (anything that inhibits participation in leisure activities) impacts on quality of life (Peppers, 1976).

- Involvement in activity is related to better health in later life: physical and social activity are consistently associated in longitudinal study not only with higher life satisfaction (Palmore, 1979) but also with better health, longer life and lower rates of institutionalisation (Steinbach, 1991). Wilcock (1998) describes how lack of opportunity to carry out occupations due to limited opportunity and choice can militate against health.

- Activity promotes psychological well-being. Physical activity and exercise can reduce anxiety, enhance mood and build self-esteem (Taylor, 2000; Mutrie, 2000; Fox, 2000). Physical and mental activity can help to distract from thoughts that maintain anxiety and depressed mood, and structured activities may distract from drinking.

- Research has found that group activities are effective for alleviating social isolation and loneliness among older people. The development of friendships often takes place within the context of activity: at work, leisure or play. Leisure activities may help combat loneliness by providing a structural context for friendship (Adams, 1993).

Homelessness policy and meaningful occupation strategies

The Rough Sleepers' Unit (RSU; replaced by the Homelessness Directorate in summer 2002) was set up by the Government following a report by the Social Exclusion Unit on rough sleeping. The RSU developed a homelessness strategy, in which meaningful occupation was integral to help people become 're-integrated into society and to sustain a lifestyle away from the streets' (DTLR, 2002). However, the focus was on returning people to the workforce and 'encouraging homeless people into courses, apprenticeships or jobs [which] is a crucial part of helping them out of homelessness' (DTLR, 2002). Similarly, while the RSU promoted volunteering for former homeless people, volunteering was mainly perceived as a means towards paid employment.

Alternative activities to paid work should be considered only if it is 'not possible' for a person to get a job:

...some former rough sleepers may need a lot of help to be able to take up a job but if it is not possible people should be helped to re-gain the confidence to re-integrate into the community in other ways. (DETR, 2000)

Little attention is paid to older people or the intrinsic value of activity for promoting health and well-being in later life, as emphasised by the Department of Health. The National Service Framework for Older People advises that:

Any form of social, physical or mental activity is good for health and well-being... Activity and exercise, which improve physical health, increase the sense of well-being and also tend to promote more positive social interaction and will in turn promote positive mental health. (DoH, 2001)

While some older homeless people may want to find a job – and where this is the case they should be supported in doing so – very few older people interviewed for this research were seeking paid employment. This was considered neither realistic (in relation to their needs, experiences and disabilities) nor desirable. Some participants pointed out that they had already made their economic contribution to society earlier in their lives and they were, or perceived themselves to be, retired. They now wanted to contribute to society in other, equally meaningful, ways.

Lack of meaningful activity

Social isolation may be linked to the loss of social networks linked to employment and with subsequent lack of meaningful activity. Meaningful activity could provide the opportunity to build new social networks. Participants had experienced role loss (often preceding homelessness) associated not only with retirement or cessation of work, but also with widowhood or family breakdown (role of partner, parent and so on). Role loss was exacerbated by other restrictions, including poor health and loss of mobility and the exclusion associated with homelessness. Such complete role loss is associated with isolation, loneliness, boredom and depression (Duncan and Whitney, 1990).

The majority of participants had previously been employed. Some had been consistently employed for much of their adult lives and some had worked until (or close to) retirement age. Others had been made redundant earlier in life or had lost their job, sometimes due to physical ill health or a breakdown in mental health.

In interviews, older people often reflected upon their working lives. As has been found in other research (Crane, 1999), a high proportion of participants had served in the armed forces. Many had worked as building and construction labourers, in the catering industry or as long-distance lorry drivers and some had stayed at hostels while they worked as labourers or were employed in casual or seasonal work. Some participants had worked in a managerial capacity and a few had been self-employed or run their own company. In line with other recent research (Pannell et al, 2002), a number of participants had held highly skilled or professional status, including health and social care staff, teachers, police officers, carpenters and engineers. In some cases, since ceasing work, they perceived a loss of status; they sometimes found it degrading to claim benefits and had lost self-esteem.

Some older men said they had found it hard to cope with boredom and loneliness following redundancy or retirement. Having often been previously work-based, the lives of many participants were now characterised by boredom and lack of purpose. Inactivity was commonly reported and, according to participants, was associated with their continued use of

alcohol. Some participants had engaged in activities at hostels and day centres and this had boosted their confidence and increased their motivation. Many participants, however, spent their days sitting around at day centres or at a hostel with other residents, sometimes drinking, with little else to occupy their time. They said they found it difficult to find ways of keeping occupied during the day and felt they had few opportunities to participate in meaningful activities, as the following comments by two hostel residents illustrate:

About life at the hostel:

'We haven't got enough activities. People are sat around doing nothing all the time.'

and on the subject of daytime occupation:

'I haven't got one. Would like one. I worked at a hospital before and was happy then. I used to go to day centres and talk to people, I enjoyed it. I'd like to go to day centres again, once or twice a week.'

Lack of meaningful activity was a strong theme in interviews with participants, including those who were street homeless, hostel residents and resettled older people. Participants felt there was a need for regular activities to be organised at day centres and hostels and for a wider choice of activities appropriate to their needs.

Getting active

Many older people return to the homeless life after they are rehoused (see eg Crane, 1999). When people are depressed and lack a sense of self-worth, they can be poorly motivated and may show little interest in their physical environment. Heavy drinking and associated depression may lead to self-neglect and poor motivation to maintain the home. They might get behind with paying the rent or allow bills to accumulate and take little care of their self or their home. In some cases they may abandon their home, to escape the pain of their loneliness and in response to the spiralling difficulties that depression inhibits them from resolving. Once they have gained some self-respect and find purpose in life, they may then become more aware of their environment and start to care about other aspects of their life.

Supported activities in small groups may help people build the confidence and motivation to 'move on'. Research that explored older people's perceptions of the meaning of activity (Willcock, forthcoming) found that, after engaging in small group activities, some older people made the decision that they wanted to move on to activities in the wider community and to break ties with the homeless life.

Moving on

Many participants wanted to access activities and facilities in the wider community, outside homelessness provision. This was often after they had become more settled and were living in permanent housing, although this also applied to a number of long-stay hostel residents. Involvement in activity can help older people to widen their social networks and build links with the wider community.

Participants were interested in a wide range of activities, including social and leisure activities, physical activity and exercise, educational activities and volunteering. A few participants were interested in attending full-time adult education courses. Many said they wanted to participate in a regular group activity once or twice a week, while others preferred the flexibility of informal activities they could undertake alone.

Social activities and outings

'Having something to look forward to...'

Participants often had few opportunities to have fun, with nothing to look forward to from one day to another. They were keen to participate in social activities such as a shared meal, live music or a dance. One man suggested having a 'community evening social club' and others suggested dances and other social activities at weekends or in the evenings, when they could feel particularly isolated.

Outings were popular among participants, who suggested trips to the coast and the countryside, gardens and parks or to sporting events, including athletics and football. The arts and cultural pursuits were especially of interest to older people, including trips to the theatre and cinema and local outings to places of historical interest, museums and exhibitions.

'[The day centre is] satisfactory, it passes the time, but more activities could possibly be organised, money permitting, and possibly more trips out – during the time from now 'til September, the weather should be warm. Every so often, a museum outing to see free exhibitions.'

Physical activity and health promotion

Participants often suggested health-related activities. A number of older people suggested group activities based around health education, including advice about eating healthily, nutrition, exercise, mental health promotion and general well-being. Many participants said they would like to take up some form of exercise or sport, including gentle keep-fit and exercise classes, walking and rambling (in the words of one man, a 'mature ramble'), swimming, ice skating and tennis, and especially team sports such as football, netball and volleyball. One participant, a woman in her early sixties, suggested setting up a football match for the over-fifties. The emphasis was on active ageing:

'If there's any "go" in the over-50s it's frowned upon here – I have been and others have been told to sit down. You can't make too many waves. Everything that can be done seated. It's like they think we're about to drop down any minute!'

Developing new interests and leisure activities

'It is a good idea to get people out and learning.'

Participants were keen to develop new interests and participate in leisure activities. A wealth of suggestions was offered, far too numerous to reproduce in full here, but including music, cooking classes, book groups, gardening, woodwork, table tennis, snooker and ten-pin bowling.

Reference was made to the importance of maintaining an active mind in later life. Participants were keen to learn about new and different subjects, to expand their minds and increase their knowledge of different aspects of life. One man suggested holding 'talks on specific topics, like politics, economics and history'. Another man suggested:

'...inviting experts to give talks on their subject, like different cultures, countries and travel. I would like someone to come from a travel agency or embassy to give a lecture on their country, or a film show or something like that'.

Discussion groups on current affairs and social issues were very popular among older people. Other suggestions for talks, lectures and discussion included religion, philosophy, critical psychiatry and motor mechanics.

Using skills, sharing skills

'Nobody want to know my skill any more.'

Participants felt they had few opportunities to use their skills and they wanted to participate in activities that would make them feel valued and a useful resource. Some participants said they wanted to help day centre staff, to assist with setting things up for group activity and clearing up afterwards or to help prepare snacks and refreshments for the group. A number of older people were keen to be involved in the development of activities and new projects and a few older people became involved in the planning of a new project that was developed from this research.

Activities were sometimes perceived to focus on skills they do not have, rather than on skills they do have. Participants wanted to use skills they had acquired through life experiences and previous employment and to share their skills with other people, in small groups or on a one-to-one basis.

Many older people offered skills they were keen to share with others. One man had worked as a chef during his career and had owned his own restaurant. He said he would like to help other people with cooking. Another man, aged 68, said he could help other people with budgeting skills. Similarly, a woman participant said she would be able to help with literacy skills. Other skills and experience offered by participants included carpentry, DIY, decorating, engineering, bricklaying, cleaning, and speaking other languages. One man suggested the need for workshops, providing opportunities for people to work together and share their skills.

As well as using skills they had, participants wanted to learn new skills and relearn forgotten ones. Many older people said they wanted to improve life skills – especially budgeting and paying bills, and also cooking and shopping. Some were interested in attending courses in literacy and numeracy. Many were interested in attending courses in other subjects, including first aid, language classes and especially IT. A night shelter resident, homeless for over 20 years, explained:

'You know what I'd really like to do? I just got interested in computers. Everything's computerised these days, don't you think? It's a thing that's sort of caught on. I'd like to know how to type with both hands. At [project] day centre they have a man come in to teach you, on Mondays, but sometimes it's hard to get on the computer. There's only one computer, so I haven't asked.'

Participants wanted to learn skills perceived as useful and important in today's society, as the following comments illustrate:

'Would like to know more about the internet. You can't get anywhere these days without knowing how to use a computer.'

'I must come along to one of these computer things they've got here – all these kids learning, I feel left out. You need to be computer-literate – we didn't learn all this at school. I must come along to the computer sessions. I want to learn.'

It is striking that the expressed needs of older homeless people interviewed for this research are remarkably similar to the core mission of the University of the Third Age (U3A), which is to 'encourage lifelong learning for those no longer in full time gainful employment'. The growth of the U3A movement has led to 516 branches being set up nationwide, with a total of 123,014 members as at 11 February 2003 (www.u3a.org.uk). U3A dwarfs other networks such as the Workers' Educational Association (WEA) – an organisation with similar values and mission set up for people of working age – in terms of membership (16,500) and activity (www.wea.org.uk).

This growth in social and educational activity organised by older people themselves is mirrored by the development of forums of older people set up to ensure that their voices are heard. There are now over 1,000 groups in the UK, linked to the Speaking Up for Our Age campaign, promoted by Help the Aged. Most of these are forums. This demonstrates the contribution that older people make if the right framework and support are in place. For reasons set out in this report, the contribution older homeless people can make has not been recognised because their homelessness has masked their human need for meaningful activity and for their voices to be heard.

Meaningful activity

Activity is more than filling time... The kinds of activity that seem to really make a difference [in later life] are those that are characterised by involvement, commitment, and skill... They provide not only an experience of meaningful engagement, but they tend to yield a self-definition of ability and worth... Preferably challenging mind and body, social and personal skills, such activity does far more than fill time. (Kelly, 1993)

Older people differentiated between 'activity' and 'meaningful activity'. Some activities were described as 'useful for passing the time', while others were perceived as purposeful to the individual. What is 'meaningful' to an individual is subjective and what is perceived as purposeful to one person may not be to another.

Drawing on the work of Kelly (1993) on activity and ageing, for the purposes of this report meaningful activity is defined as: an activity that yields a sense of personal accomplishment or the fulfilment of personal goals and a self-definition of worth, value or ability. Engagement in an activity that is meaningful to the individual enhances quality of life, self-esteem and sense of well-being. Having goals gives meaning to life.

This can apply just as much to the pursuit of an absorbing leisure activity, developing a new interest or renewing an old one, taking up an exercise class or improving interpersonal skills as it does to learning how to use a computer or indeed to engaging in paid employment.

In fact, an absorbing leisure pursuit may be more meaningful to an individual than paid employment, for example where a person receives little satisfaction from their job and the importance of leisure may increase following cessation of work or retirement (Burton, 1989).

Mountain suggests that careful consideration should be given to defining what purposeful activity is for older people. The synthesis of research evidence by Burton (1989) demonstrates that maintaining a quality lifestyle in older age extends beyond the ability to perform necessary tasks. It includes involvement in leisure and social occupations that are meaningful to the individual (Mountain, 2001).

Appropriate activity

It is important to consider the kinds of activity that older people perceive as appropriate and ensure that efforts are made to counter stereotypical service responses. While valued by those who participated in them, activities widely available at day centres were not always the kind of activities that older people were interested in. It is important to consider the views of those who have rejected activities as well as those who have engaged in them. Some activities, while suitable for younger users, were perceived as inappropriate for people of the participants' age, experience and skills, such as:

'Being asked to do games and drama and funny things that are not very suitable to one's needs.'

Often, little attention is paid to the types of activities that are of benefit in later life:

Narrow limits or stereotypes do not represent the wide variety of things that older people do to maintain a sense of identity. When we look at the activity of older adults, it is necessary to include the entire community, all the mass media, a full range of travel destinations and styles, home electronics, churches and schools as well as all the informal social spaces of interaction. In short, older adults are everywhere, doing almost everything, but at rates and in styles that fit their age-related abilities, interests, and resources. So much for bingo and sing-alongs. (Kelly, 1993)

One-to-one activities and support

After being rehoused, some older people had become increasingly housebound, because of deteriorating health or disability, and more and more isolated. Home visits and one-to-one activity were perceived as important by those who lived alone, were housebound (this applied to older people living in hostels as well as in independent tenancies), had physical health problems or restricted mobility, or did not want to join a group or use day centres. They valued home visits, for practical support and for company, to have someone to talk to.

'I feel lonely all the time, especially when I'm at home. I'd like a home visitation service.'

'I live alone. I need someone to speak to.'

This could be a role fulfilled by volunteers who could engage with older people in one-to-one activities and encourage and support older people to find activities they can do alone.

One man, aged 61, who had been street homeless for many years before moving into his flat, describes how he benefited from home visits from a support worker:

'I am very happy now because my support worker visit often. She got me a phone as well so we can keep in touch when she cannot visit me I'm not feeling lonely anymore. She also got me a television to keep me company. She spends time chatting with me as well.'

Telephone contact

A number of resettled older people said they would value having telephone contact, not only to reduce their isolation but also as an additional source of advice and support following resettlement. They wanted to be able to contact someone by telephone for informal support and reassurance (eg for advice about 'official letters' they received), which could help prevent problems becoming crises. A number of participants suggested a telephone befriending scheme and some proposed a 24-hour telephone service so they would have a point of contact when day centres and other support services were closed. Telephone contact was perceived as particularly important at the weekend and in the evenings, when they could feel most alone. They wanted someone to call them from time to time for a chat:

'To call me every day...I feel lonely most of the time.'

'Telephone call...I would like that very much like that, just to check on me.'

The value of volunteers

Volunteers can fulfil a valuable role in providing social contact and companionship. Lemos suggests that spending time with volunteers is 'a form of social engagement in itself, getting people out of the tightly knit universe of

homelessness' (Lemos, 2000). Research has found that people value the personal relationship which they have with their volunteer befriender, the fact that the befriender chooses to spend time with them, rather than being under a professional or family obligation to do so (Dean and Goodlad,1998).

With appropriate training and supervision, volunteers can take on an enabling role. They can support older people to make new social contacts outside homelessness provision and build links with the community, perhaps accompanying older people to facilities until they feel comfortable about attending alone.

Studies have emphasised the importance of matching user and volunteer by shared leisure interests, background and age. From their study of befriending schemes, Dean and Goodlad conclude that 'befriending organisations, volunteers and users all considered matching volunteer and user to be a key to success' (Dean and Goodlad, 1998). Similarly, Cattan found that isolated older people felt that shared age, culture, interests, personal history and background were important when matching volunteers with their clients (Cattan, 2002). Recruiting older volunteers may help develop social contacts with older people outside homelessness provision, although the research by Dean and Goodlad found that befriending organisations for older people are the most likely to encounter problems in matching (Dean and Goodlad, 1998).

Befriending schemes recruiting users as volunteers can facilitate reintegration into the community for isolated and excluded older people. Dean and Goodlad, in their study of befriending schemes, found some examples of users-as-volunteers, including a 'case study scheme serving frail elderly people which draws a number of volunteers from the older population'. The authors suggest that befriending organisations 'encourage socially excluded people to become active participants through volunteering, thus promoting inclusion in community life'.

Volunteering

'Would like to help others.'

'Doing shopping, and odds and ends for others.'

A number of participants were interested in volunteering – 'to help other people' – in various settings, including at day centres they attended or in the wider community. The interest in voluntary work applied mainly, though not exclusively, to those who were housed. People expressed interest in:

- DIY and decorating;
- volunteering at community centres;
- doing office or administrative work; and
- helping at charity shops and jumble sales.

Participants wanted to contribute to society and the local community and to have the opportunity to give to others, rather than always being 'given to'.

Some participants were interested in working with homeless people, either helping with practical tasks at day centres, or with basic skills, or by volunteering for a charity in an administrative capacity. Some pointed out that they had much to offer in this field because of their personal experiences of homelessness and their ability to relate to others in a similar situation.

A number of participants were interested in doing voluntary work with isolated older people in the community, such as helping out at day centres, preparing lunch or serving tea, providing company or assisting with practical tasks such as shopping.

Volunteering can provide a continued role in life and a context for retaining continuity in a sense of worth and value (Kelly, 1993). A number of studies have found that replacing lost roles with new ones, by undertaking voluntary work, is associated with increased life satisfaction among older people (Duncan and Whitney, 1990). Other research has found that volunteering in later life is associated with psychological well-being (Cutler and Danigelis, 1993). One study of a volunteer programme found that older volunteers had higher life satisfaction, a stronger will to live and fewer somatic, anxious and depressive symptoms than non-volunteers (Hunter and Linn, 1980–1).

Enabling access to activities

Although many day centres organise regular activities, such as art groups, basic skills training and creative writing, and these were valued by those participants who had engaged in them, many older people interviewed had not accessed activities provided by homelessness services. This was the case for many formerly homeless older people, now housed, who attended day centres, those who were sleeping rough and using day centres, and particularly so for hostel and night-shelter residents, many of whom did not engage in any activity.

A high proportion of participants, both homeless and ex-homeless, said they wanted to find some way of occupying their time meaningfully. However, there can be a big gap between wanting to get involved and actually getting involved. Group activities can take time to establish and numbers are likely to be low until a project is well established. However, once people get into the routine of attending, enjoyment and other gains may become sufficient incentive to prolong attendance. Research has found that once older homeless people become involved in an activity that interests them, they tend to continue to attend (Willcock, forthcoming).

Accepting support

Although extremely assertive in many areas of their lives, participants were sometimes unassertive in making their needs known or asking for help.

'I could do with talking to someone. I should do, because of the drinking, and my health, but I don't think it'd make any difference. I brought it on myself, the drinking and that. Anyway, I'm not sure I can be helped, I'm too old to take advice, and I don't like to bother people. The staff are always so busy, I don't like to ask.'

A number of participants said they experienced problems in articulating their needs or asking for help when they needed it. Many were depressed, demoralised and poorly motivated (sometimes related to heavy drinking) and they lacked confidence and self-esteem.

Workers reported that sometimes when older people had been asked if they needed support, they expressed satisfaction with their situation (sometimes saying they did not need any help) and refused offers of assistance. Some had become institutionalised and were compliant and undemanding. They had become 'stuck' in a pattern of behaviour and this was difficult to break out of.

Participants were an extremely independent group, many of whom had survived on the streets, often for many years, and found it difficult to accept their need for support. They were sometimes reluctant to accept help, which they perceived as 'charity'. Thompson (2002) suggests that an older person who has internalised ageist messages about being 'a burden' often chooses not to bother the staff for fear of being thought a nuisance.

One man, interviewed at a day centre, talking about the idea of joining a group activity, explained:

'I used to come here every day, but now just once every couple of weeks. I find it difficult walking too far these days because of the [physical illness] and I can't use the bus, because [of a disability]... They provide cabs, the people who came to talk to me about it, they told me, but I wouldn't want to put them out. I'd be embarrassed for all the fuss.'

For many participants, their refusal to accept support seemed to be related to a perceived threat to their independence.

'I want to help myself out again, don't really know how. Always looked after myself before.'

When workers offer help with various activities of daily living (eg transport assistance), the help may be refused. Thompson (2002) suggests that when older people refuse offers of help by practitioners, such refusals are sometimes interpreted as the older person being 'obstinate'. However, she suggests, if we try to understand it from the perspective of the older person, it becomes easier to conceptualise it as a loss experience: the loss of an independent lifestyle. The older person may perceive offers of help as a challenge to their self-identity as an independently coping person (Richards, 2000). Thompson emphasises that we should not underestimate the loss of individuality that can arise as a result of needing help. Such need for help with daily life activities can be a devastating experience for some people (Scrutton, 1995). Corr et al (1997) explain that ageism devalues the experience of old age, suggesting that experiencing multiple, but devalued, losses (such as health losses and reduced mobility) can lead to a devaluing of self and self-worth by the older person.

With this in mind, Lustbader (1994) emphasises the importance of interdependence and reciprocity when working with older people. She refers to the need to be of use and indicates how carers can (unintentionally) alienate older people by not recognising the impact that their actions (of assistance) can have on an individual's self-esteem. Frail older people are often denied chances to give something back to those who help them or to their communities and their offers of help are refused when the need for interdependence is not recognised.

With implications for practice, and as discussed elsewhere in this report, the importance of supporting self-help and peer support, of interdependence and reciprocity, of sharing skills, helping others and of being able to 'give something back', were all strong themes in interviews with older people in this research.

Barriers and enablers

Older people were asked how they felt about joining a new group or activity and what would encourage and enable them to participate in activities. The research identified a number of barriers and enablers to engagement in activity.

The main factors in deciding whether or not to join a new group were:

- the type of activity or topics to be covered (whether or not an activity interested them and seemed appropriate to their needs);
- the characteristics of other group members (having common ground, similar abilities and shared expectations); and
- the environment (holding the group in a quiet, safe place).

Similarly, among those who had rejected activities or who had joined a group but discontinued attending, the most common reasons given were:

- feeling the activity was inappropriate to their needs or not to their taste.
- having nothing in common with other group members; and
- having different expectations of a group.

Enablers included having someone to go with, building a relationship of trust with the group facilitator in advance of the group, and information about what to expect and reassurance about the voluntary nature of an activity. Other incentives seemed less important to older people, although some said a meal or transport provision would encourage them to attend.

Perceived or actual youth focus

Older people sometimes perceived activities as being targeted at young people, which put some of them off attending. One man, talking about a group at a day centre, commented:

'But they're for youngsters, those sort of things, aren't they?'

This may reflect the actual content of activities or the way services are promoted, which may make them appeal more to younger people. Consideration needs to be given to the way services are promoted and whether they appeal to older people.

Activities need to be developed with the older person in mind, working at an appropriate pace, with sufficient time allowed for each activity. Participants referred to difficulty in concentrating and poor memory, which sometimes put them off joining a group as they were concerned that they would not be able to keep up with other (often much younger) group members. One 62-year-old man, commenting on a group he had attended, said:

'A lot was crammed into the time. I felt relieved when the group was finished. It takes me a long time to digest new information.'

Going into the unknown

Many participants were apprehensive and anxious, sometimes frightened, about the idea of trying something new or joining a group. They anticipated (unrealistic) negative outcomes from attending a group activity. They feared the embarrassment of not fitting in or being left out, and sitting alone not talking to anyone, and compared themselves unfavourably to other potential group members. In group discussions, some older people were reassured and somewhat surprised to hear that many people feel the same way about trying something new.

Some were unaccustomed to group situations and found the idea intimidating. They said they did not know what it would entail, what might be expected of them or what topics might be discussed in a group. They were sometimes concerned that they would have to contribute or talk about things they did not want to talk about, in front of others. Some older people may need a lot of reassurance and encouragement to engage in a new activity.

Safety

When discussing the idea of joining a new group, older people expressed concern over personal safety. For example, one man said he would only join a group 'if it was local and in a safe environment'.

Participants felt apprehensive about the behaviour of other users in a closed and confined space:

'I feel nervous when arguments break out. You need more security in case of trouble.'

Perceived safety was also associated with the size of group and confidence in the workers who would be facilitating the group. Participants felt there was need for a high staff:user ratio, so that they would feel comfortable and safe, and to have sufficient one-to-one time (some said it was difficult to get involved in large groups). In relation to the complex needs of many homeless people, participants emphasised the importance of staff being able to manage difficult behaviour, to 'keep control' of the group or to 'keep everyone in order'. For these reasons, some older people emphasised that groups needed to be small. For example, when asked about the desirable size of a group, typical comments were:

'Up to six. That's more than enough to cope with their problems.'

'It needs to be small, to able to cope with and manage the group.'

Size of groups

'I don't like crowds.'

Size of group was important and in some cases determined whether older people would consider joining a group activity. Some participants preferred larger groups but those who found it difficult to join new groups and who lacked confidence or had difficulty mixing with people, emphasised that groups needed to be small. This was particularly so for older women, who often found the idea of a group situation intimidating, especially in the typically male-dominated environment of homelessness facilities.

The same may be true for many socially isolated older people in the general population, who can sometimes feel vulnerable in a large group of people. Cattan (2002) explains that many older people prefer to meet in small groups where they can feel safe and comfortable:

Older people said attending a group for the first time can feel both frightening and intimidating. Having someone familiar to escort and introduce them to the group the first time helps to overcome some of the initial worry. Some older people are reluctant to join activities even though they feel lonely because they have lost the confidence to go out and find socialising difficult. (Cattan, 2002)

Building trust and having someone to go with

Some participants felt happy going along to a group alone, but many found the idea daunting. It was important for potential group participants to know someone else who would be going. Older people said that getting to know another group member beforehand would encourage them to go along. Participants also emphasised the importance of building a relationship of trust with the group facilitator prior to the start of a group.

'To know the people – facilitators and group members beforehand. I'd need to know I could trust the people who ran the group.'

Services might choose to consider the potential of peer support for older people in attending groups and activities.

Matching group members

'It depends on people in the group.'

Some participants felt it was important to match group members by ability, previous experience of an activity and, crucially, by their expectations – whether it would be a quiet, structured discussion group or more lively and informal, to use one example cited by a few participants. This was why some were not interested in participating in activities at day centres and why others had stopped attending.

Participants emphasised, however, the importance of not excluding anyone from a group activity. They valued the principle of equal opportunity, considering it important to include all people in activities, irrespective of their characteristics, needs or background, their lifestyles or their 'dishevelled' (as one man described it) appearance. In particular, it was stressed that heavy drinkers should not be excluded from an activity, so long as ground rules were acknowledged (such as not drinking during an activity).

People have diverse backgrounds, needs, aspirations, expectations and capabilities. Older people made it clear that a 'one size fits all' service response is inappropriate. Of course, it would be unrealistic to expect any single day centre to provide for the diverse needs and expectations of each individual service user. This calls for a more flexible and individually-tailored approach to enable older people to access activities of their choice and to support older people to access activities available within the wider community.

Age-specific service provision: the views of older people

It is widely believed that older peers are vitally important in the ageing process. Older people may have much to gain from socialising with members of the same cohort:

Members of the same cohort have much in common. They provide continuity with the past, and socialisation to a variety of roles at a time of life when normative prescriptions are vague, social supports have been withdrawn, and cultural stereotypes are negative. Peer-grouping may be a product of identification with elderly peers and voluntary association with them. Belonging to the same cohort, they have similar values based on common life experiences, and at the psycho-social level, friends provide confirmation of existence as a person worth knowing. (Jerrome, 1993)

It is noted, however, that the tendency for some older people to associate primarily with other older people may not always be from choice:

It is sometimes a product of necessity rather than choice, in the face of abandonment by younger people. (Jerrome, 1993)

A study of the activity patterns of American older adults revealed that only a small proportion of older people choose to use age-segregated centres:

One thing that is evident is that age-designated and age-segregated activities take a relatively small place in the overall life patterns of most older adults. In the 1984 National Health interviews, less than 10% of those aged 60 and over were found to participate regularly in senior centers. (Kelly, 1993).

Conversely, when an older person enters the world of homelessness provision, that individual often has no choice but to mix with people of all ages and (within the context of meaningful occupation provision) sometimes predominantly with much younger people. Activities provided by homelessness organisations may be dominated by younger users (sometimes reflecting the nature of activities which tend to be vocational in their objectives). Consequently, older people may be denied the potential benefits derived from peer group identification.

Participants were asked what they thought of the idea of having groups and activities for people aged 50 and over. The researcher used the term '50 and over' (rather than 'older people'), which may have influenced the terms of reference to the age group used by participants.

Views were mixed, varying according to age and gender. Women often preferred age-specific provision, while men were more divided. Among those in their fifties and sixties, some said they would like to have group activities for their age group, although others preferred all-age activities. Participants aged 70 and over generally preferred age-specific provision, although their reasons for this (as with women and participants of all ages) were not always age-related, but influenced by the behaviour of other users. While valuing the opportunity to spend time with people of a similar age, they generally did not want to be segregated by age. They valued the company of people from all age groups.

Common ground

Some participants said they had more in common with people of a similar age, with shared experiences and common ground. They said they could relate better to people of a similar age and sometimes felt that they had little in common with young people, who had different interests.

'Young people have different interests – I find young people don't have manners today.'

'Everybody needs help at some point but if they had a place just for the over-50s everyone would be on the same wavelength. You can talk to people. In all ages they wouldn't know what you're talking about. You can talk to people of a similar age – they understand what you're saying.'

There was a sense of group solidarity and shared identification with older peers:

'The over-50s, of course we're not similar in all respects, but physically, we're on the same wavelength.'

'It concentrates the mind more, and make friends, being more compatible, not being left out. Alienation, I think that's the word.'

Many older people expressed a desire for age-specific activities, which would provide an opportunity to develop social relationships with older peers.

Another reason for saying they wanted age-specific activities was, among men, to meet women. Some said they wanted the potential to meet a partner and a number of men participants said they preferred the atmosphere of a mixed group to the typically male-dominated environment of homelessness services.

The desire for age-specific groups was sometimes with reference to a perceived lack of activities relevant to older people, as indicated by the following comment:

'It's very good it's aimed just for that age group. There is a lot for the under-50s but not much for the rest.'

One man, a shelter resident who had been homeless for over 20 years, explained:

'It would be good to get together with people of your own age group or bracket... There are a lot of day centres for people in their 30s, but there's not much for the rest. I go out on my own to day centres, but they're all age groups... Some day centres do things for "50-plus" once a week. They're all right, for one day a week. It would be nice if you could meet up with people on a regular basis, not just once a week. It would be good to get with your own age group.'

He also said, significantly, that this expressed preference for being with people of a similar age was related to the exclusion associated with being homeless, as well as the inactivity characteristic of some day centres:

'It would be nice to have somewhere to go during the day...a community centre that deals with 50-plus – not homeless, for anyone really, for 50-plus, unemployed, retired, semi-retired... It'd be nice if the 50-

plus people had a place where they could go every day, do something constructive or sit down and talk. Anything – I don't mind helping in anything. A lot of day centres, people sit around doing nothing.'

Two of the agencies involved in the research developed group activities for older people. Some participants who had attended these groups valued having time with others of a similar age and they had made friends. One participant commented:

'I think it's good like that – just for over-50s. It's very interesting like that. Younger people have different interests. Quite a lot of people enjoy it as it is.'

However, the reason for choosing to join age-specific activities was, for some people, because this gave them some extra time at a day centre, when these sessions took place outside normal day-centre opening times, at which time they would otherwise have to leave. For example, one man, in his mid-fifties, explained why he attended a group for the over-fifties:

'Because you get thrown out too soon if you don't. There has to be a cut-off point, I suppose.'

He indicated that using age-segregated provision can be perceived as stigmatising or segregating:

'Everyone immediately knows your age if you stay behind for the group.'

This was a common theme in interviews with participants aged in their fifties and early sixties. While participants referred to the effects of homelessness and use of alcohol on ageing, they sometimes did not want to be seen to be using services for older people, irrespective of personal preferences. This was sometimes felt to be stigmatising, perhaps associated with negative stereotypes of old age inherent in our society.

'Not age but behaviour'

Participants often reported feeling uncomfortable in the sometimes intimidating environment of homelessness day centres because of the use of drugs, drinking, the noise and the occasional incidents of aggressive behaviour. Young users can take advantage of older people, for example by repeated requests for money or cigarettes. As has been found in other research (Crane and Warnes, 2001b), some older people felt intimidated by younger users and this was especially true for older women.

Participants perceived age-specific schemes to be quieter and safer. Some preferred age-specific groups as they felt that young people might disrupt group activity:

'If you have young people in they can be disruptive for the group.'

'I think it's a good idea because younger people, they have too much energy, they spoil it for the over-50s, younger people drinking and taking drugs.'

Another man, talking about a day centre he used, said:

'No complaint. Not for me to judge. I do agree with one thing, though – with no young people coming in. They take drugs. Yes, definitely, because I don't take drugs. I'm non-violent.'

As indicated by these comments, reasons given by older people for preferring age-specific services often related to the behaviour of other users, especially where substance misuse and drinking was an issue, rather than age per se. It was pointed out that behaviour was not necessarily age-related and that older people (themselves included) could sometimes be disruptive too. One man commented:

'There was one fight here, but that was a man in his 70s. He went for a man much younger.'

There was an inference that the issue was about maturity rather than age as such, as the following comment illustrates:

'I think everyone, whether it's male or female, in their youthful years are boisterous, and do things they know they shouldn't do People over 50 are generally more relaxed, younger people a bit more exuberant. People drinking can be a bit of a problem. You don't want too many people, of any age. It gets out of hand – drinking etc. When you get over 50 you get a bit more reflective, I'm now 56, [and] discuss things in a more mature way. It's not a question of age so much as maturity.'

People being under the influence of alcohol at day centres was a problem to participants, including those who were themselves heavy drinkers. Many felt people should not drink during a group activity or at a day centre or be allowed into a facility if they were intoxicated. This was felt to be disrespectful to other people and because they made an effort not to drink while they attended a day centre, they felt others should do so too. One man, interviewed at a day centre, explained:

'I don't think they should be allowed in under the influence. I drink but I don't come here when I've been drinking.'

Another man, talking about a day centre he used, commented that:

'I enjoy it most times as a place to come for a coffee and relax. They should make rules more stringent that people should not be permitted under heavy influence of drink or drugs to enter the centre as it disrupts the good atmosphere.'

This view applied whatever the age of service users. For example, another man, talking about a group for the over-fifties he had attended, noted that:

'I would have preferred the group to be a sober group because they caused too many interruptions.'

Participants generally felt strict ground rules about drinking were needed at day centres and in group activities and these should be abided by and enforced by workers. Some felt that such rules were sometimes ignored (or behaviour went unnoticed) by staff. Having rules and clear boundaries and confidence in staff to keep them helped people feel safer.

It seems conceivable that other groups of people may feel equally vulnerable using homelessness services and not only older people – women, for example, and people from black ethnic minority groups, who may feel intimidated by using services dominated by white men. An evaluation of two projects providing group activities for older homeless people found that these activities appealed to service users of all ages, for similar reasons (Willcock, forthcoming). Workers reported that a number of people aged in their thirties and forties had approached them asking if they could join these groups, which they perceived to be quieter and safer. They too lacked confidence and found the idea of joining a new activity daunting.

Participants wanted a quieter environment, without drinking, without drugs and without intimidation: they wanted to feel safe. This does not necessarily indicate a preference for age-segregated service provision but, rather, indicates the need for an alternative to the sometimes intimidating environment of homelessness day centres.

'Age makes no difference'

Some older people said they would not want to use age-specific provision because this would exclude their peers. One man, for example, had a friend in his early forties. He said he would not want to join a group for the over-fifties because his friend would not be able to join.

Older people can be indirectly discriminated against owing to the content of activities provided by homelessness

services, which may sometimes appeal more to younger people, and because of the inaccessibility of some venues to people with disabilities. However, some participants expressed clear views that they felt it was wrong to discriminate on the grounds of (younger) age.

'Groups should be open to younger people, to give them a chance.'

Many participants felt group activities should be open to people of all ages. Typical comments were:

'Don't mind. Age doesn't matter. Any age could enjoy music and a dance or play darts.'

'Groups should be open to younger people. It doesn't matter.'

Some pointed out that much homelessness provision focused on very young people and there were few services for middle-aged or older people. Sometimes people referred back to their own situations when they were younger and the perceived lack of opportunities that were open to them in middle life:

'There was nothing for me until I reached the age of 50. You get kicked out at 49, although we're all in the same boat.'

While many participants expressed a desire to engage in age-specific activities, which would provide an opportunity to develop social relationships with their peers, they generally did not express a preference for age-segregated provision. They valued spending time with younger and older people too. Such views were informed by the perceived benefits of inter-generational sharing of knowledge and experience:

'Older people can learn from younger people and vice versa.'

'To increase experience from other people... It gives you fresh ideas.'

'To pass our experiences on...'

A man in his mid-fifties commented on a group he had attended:

'Age makes no difference. There was a man in his 70s in our group, and he was just as good as the rest of us.'

Without opportunities to meet others of a similar age and without the availability of age-specific group activities, older people may be denied the solidarity and support they could gain from association with older peers. However, age-segregated provision may deny them the value they perceive from inter-generational contact and could in itself create a new source of social isolation and exclusion.

8 Involving older people in finding solutions

The Rough Sleepers' Unit (RSU) emphasised the importance of involving homeless people in delivering services and it was asserted by the Department for Transport, Local Government and the Regions (DTLR) that the views of homeless people would be vital in determining any future strategy:

The RSU is encouraging all agencies not only to consult fully with their clients, but to develop user-led groups who play a full role in running services. Homeless people are part of the solution, not the problem. Where they have helped themselves to move away from the streets and to support others in doing so, much success has been achieved. The RSU developed the strategy 'Coming in from the Cold' using the views and experiences of rough sleepers. They have formed a part of its ongoing work and will be vital in determining any future strategy. (DTLR, 2001)

All agencies participating in this research had some kind of strategy in place for consulting with users, including user forums, residents' meetings or user satisfaction surveys. Some of the older people interviewed for the research reported having been involved in their care plan, needs assessment or resettlement planning. However, very few participants reported having been involved at a wider level, such as in planning, developing or evaluating services. Two participants reported that they had been involved in user forums or meetings, but in both cases had discontinued attendance as they felt their involvement had made little difference. However, at least three organisations held regular (usually annual) user surveys and the researcher is aware of instances where changes in practice were made in response to feedback from users. Older people who had participated in these surveys were sometimes unaware of the impact of their contributions and felt they had not been listened to. This indicates how action taken in response to feedback from users may not always be communicated to users.

The reality of involvement

An evaluation of the Partnership Programme between Help the Aged, hact and Crisis (which included 17 projects for older homeless people) found the level of user involvement to be limited. Most projects did not have direct user input into planning or running the project (Pannell et al, 2002). The authors acknowledge the complex needs of this group that, they suggest, may place limits on their level of participation:

It was widely acknowledged [by project staff] that the complex issues facing many older homeless people including their lack of confidence, value and self-esteem, prevented involvement except at very basic levels Older homeless people constitute a disenfranchised, vulnerable user group not used to voicing their opinions or having their voices heard, and for whom priorities are about very basic strategies of survival, and 'recovery'. (Pannell et al, 2002)

The authors suggest this indicates the need for a flexible interpretation of what constitutes user involvement, allowing for users' own concepts of participation, and that less obvious, sometimes very small, examples of user involvement may therefore be significant.

As suggested by Pannell et al (2002), traditional methods of user participation may not be appropriate with vulnerable groups of users, who may not feel comfortable attending formal meetings and user forums. Older homeless people are not used to being asked their views or giving their opinions or participating in formal group discussions. It is likely that few older people participate in such initiatives set up by homelessness

organisations, which may be dominated by younger people who are more assertive in stating their needs. Unless services are targeted at involving older people, the older users may not have the opportunity to have their voices heard.

To ensure that strategies for user involvement are accessible to 'hard to reach' groups of users, these need to be built around the needs and characteristics of the group, rather than expecting users to fit into pre-existing or 'traditional' mechanisms which they might feel uncomfortable with. With some vulnerable older people, a one-to-one approach to consultation may be more effective. Alternatively, informal group discussions could be held in an environment they feel comfortable with. In this way, users' views can influence project planning and development in a less direct way, provided there is adequate allocation of time and resources to follow this through meaningfully and for effective communication with users throughout the process. Pannell et al (2002) suggest that national funders wishing to support initiatives for user participation need to set realistic targets as well as make appropriate funding available.

Research into action

The research discussed in this report was part of an action research project, which involved developing services in response to feedback from older people (from a user-centred evaluation of services, and incorporating the emerging themes from the exploratory study) and monitoring the effect of action taken. The work developed a model of involving older people in evaluating services and using research to inform practice. Action and research ran concurrently. The findings from the research were fed back into practice. Project staff and managers were involved throughout the research process and in discussing findings and their implications for practice.

Action was planned and taken by project workers and managers, which included making changes in practice and, in some cases, planning and developing new projects.

There are numerous examples of how feedback from older people directly influenced service development, including:

- developing day centre activities, setting up new groups and organising outings;
- developing a home visitation scheme, by recruiting volunteers to provide one-to-one befriending support to resettled older people, to reduce isolation, increase telephone contact and enable a faster response to problems;
- recruiting a volunteer at a day centre to provide one-to-one listening and informal support and advocacy for older users;
- developing a simple needs assessment and action plan to engender a more proactive approach to working and to involve older people in defining needs;
- building on existing partnerships between agencies to enable older people to access alcohol and counselling services;
- improving information systems; and
- developing user consultation more widely within services.

The research informed the development of two new projects for homeless and ex-homeless older people in London. These projects aim to address some of the gaps identified by the older people who participated in this research, in relation to isolation and loneliness, psychological well-being and meaningful activity.

Older Persons' Emotional Well-Being Project, City and Hackney Alcohol Service

A high proportion of participants reported problems with alcohol misuse and depression. The research found that, while many older people had accessed support with practical issues, a high proportion had not accessed support with emotional needs. Interventions suggested by participants included:

- counselling;
- one-to-one emotional support;
- advice and information about mental health and alcohol issues;
- complementary therapies; and
- a range of therapeutic group interventions, including alcohol support groups, anxiety management and skill-based groups.

Help the Aged approached the City and Hackney Alcohol Service (CHAS) to discuss the research findings. CHAS provides a range of alcohol services to people living in East London, including counselling, therapeutic group work, complementary therapies and adult education.

In response to the research and the perceived needs of older people, CHAS set up a specialist project for older people, with funding from Help the Aged and the King's Fund. The project targets socially isolated older people with histories of homelessness or housing-related problems. The aims of the project are to:

- support older people to reduce alcohol intake;
- improve depression;
- build confidence and skills; and
- reduce social isolation.

The older persons' project employs a full-time specialist worker, who has developed a programme of therapeutic work with older people. The worker has found that many clients engaging with the project are not ready for formal counselling and so provides informal counselling and emotional support to older clients, usually once a week over a six-week period, although this can be extended where appropriate. After engaging in informal counselling or group work, a number of older clients have been referred to formal counselling with other CHAS counsellors.

The worker has developed a group-work programme with a co-worker from CHAS. Groups have been developed in response to the perceived needs of older users, gauged from user surveys and informal feedback from older people. The specialist worker facilitates a weekly relaxation and support group (using relaxation techniques and sometimes cognitive-behavioural approaches). Other occasional sessions are planned according to client demand, which might include health promotion activities or skill-based groups. The project provides access to other in-house or satellite services, including complementary therapies and adult education services, and referrals to other support agencies.

The relaxation and support groups appear to have worked well with older clients. The groups provide a context within which clients feel they can share their experiences and concerns with others in the group. Complementary therapies have proved to be popular among older people, many of whom have been referred to the acupuncture service to help with alcohol withdrawal symptoms and to reduce anxiety. A number of older people have been referred to homeopathy and shiatsu services available on-site. After engaging in one-to-one support or therapeutic group work, some older clients have been referred to the meaningful occupation project for older people being run by St Botolph's Project (see below).

Live Choices, St Botolph's Project

Lack of meaningful activity was a common theme in interviews with older people. Participants wanted opportunities to engage in meaningful activities, where they can share their experiences and skills, build confidence and learn new skills, develop social networks outside homelessness provision and explore opportunities for meaningful occupation available in the community. In consultation with older people and a number of homelessness and other support agencies in London, Help the Aged drafted a project specification and invited bids for a meaningful occupation project.

Sbp (St Botolph's Project) was successful in its tender and launched an older persons' meaningful occupation project in July 2002, with funding for three years by Help the Aged and Zurich Financial Services Community Trust. The project targets older people who have experienced homelessness and who are socially isolated. The project aims to:

- provide basic skills training to older people;
- provide opportunities for social contact within the local community; and
- help older people who have experienced homelessness to build confidence and skills to enable them to access resources and services in the wider community.

The project provides information about opportunities for meaningful activity, supports older people to access a wide range of activities in a variety of settings and helps older people to build links with the local community. Activities are being developed according to the perceived needs of older users and may include leisure, social, therapeutic and educational activities and volunteering opportunities.

The project is staffed by a full-time co-ordinator with the support of co-workers and volunteers. The project recruits older people to the project through outreach work and self-referrals and also takes referrals from other agencies. The co-ordinator supports older people to access activities of their choice and maintains contact with users, typically on a monthly basis, to support their continued engagement in activities. It is planned to recruit volunteers to provide sustained support to older people in the longer term, once they have become more settled.

Working closely with other organisations, the co-ordinator facilitates small group activities to engage with potential users and to build confidence to enable people to move on to activities in the community. This includes work with older people with long histories of rough sleeping or institutional living and long-stay hostel residents. The co-ordinator also arranges regular social trips for older people, including to the cinema, and occasional day trips out of London, which provide an informal and non-threatening context within which older people can engage in the project.

A key aspect of the project is partnership working. The co-ordinator is developing opportunities for co-working with a number of local organisations, to promote the project to vulnerable groups of older people and make facilities more accessible to the target group, and to develop new activities where gaps are identified.

The project co-ordinator is committed to involving older people in developing the project so that the service is responsive to the needs of users. Older people have been actively involved in promoting the project, for example by producing a regular newsletter, to try to engage with the most severely isolated older people.

An evaluation of these two projects is currently being undertaken and will focus on the views of older users on the beneficial effects of different activities and other interventions. The research will explore the potential benefits of activity for the rehabilitation and resettlement of older homeless people.

The challenge of involving older homeless people

Reflecting on the experiences of the action research, it cannot be denied that involving older homeless people can provide a challenge. A high proportion of participants had long histories of rough sleeping or institutional life. Participants were sometimes alienated and distrustful and had often refused offers of support or assistance. Participants had enduring and complex needs. Many experienced mental health problems and often had not received specialist support with these difficulties and a high proportion of participants were heavy drinkers or binge drinkers. Participants were vulnerable because of poor health, experiences of unresolved trauma and psychological distress. Some were confused and many had poor memory. Their lives were often 'chaotic', perhaps exacerbated by the lack of structure and routine and as a consequence they sometimes had limited concept of time. Participants had poor confidence and many were demoralised, depressed and withdrawn.

A particular challenge was their transience. Some moved between hostels and the street (and between various day centres), sometimes staying for only a few days and sometimes disappearing for weeks or months before returning. However, many of these participants returned repeatedly to one agency and so it often proved possible to include them.

Despite these difficulties, older people were keen on the whole to participate in interviews and small group discussions and to have the opportunity to give their opinions. Interest in participation grew over time. Indeed, a number of older people approached agency staff or the researcher, volunteering to participate. Project workers from three different agencies expressed surprise, because some older people who participated in the research (including those who volunteered themselves) were people they did not think would be likely to. These included older people who had not previously engaged with workers, those who did not normally get involved in activities or those who had formerly refused offers of help. Some participants took part in one interview or group discussion, although the majority participated in three of four (using a combination of in-depth interviews and semi-structured questionnaires).

Being asked to participate in research of this kind perhaps denoted a slightly more equal partnership with workers and gave them the opportunity to 'give something back'. Older people said that they thought it was important for them to take part in the research, sometimes because they felt this would be helpful to workers, who they felt might be able to use the information they contributed to improve 'their' services. They were also aware that it was about the views of users and they wanted to have their say. Older people valued the opportunity to talk about issues important to them in one-to-one interviews and the exchange of opinion and sharing of experiences within a group.

As might be expected, it proved more difficult to involve older people who had not engaged with services at any level or who were particularly hostile or distrustful, reflecting the difficulties of working with this group generally. One man, for instance, who had slept rough for many years and had recently entered a

hostel, was hostile and often became verbally abusive and on occasion aggressive when approached by staff. He had always refused to disclose any information about himself. A hostel worker approached him and tentatively outlined the purpose of the research, explaining that it was about the views of residents on their needs and service provision. In response, this man reported that he thought it sounded interesting and he sat down and talked about himself for an hour. The project worker explained that this was the first time he had 'opened up'.

One agency involved in the research targets older people with complex and challenging needs, and difficulties were encountered engaging with older people at this project. There were a number of reasons for these difficulties. The main issue was their transience: some stayed at the project for only a few days at a time and sometimes did not engage with staff. Some were particularly alienated from services and a fairly high proportion (35 per cent) displayed challenging and sometimes violent behaviour. There were very high rates of heavy drinking (73 per cent), often with co-existing mental health difficulties. A number of older people at the project were rarely sober and were often incoherent, which posed a particular challenge to consultation with this group. Yet, despite these difficulties, a number of older people at this project were keen to participate. Ten older people actively engaged in the research, participating in a number of interviews, in some cases over two or three years.

The meaning of participation: the views of older people

In interviews and group discussions, participants were asked about their views on user involvement and consultation. We might expect that, given the day-to-day difficulties and complex issues many older homeless people face, participants might have expressed a degree of indifference or disenchantment with the concept of user participation. However, the older people interviewed for this research expressed very clear views about why they felt it was important for them to be consulted by service providers. This does, of course, reflect the views of those who participated in the research and does not include the views of those who did not.

Some participants wanted to be involved in service delivery, including at day centres (preparing and serving lunch or helping staff with practical tasks). A number of participants said they wanted to be involved in planning activities and developing new projects. A small number of older people became involved in planning a new project that arose from the research (as members of a steering group) and one man facilitated a group discussion with older users for this purpose. A few older people participated in a workshop at a seminar about user involvement. These were all older people with long histories of homelessness who were now resettled.

Many others, on the other hand, did not want to be directly involved in planning or delivering services or indeed to be involved in the research process, for example as interviewers. They did, however, want to be involved less directly in planning and developing services – through their involvement in evaluating services and finding solutions.

Although the question about user involvement was an abstract one, comments made by older people often related to their experience of being involved in interviews and small group discussions for the research, as might be expected.

'No, not in previous day centres or here, didn't ask me about my views, not before this. It's a good idea, to get different viewpoints, different opinions from different people. Some are quite interesting.'

Older people felt it was important to build a broader perspective of issues affecting services and the people who use them, so that services would be more appropriate to their needs.

'To get different people's opinions about it, to get a broader perspective of things.'

'It's what people want – more geared towards their needs.'

'The knowledge shared is more appropriate.'

Being involved in planning and developing services may encourage greater independence and enable older people to exercise greater control over their lives.

'People can speak their own minds.'

'We get to decide issues.'

'Responsibility.'

By participating in group discussions about service provision, older people said they had learnt from listening to others' views. They valued the opportunity to share experiences and felt they had gained a better understanding of other people from the exchange of opinions within a group.

'Understanding what other people want, of what is important to other users and to try and help others.'

'Listening to others and helping each other.'

Their involvement in the research was perceived as important for providing the opportunity to improve services and potentially to guide the planning and development of new ones. It was noted that it was important to be proactive and to consult widely, for services to take on board a wide range of views, so that everyone affected had the opportunity to have their say. One man commented:

'You need to ask all people and put what they say together It's no good if it's just one or two, it has to be what the majority think.'

It is important to consider the kinds of interventions that older people find helpful, so that services can be tailored to their individual needs. One man explained the potential value to service providers of consulting service users and, with a clear message to the Charity undertaking the research, he observed:

'I think it's a good idea. I firmly approve of it, listening to other people's views. It could help improve services and possibly some new projects in the future. And it's important to Help the Aged too, so they know where to put the money.'

A 64-year-old man, sleeping rough for 21 years, explained how he perceived the purpose of the research:

'I haven't been involved in anything like this before, not before this. It's important. It's very, very helpful. Many people don't know how helpful it is, but it is. If we tell you what we think, you can tell them, and then they might improve their services. Well, they might not. But they might.'

9 Conclusion

The older people interviewed for this research had complex needs and multiple disabilities, but with appropriate support they often adapted to a more settled life. Many older people, where they had continued support, had settled in their accommodation and they compared their current situation favourably to their former homeless life. Others, however, repeatedly returned to the homeless lifestyle after moving into permanent housing.

The majority of participants wanted to be resettled, but they experienced obstacles and difficulties along the way. For them, homelessness was not some kind of 'alternative lifestyle' choice and, despite their experiences and the repeated knock-backs encountered in their journeys out of homelessness, they displayed extraordinary resilience, independence and determination.

Many of the difficulties experienced by participants seemed to stem from experiences earlier in life, prior to becoming homeless. This study supports the findings of other recent research (Pannell et al, 2002), which similarly found that homelessness was often preceded by a traumatic event or a succession of stressful events. For some people such an event directly preceded homelessness, while for others homelessness occurred some time after these events. The authors conclude that:

Contrary to the popular image of the older homeless person as the archetypal 'tramp' figure who 'chooses' the lifestyle there are complex reasons for homelessness amongst older people. It also shows how even people who have been securely housed can, in some circumstances, fall into homelessness. (Pannell et al, 2002)

Crane and Warnes (2001b) challenge the influential school of thought that attributes homelessness primarily to shortages of affordable rented housing, unemployment and poverty. They suggest that these factors had little influence on the entry into homelessness for most of the older people interviewed for their research for whom the reasons for becoming homeless were 'predominantly associated with a destructive combination of long-term personal difficulties and negative and stressful life events'. Crane and Warnes draw an important distinction between the problems of 'housing stress', in which economic and income factors play a large part, from those of 'volitional housing abandonment', in which, they argue, personal and psychosocial factors have the dominant role (Crane and Warnes, 2001b).

Loneliness may be traced to experiences throughout the life course. For some older people, isolation and loneliness may be linked to recent states and events, while for others the causes of loneliness may be rooted in early life experiences that accompanied them into later life. Participants had experienced multiple losses and sometimes deeply traumatising experiences in childhood and adulthood. Many had experienced broken and disturbed childhoods and had early experiences of loss and abuse. These experiences may influence how an individual responds to experiences of loss and trauma in adulthood and can adversely affect a person's ability to form trusting relationships with others later in life.

Many participants had spent much of their lives living in institutions. Some had become institutionalised at an early age, sometimes in childhood, and had spent many years living in psychiatric or learning disability hospitals. Others had lived in other forms of institutions, including residential care homes, the armed forces and prisons. Many had subsequently become institutionalised into homelessness or hostel life. As might be anticipated, they experienced difficulties coping with life after homelessness: they had lost, or had not had the opportunity to fully develop, the skills necessary to enable them to

rebuild their lives. Some older homeless people may need intensive rehabilitative work, to develop the skills and confidence to enable them to build social networks outside the homeless life.

For many older people who are isolated, supporting them in developing social networks may be effective at reducing their isolation and loneliness. However, for those with experiences of prolonged and severe isolation, who are depressed, demoralised, who have alcohol problems, or where lost skills prevent them from forming close relationships, increasing their level of contact with other people may do little to alleviate their loneliness. In fact, in some cases increasing social contacts may even intensify feelings of loneliness. According to Larson, 'there is considerable evidence that higher amounts of social interaction in later life are not associated with subjective well-being' (Larson, 1978) and have even been shown to be negatively related in some cases (Freysinger, 1993; Longino and Kart, 1982). The quality of interaction and the intensity of commitment, on the other hand, are related (Larson et al, 1985; Ray and Heppe, 1986).

If people do not engage meaningfully with those with whom they are in contact, being with people may be a more lonely experience than being alone. The environment of homelessness facilities, where older people may feel intimidated, might in some instances exacerbate feelings of loneliness, as loneliness 'can be promoted not only by a deficit of desirable social resources, but also through over-exposure to undesirable social experiences' (Murphy and Kupshik, 1992).

Many participants reported being lonely although they did not always appear to be isolated. Woods advises that day centres are often seen as the 'solution' to social isolation in the older person vulnerable to depression, but 'may not provide the type of relationship which would make a difference to a person's mood or feelings of loneliness'. For some, he suggests, it is 'only relationships with close family or valued friends which will meet the need for social support' (Woods, 1999).

Older people in this research emphasised the need for the development of interventions conducive to the development of social relationships and to tackle the barriers to alleviating loneliness, including lost social skills, depression and anxiety and the underlying issues associated with their use of alcohol.

It is important to involve older people in finding solutions, so that services are tailored to their individual needs. The research explored older people's perceptions of their circumstances and needs and aimed to identify the kinds of interventions perceived as appropriate and acceptable to older people.

Participants' aims were to:

- reduce social isolation and expand social networks outside of homelessness provision;
- alleviate loneliness and form social relationships;
- develop interpersonal, relationship and social skills;
- improve mental health and psychological well-being (and especially to reduce anxiety and depression);
- build confidence and improve self-esteem;
- reduce alcohol intake and increase control over drinking;
- learn new skills and re-learn forgotten ones; and
- increase activity levels and engage in purposeful activity.

Interventions and activities valued by older people included:

- one-to-one informal support;
- individual counselling;
- group counselling and peer support groups;
- anxiety management and skill-based groups;
- complementary therapies; and
- social, leisure and educational activities and volunteering opportunities.

It is widely believed that regular engagement in activity is vital for quality of life and for the health and well-being of older people. Careful consideration needs to be given to the kind of activity that is beneficial in later life. Meaningful activities do far more than alleviate boredom: they give purpose to life. Older people said they wanted activities that provide opportunities for them to share their knowledge, experiences and skills with others. They wanted to feel valued and useful.

Participants indicated a need for a greater choice of activities appropriate to their needs and identified a wide range of activities they thought would benefit them. The kinds of activities valued by older people were those that would encourage the sharing of skills and promote the acquisition of self-help strategies. While some preferred informal, solitary or one-to-one activities, the focus by participants was on group approaches, often with reference to the perceived benefits of groups in terms of providing opportunities for mutual support, skill-building and the development of friendships within the group.

There is a need for regular activities to be organised at hostels to build confidence and increase motivation, to develop skills and to help people to cut down on their drinking. Participants wanted to access activities and facilities in the wider community, outside homelessness provision, but they lacked confidence to go alone and were often unaware of the options open to them. Some older homeless people may need a lot of encouragement and continued support to engage in activities. As part of resettlement, homelessness organisations (in collaboration with other agencies) need to support older people in engaging in group activities and accessing community facilities, developing interests and finding activities that older people can undertake alone.

Isolation and loneliness were common among resettled older people. This was related to the immediate and complete loss of social and support networks associated with leaving the institution of homelessness:

It is the nature of many institutions that the break from them is immediate and further contact impossible. At worst this can mean simultaneously losing accommodation, a daily structure, friends, support networks and a sense of belonging – and with no way of replacing any element of this. (O'Leary, 1997)

After being rehoused, the consequence of loneliness is, for some older people, to return to the homeless lifestyle. Strategies for preventing social isolation and for alleviating loneliness need to be in place prior to resettlement and incorporated into resettlement plans, to break the cycle between loneliness and homelessness.

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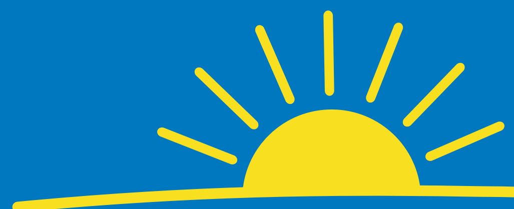

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