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Literature Review: Housing Options for Older Homeless People

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"Homelessness in late life: growing old on the streets, in shelters and long-term care" (project no 435-2012-1197)

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1.0 Introduction and Overview

Older adults are an important subset of Canada's homeless population and their numbers are projected to increase as baby boomers age (Cohen, 1999; Crane & Warnes, 2001; Hecht & Coyle, 2001; McDonald, Donahue, Janes & Cleghorn, 2006). Research indicates that homeless seniors have significant unmet needs and that it is necessary to provide them with stable, permanent housing. Developing and implementing effective housing programs and supports, however, is challenging because little is known about older adults' pathways through homelessness (Crane & Warnes, 2007).

This report reviews the literature on housing and re-housing options for homeless older adults. The first section explains the key terms relevant to this topic. The second section summarizes the types of housing available for precariously housed older adults in Canada. These include alternative and affordable housing, emergency shelters, and residential or long-term care. The third section describes best practices for re-housing older adults, including rapid re-housing, a range of service and support options, client-centred approaches, strong social support networks, and age-appropriate and affordable accommodations. The final section discusses the shift toward 'housing first' models in Canadian and international housing policy and reviews case studies of housing initiatives that target Canada's hard-to-house population.

Methodology

The primary goal of this project was to identify the housing options, barriers, and best practices for housing older homeless adults. A precursory scan of the literature was conducted to find relevant literature reviews on this topic. Key articles from these reviews were identified and incorporated into the final report. From here, additional articles were identified through the AgeLine database (1978 – 2004) and Google Scholar, using a combination of the following keywords: 'elder', 'elderly', 'precariously housed', 'homeless', 'older adult', 'housing', 'housing options', 'support', 'shelter', and 'Canada'. Because many of these articles were largely irrelevant to the topic (i.e., broad in scope and/or demographics), only those that specifically addressed older adults, housing, and homelessness were included in the final report. This report also drew on grey literature, which was found using Google and the same keywords listed above.

2.0 Terminology and Definitions

Understanding Elderly Homelessness

'Homelessness' and 'old age' are both ambiguous terms. It is necessary to clarify their meaning before discussing the housing options available for this population. The Canadian Homelessness Research Network (2012) provides a comprehensive definition of homelessness, defining it as "the situation of an individual or family without stable, permanent, appropriate housing, or the immediate prospect, means and ability or acquiring it" (1). The term homelessness refers to those who are visibly displaced as well as those whose housing is insecure or who are at risk of becoming homeless. Other researchers use the term homeless in a narrower, more literal sense, referring to those who live in temporary shelters or on the streets. These individuals are referred to as "rough sleepers." This report employs the broader definition, but reviews research that uses both narrow and broad understandings of homelessness.

The experience of homelessness challenges mainstream definitions of aging (Crane & Warnes, 2001; Gonyea, Mills-Dick, & Bachman, 2010). In North America, old age typically refers to people who are over 65. Older homeless adults, though, tend to exhibit characteristics that are more consistent with persons in the non-homeless population who are ten to twenty years older than them (Cohen, 1999; Frankish, Hwang, & Quantz, 2005; Hibbs et al., 1994; Hwang et al. 1998; McDonald et al., 2006; Morrison, 2009). The poor conditions experienced by those living on streets or in precarious situations exacerbate existing health problems, and older homeless adults are more likely to suffer from preventable diseases (Frankish et al., 2005; Hwang, 2001). Researchers tend to define "older" homeless persons as those who are over 50 (Crane & Warnes, 2001; Gonyea et al., 2010).

Research often distinguishes between two groups of older homeless people: the 'recent' and 'chronically' homeless. Recently homeless people are those who have access to permanent housing throughout their lives, and then become homeless for the first time in later life (Dennis, McCallion, & Ferretti, 2012; McDonald et al., 2006)**.** The chronically homeless consists of older adults who are homeless in their youth and/or adulthood and continue to experience homelessness in later life (Caton et al., 2005). The needs of recent and chronically homeless older adults can differ dramatically (Caton et al., 2005; Crane and Warnes, 2000, 2007). It is therefore necessary to distinguish between these two groups when developing appropriate housing options.

Determining the number of homeless people in Canada and their demographic characteristics is challenging. Estimates suggest that Canada's homeless population ranges from 150,000 to 300,000 (Laird, 2007; Mental Health Commission of Canada, 2012). The majority of these individuals live in major cities of Toronto, Vancouver, and Montreal (Laird, 2007). One study estimates that approximately 6% of the visible homeless population in Canada is over 65 (Stuart & Arboleda-Flórez, 2000), and another finds that 9% are over 55 (Social Planning and Research Council of BC, 2005). Homeless older adults are a minority among homeless people—perhaps due to higher mortality rates in this population —but their numbers are thought to be on the rise in Canada (Stergiopoulos & Herrmann, 2003). Older homeless people are also particularly vulnerable.

3.0 Housing Options for Homeless Seniors: An Overview

Various housing and support options are available to homeless and formerly homeless older adults in Canada. This section briefly reviews the following options: affordable housing units, alternative housing models, emergency shelters, and residential and long-term care facilities. This report does not provide an exhaustive list of housing options, but rather a general overview of Canada's housing landscape.

Affordable Housing

Affordable housing refers to a range of low-cost or subsidized models where residents spend less than 30 per cent of before-tax household income on housing (Canadian Mortgage and Housing Corporation, 2013). Funded through the public, private and not-for-profit sectors, affordable housing includes both supported and supportive models and targets broad segments of the public who lack the financial means to pay rent at market levels. While appropriate for some older adults, this type of housing is not typically designed to meet the needs of older homeless or other "hard-to-house" people (City of Toronto, 2013). The availability of affordable housing is

also severely limited. Gentrification, increasing house prices, and a lack of government subsidies make the demand for affordable housing in most Canadian cities much higher than the supply (City of Toronto, 2013).

Alternative Housing: Supportive and Supported Models

Alternative housing is another option available to older homeless people in Canada. Alternative housing is funded on a not-for-profit basis and is designed to provide housing to people who are hard-to-house as a result of mental health or addiction issues (City of Toronto, 2013). There are two categories of alternative housing: supportive and supported. Distinctions between supported and supportive housing are sometimes unclear and categories vary in Canada and internationally. In general, supportive housing comprises models in which support services are directly linked to the housing facilities and where in-house support staff are available (Culhane, Metraux, and Hadley, 2002; Tabol, Drebing, and Rosenheck, 2010). In this housing option, residents may be required to undergo mental health or addictions treatment (Tabol et al., 2010). Table 1 provides a list of supportive housing options; demonstrating the diversity that exists among them.

Supported housing, conversely, refers to models in which support services are provided though community agencies rather than the housing facility (McDonald, Dergal, & Cleghorn, 2004). Supported housing is considered more flexible while supportive housing is more restrictive. The former emphasizes community integration and empowerment and is a means of accommodating homeless individuals' diverse and changing needs (McDonald et al., 2004). Supported housing reflects research suggesting that people with mental illnesses and addictions prefer to live alone and access support services in the community (Tanzman, 1993). Several research studies cite that homeless people, in particular those with complex needs, have benefited from supportive housing models (Culhane & Metraux, 2008; Tabol et al., 2010; Walker & Seasons, 2003, cited in Mott, Moore, & Rothwell, 2012, 27-28).

The literature comparing various supported and supportive housing options is largely inconclusive and due to the limited research on homelessness in later life, pertains to other 'hard-to-house' populations. A handful of these studies find favour with either supportive (Culhane et al., 2002) or supported (Goldfinger et al., 1999; Gulcur, Stefancic, Shinn, Tsemberis, & Fischer, 2003; Tsemberis & Eisenberg, 2000) housing, while others find no significant difference between the two approaches (Rog & Randolph, 2002)**.** *Both* alternative housing models, though, effectively increase consumer satisfaction and ensure stable housing for people with mental illnesses and/or addictions (Kirsch et al., 2009) One downside however, is that unlike other models, providers of alternative housing are not obliged to find tenants or clients through a centralized waiting list (City of Toronto, 2013). This can add challenges for people trying to access alternative housing.

Table 1: A List of Supportive Housing Models (Adapted from McDonald et al., 2006)

Campus Model Housing	• A model in which tenants can access a range of housing options (i.e., private, self-contained units; congregate housing facilities; residential care homes) as required. • Intended to allow for seamless transitions between housing with varying levels of supports as a tenant's condition regresses or improves.
Congregate Housing	• Housing models in which tenants live in independent units and support staff remain on site. • This model can be adapted to service populations with varying levels of support needs.
Domiciliary Housing	• Private residences that are often run by the for-profit sector, but regulated by government bodies. • Although meals and housekeeping services are typically provided on-site, other health supports are provided off-site by outside agencies.
Evolving Consumer Household	• A model similar to congregate housing that offers varying levels of support. • Over time, the level of staff support is phased out as tenants gain responsibility.
Shared Housing	• A larger facility in which tenants are given private rooms but share a common living space.

Emergency Housing and Shelters

Shelters are a well-know option for Canada's older homeless population. There are three different kinds of shelters: *emergency shelters*, which are used in crises and may provide access to other forms of support; *transitional shelters*, which emphasize self-sufficiency and provide temporary residence while an individual looks for stable housing; and *permanent shelters*, which are long-term accommodations for people unable to remain in stable housing independently (Wong, Park, & Nemon, 2006).

Shelters are not designed to be permanent accommodations, but they are increasingly being used as long-term residences for older adults rather than as a means of transitioning to stable housing (Culhane & Metraux, 2008; Serge & Gnaedinger, 2003). A Vancouver-based study found that older people spend more time in shelters than their younger homeless counterparts (Serge & Gnaedinger, 2003). With a lack of viable housing alternatives for older adults and over-crowding in acute hospitals, there is pressure on shelters to fill the gap in convalescent care by accepting elderly and unwell patients who can no longer care for themselves (Serge & Gnaedinger, 2003). In Vancouver the number of people referred directly to a shelter from hospital doubled between 1994 and 2003. This problem also occurs in Montreal,

where older people sometimes move from hospitals, psychiatric hospitals, and prisons to homeless shelters (Serge & Gnaedinger, 2003).

For a variety of reasons shelters are not optimal housing alternatives for older people. Shelter services and programs tend to emphasize the needs of younger homeless individuals and families. There is often a lack of personnel and expertise available to support older people with extensive needs. Older adults often find the noise and activity levels at shelters overwhelming (Bottomley, 2001; Gonyea et al., 2010; Kutza & Keigher, 1991). In addition many shelters, particularly those in older buildings, are structurally ill-equipped for individuals with limited mobility (Gonyea et al., 2010; Serge & Gnaedinger, 2003).

Residential or Long-term Care

Residential or long-term care (LTC) facilities are another housing option for older homeless adults in Canada. These facilities are tailored to those with impairments. Some shelter users transition to residential care successfully. However it is often difficult for them to move to residential care because of resource and funding shortages, assessment processes that are ill suited to the needs of older homeless people (Serge & Gnaedinger, 2003), and a lack of support from informal networks of family and friends (Crane & Warnes, 2005; Dennis et al., 2012).

The state of LTC differs slightly between provinces, but in many areas restrictions on funding subsidies mean that publicly funded residential facilities are only able to accommodate a limited number of older adults with high needs (Serge & Gnaedinger, 2003). Those who are homeless often have particularly complex conditions and require high levels of care. With a shortage of publicly funded residential services, community-based organizations are increasingly responsible for eldercare. Given that community care is typically provided in clients' homes, it can be particularly difficult for homeless older adults to access this form of support. A significant gap in long-term and residential care services exists and many homeless older adults' needs are unmet.

Even where residential services are available, assessment processes are often ill suited for older homeless adults' needs. Assessment processes evaluate an applicant's physical and cognitive abilities, support needs, and potential for self-harm or injury to others (Serge & Gnaedinger, 2003). Case managers rank applicants based on their responses and those who receive high aggregate risk scores are deemed eligible for residential care. This process requires an individual to stay in the same place for a sustained period of time so that he or she may be assessed and referred to a long-term care facility. This is challenging for older homeless adults because many of them move frequently and have difficulty keeping appointments. Providing these individuals with some form of stable accommodation throughout the assessment process is often the only way ensure its completion (Serge & Gnaedinger, 2003). Fears of institutionalization may also contribute to an older homeless adult's inability or unwillingness to transition into long-term care (Keigher & Greenblatt, 1992).

Lack of support from informal networks is another barrier to placement in residential care. Older adults often rely on support from friends and family when navigating Canada's health and residential care systems. Homeless people often lack these critical support networks (Crane & Warnes, 2005; Dennis et al., 2012). Front-line workers, such as liaison staff in shelters may provide some assistance with placement, but this is often less reliable than family support. There is a high turnover rate in front-line work; making it difficult for homeless individuals to

establish long-term, continuous relationships with shelter staff and other professionals (Serge & Gnaedinger, 2003).

Challenges with service co-ordination are particularly acute in larger Canadian cities because the various agencies involved in supporting older adults are often decentralized. This is a barrier to placement in long-term care, especially for those with limited support networks. Service co-ordination is less challenging in smaller towns, where agencies may overlap, and in parts of Quebec (Serge & Gnaedinger, 2003). In the latter case multi-disciplinary, multi-service Community Health and Social Services Centres (CSSS in French; formerly CLSCs) assist with coordinating among various agencies. Links between shelters and Community Health and Social Services Centres facilitates the delivery and integration of medical and social services to older homeless people (Serge & Gnaedinger, 2003).

Even when placement in residential facilities is successful, the living environment may not suit the needs, interests, and preferences of some older people who have been homeless (Serge & Gnaedinger, 2003). Excessive alcohol and substance use, poor hygiene and housing-keeping skills, smoking habits, and anti-social behaviours can make the transition to long-term care very difficult. Older homeless adults who exhibit these behaviours and do move to residential care may feel ostracized in these facilities and may not integrate successfully (Serge & Gnaedinger, 2003).

4.0 Best Practices for Housing Older Homeless Adults

Following best practices may mitigate some of these challenges involved in finding appropriate housing for older adults who are homeless. Best housing practices include the following: rapid re-housing, providing a continuum of housing and support options, ensuring client-directed and respectful services, ensuring social support networks, and ensuring age-appropriate and affordable housing facilities.

Early Intervention and Rapid Re-housing

Rapidly re-housing newly homeless older adults has emerged as a best practice in the field (Barrow, Soto, & Cordova, 2004; Crane & Warnes, 2000, 2007; Greater Vancouver Shelter Strategy, 2013; McDonald et al., 2006). This helps to mitigate the challenges associated with re-housing older adults who are chronically homeless. During extended periods of homelessness, many older adults experience significant anticipatory stress as they prepare for relocation and contend with future uncertainties. These individuals experience greater challenges adapting to stable accommodations than those who are recently homeless. Barrow et al. (2004) report that that less than half of those who experienced chronic homelessness were able to remain in permanent housing at a two-year follow-up point. Crane & Warnes (2000, 2007) similarly observe that older clients who experience extensive periods of homelessness are more resistant to being re-housed. Conversely a history of stable accommodations and maintaining contact with family members are positively associated with housing efforts for older adults (Crane & Warnes, 2007). The quick provision of permanent housing can help to relieve some of the fears and stresses associated with homelessness, contribute to a smoother transition to housing, and potentially lessen the risk factors for suicide and depression among individuals who are recently homeless (Crane & Warnes, 2007; Greater Vancouver Shelter Strategy, 2013).

A continuum of support and housing options

A full range of housing and support options is a best practice because older adults have diverse histories, needs and preferences, and living expectations (Cohen, 1999; Gonyea et al., 2010, McDonald et al., 2006). Some individuals may transition to stable housing easily, while others will require significant support (Kutza & Keigher, 1991; Serge & Gnaedinger, 2003). Crane & Warnes (2007) recommend that service providers and frontline workers systematically monitor and respond to each client's unique needs prior to, during and following their move to a temporary or permanent residence. A 'one-size-fits-all' approach to housing is neither desirable nor appropriate (McDonald et al., 2006), and service providers should avoid imposing expectations on clients (Serge & Gnaedinger, 2003).

Client-Directed and Respectful

Client-centered models that respect older homeless adults' needs and desires and emphasize trusting relationships with services providers are key aspects of successful re-housing (McDonald et al., 2006). Independence and self-determination are critically important to homeless older adults because many of them have experiences losing control and/or trust in authority figures (Dennis et al., 2012). These individuals might, for example, have had experiences where they are forced to undergo addictions counselling, or to live in communal living where they share a room or bathroom with others against their wishes. The relational aspects of service provision, especially respect for each client's interests, are perhaps more important to the re-housing process than the facility itself (Serge & Gnaedinger, 2003).

Support Networks and Engagement

Developing strong social support networks is another best practice for successfully re-housing older homeless adults (Caton et al., 2005; Gonyea et al., 2010). Connections with other homeless people can negatively affect an individual's ability to remain in housing, but relationships with individuals beyond this community can contribute to successful re-housing (Caton et al., 2005; Crane & Warnes, 2007). Where family members are supportive, rekindling these relationships can contribute to strong social support networks. The exception, of course, is where abusive relationships with family were a contributing factor to homelessness in the first place. Researchers also encourage service providers to help older homeless adults engage in activities that foster new social networks (Crane & Warnes, 2007).

Age-Appropriate and Affordable Facilities with Integrated Care Networks

Ensuring the availability of age-appropriate and affordable housing is critical to successful re-housing. Appropriate housing can enable older adults to age in place as their needs change; potentially reducing the high costs associated with long-term care and hospitalization (McDonald et al., 2006). Integrating key services is also necessary to ensure the seamless delivery of supports to those who are transitioning to housing (Gonyea et al., 2010). Formerly homeless older adults have emphasized the challenges they encounter when negotiating a fragmented service system with overwhelmed or inaccessible staff (McDonald et al., 2006). To

mitigate these challenges it is necessary to develop a collaborative, integrated network of service providers.

5.0 Implementing Best Practices: The Housing-First Approach and Case Studies from the Field

This section will review the basic tenets of the housing-first model and describe its implementation through *Pathways to Housing* in the United States and *At Home/Chez Soi* in Canada. This approach does not specifically target older homeless people, but it has been particularly successful in responding to the needs of those who are harder-to-house.

Trends in Housing Policy for the Homeless: The Housing-First Model

The "housing-first" model of care emerged in the 1990s and is founded on the belief that all people have a right to shelter. The approach is to first provide homeless people with permanent housing, and then offer them other forms of support (Tsemberis, Gulcur, & Nakae, 2004). Housing is considered both a starting point and a prerequisite for overcoming social and physical challenges. This model counters "popular clinical assumptions about the limitations of people with severe mental illness and the type of housing and support that is best suited to meet their needs" (Tsemberis & Eisenberg, 2000, p. 492).

The housing first model contrasts with the "continuum of care," or staircase approach of most housing programs in North America (Remaeus & Jönsson, 2011). The aim of the continuum model is to support clients through a linear progression of outreach, treatment, and permanent housing services (Tsemberis & Eisenberg, 2000). The continuum approach is effective for some, but advocates and policymakers critique its lack of consumer control and flexibility, that it forces homeless people to live in congregate housing, and that it denies housing to those most in need (Tsemberis & Eisenberg, 2000). The continuum model of support is also inaccessible for homeless people who are unable or refuse to accept treatment (Remaeus & Jönsson, 2011). While the continuum model is still prevalent, housing-first programs are becoming increasingly common in North America, Western Europe, and Nordic countries (McDonald et al., 2006; Tainio & Fredriksson, 2009).

Pathways to Housing

Pathways to Housing, a New York City housing service, was one of the first programs to implement the housing-first approach. *Pathway to Housing* provides services to people with severe mental health problems and/or addictions who are unwilling or unable to progress through linear treatment programs (Remaeus & Jönsson, 2011). Clients are immediately provided access to permanent, furnished apartments (Tsemberis & Eisenberg, 2000). To stay in the program, clients are required meet program staff twice a month and to participate in a money management program where thirty percent of their income is allocated to rent (Tsemberis et al., 2004).

Unlike in continuum models of support, *Pathways to Housing* does not require participants to receive psychiatric treatments or addictions counselling. Following a harm-reduction approach to drug and alcohol addictions, it recognizes that individuals are at different stages of substance use recovery and that effective interventions need to meet unique needs (Tsemberis et al., 2004). *Pathways to Housing* emphasizes individual choice and allows program

participants to accept or refuse various supports, and to continue using substances, without jeopardizing access to housing (Tsemberis et al., 2004). Supports are typically offered through an Assertive Community Treatment (ACT) team (Tsemberis et al., 2004). ACT teams are designed to provide client-centred support for homeless individuals with mental illnesses and typically involve social workers, nurses, substance abuse counsellors, and psychiatrists (Tsemberis et al., 2004).

Pathways to Housing has high success rates in providing stable accommodations for people who are harder-to-house (McDonald et al., 2006; Tsemberis & Eisenberg, 2000; Tsemberis et al., 2004). It has successfully engaged a significant portion of chronically homeless enrolees, and retention rates for this group were at least 80 percent—an unprecedented outcome—two years after housing entry (McDonald et al., 2006). Enrolees also experience much greater control and autonomy than those participating in continuum of care approaches (Tsemberis et al., 2004).

At Home/Chez Soi

At Home/Chez Soi is a Canadian initiative based on the housing first model. It was launched in 2008 by the Mental Health Commission of Canada (MHCC) in five cities: Montreal, Toronto, Winnipeg, Moncton and Vancouver. *At Home/Chez Soi* operates on the basis of 5 central tenets. First, there are no conditions on housing readiness. Participants receive immediate access to housing and may choose to engage in a range of support programs and services. Second, clients' choices are highly valued and respected. Third, each client receives individualized supports. Fourth, a harm reduction approach to substance use is emphasized. Participants are not required to maintain sobriety throughout the program. Fifth, the project strives for social and community integration (MHCC, 2013). *At Home/Chez Soi* does not specifically target older homeless people, but some have been included in the program. See Serge & Gnaedinger (2003) for a review of several Canadian housing initiatives focused specifically on the older population.

At Home/Chez Soi's final report is not yet complete, but preliminary findings suggest that the program is successful. Twelve months after receiving immediate access to housing, participants fared much better than homeless individuals receiving the conventional approaches to homelessness existing in each city. Program participants spent an average of 73 percent of the year in stable accommodations, compared to 30 percent of other homeless people (MHCC, 2012). In August 2012, 86 percent of clients who had enrolled in the program in 2008 were living in either their first or second housing unit.

Outcomes of *At Home/Chez Soi* and *Pathways to Housing* both demonstrate that housing-first and harm-reduction approaches provide the opportunity for better long-term health and social functioning among homeless people who have experienced trauma and poor health (MHCC, 2012). Early findings from *At Home/Chez Soi* also indicate that housing-first programs are financially sustainable (MHCC, 2012). For every dollar spent on housing first, 54 cents is saved through reductions in other shelter and health care use (MHCC, 2012). When the project was completed, in 2013, the original test cities—excluding Montreal—chose to continue implementing the housing-first approach.

6.0 Conclusion

This aim of this report was to review literature on housing and re-housing options for homeless older adults, with a focus on the Canadian context. This vulnerable population currently has significant, unmet needs regarding access to housing and support services. Recent approaches to address homelessness include housing-first models, harm-reduction programs, client-centred care, and integrative support networks. These initiatives are not specifically designed to meet the needs of older homeless people, but they have been effective in meeting the needs of people who are harder-to-house in Canada. They have also inspired *At Home/Chez Soi,* one of the largest housing initiatives in Canada's history. Despite these efforts there is a critical need to develop effective programs, based on the best practices outlined above, which specifically target older homeless people. Ensuring access to affordable, age-friendly, and permanent housing is a priority.

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