



Executive Summary

IN FROM THE STREETS: THE HEALTH AND WELL BEING OF FORMERLY HOMELESS OLDER ADULTS

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EXECUTIVE SUMMARY

Study Context and Objectives

This study explores the impact of housing on the health and well-being of formerly homeless older adults. The study was informed by several theoretical frameworks:

- the “causes” of homelessness are the result of the interaction and overlap of both structural and individual factors;
- an understanding of the social determinants of health provides a powerful conceptual tool for understanding how homelessness and housing impacts health;
- a social inclusion framework extends the scope of the study to include quality of life, social capital, belonging and social connections, participation, employment, civic engagement, and discrimination; and
- a human rights framework that maintains that housing is a right, as outlined in the Universal Declaration of Human Rights Article 25 (1948).

The primary research question was formulated to ask, what are the health and housing outcomes for formerly homeless older adults? Seven key objectives were identified to answer the research question. The study objectives are:

1. To better understand the characteristics and socio-economic status of older people who were once homeless;
2. To examine the extent to which older homeless people are recovering from health consequences once they are housed;
3. To identify the service, support, and housing needs of formerly homeless older adults, and the barriers and successes in current practice;
4. To determine the effective recovery supports/services/programs;
5. To describe the models that allow these programs to be effective;
6. To clarify the limitations of these models for older adults; and
7. To articulate policy, funding and program implications for government, service providers, and other community stakeholders.

Methodology

Data to evaluate health and housing outcomes was drawn from a non-random sample of formerly homeless older adults (50 years of age and older) living in supportive (housing with onsite supports) and supported housing (housing with de-linked community supports) in Toronto, Ontario and Calgary, Alberta. A mixed-method approach was employed with data collected from 237 face-to-face quantitative interviews (Toronto, n = 201; Calgary, n = 36¹), 53 qualitative interviews (Toronto, n = 35; Calgary, n = 18) and 6 focus groups (69 participants total: Toronto, n = 33; Calgary, n = 37). Other sources of data included a literature review and the personal health information² (PHI) of the consenting Ontario participants. The PHI data was used to track utilization of health care services before and after becoming housed. Data emerging from a comprehensive literature review informed the content of the data collection tools and provided context for the findings.

Data was analysed using both quantitative and qualitative strategies within a concurrent triangulation model. Descriptive statistics were used to analyse data from the survey and from the PHI. The transcripts from the qualitative interviews and focus groups were coded, organized into emergent categories and then clustered according to central themes. Finally those themes were interpreted and a qualitative narrative, embedded with representative quotes, was produced.

Supplementary funding was secured to develop a working group of research participants tasked with creative dissemination. The dissemination focused on two primary actions: a postcard campaign and a speakers' bureau. The group developed an innovative research poster using paint and collage, which was displayed at a number of forums. This poster was scaled down to a postcard messaging key actions that emerged from the study. The working group coordinated outreach to the community to solicit signatures and the signed postcards will be mailed and delivered to relevant policy makers.

Key Findings

Quantitative Survey Key Findings

- Of the 237 participants who responded to the survey in Toronto and Calgary, the majority were male, which accurately reflects the proportion of men to women in

¹ Recruitment challenges resulted in a lower number of survey interviews in Calgary than initially targeted.

² Initially the PHI of Calgary participants was to be analysed. However, only 28 participants consented to release of the PHI, a sample too small to conduct a meaningful analysis.

the homeless population. The average age was 57 in both samples, an age both groups considered to be “old.” Most of the participants were born in Canada and identified as ‘white,’ although Toronto had a larger percentage of immigrants and Calgary had a higher percentage of Aboriginal peoples. Most were unattached in terms of marital status and were mainly single or divorced, and over half in both samples had attended or completed high school.

- Over 60 percent of the participants in Toronto and 56 percent of the formerly homeless participants in Calgary had been homeless more than once, with men reporting significantly more homeless episodes than women in both cities.
- In Toronto, 71 percent lived in supportive housing compared to 42 percent in Calgary and the remainder lived in independent housing with the help of community supports.
- In Toronto, about 50 percent had been housed for over five years compared to only eight percent for Calgary.
- The last episode of homelessness in Calgary was much shorter than for Toronto, suggesting a quicker turn around in interventions that provided support and housing.
- About one-half of the participants in both cities had found their housing with help from a professional service worker. The other half relied on word of mouth and informal networks indicating that this informal system is an important mechanism for communication.
- Overall the health and well-being of formerly homeless older adults improved relative to health indicators for homeless older adults in previous research, but were lower than similar indicators reported for the general population. The Calgary sample reported poorer physical health than the Toronto group but better mental health.
- In 6 months prior to the survey, two-thirds of Toronto participants reported receiving care from a private doctor, while slightly less than 50 percent saw a private doctor in Calgary. The percentage of emergency visits was almost identical for both groups but Calgarians were more likely to be hospitalized (33 percent vs. 23 percent). A larger proportion of Calgary respondents used walk-in clinics and community health centres (CHC).
- The findings from a pre to post housing analysis of health care utilization data in Toronto indicated that there was no significant change from pre-test to post-test for fee-for-service, but there was a significant decrease in the mean days of emergency room use, and the mean days used for in-patient/day patient care.

- The scores on the measures of social isolation and networks for both the Toronto and Calgary respondents indicated that formerly homeless participants were at considerable risk of social isolation and relied heavily on service providers for support.
- Little more than one-quarter of the participants reported any income from employment in the previous six months. The majority of participants reported a yearly income for 2004 in the range of \$10,000 to \$11,999, well below the current Low Income Cut-Off for individuals. Notably, a high proportion of participants relied on food banks and meal programs.

Qualitative Interview Key Findings

- Participants reported lingering “homeless effects,” such as feelings of trauma and mistrust, that impacted their psycho-social health and well-being, and many mentioned that recovery was an ongoing process.
- While health status and well-being varied across participants, most participants acknowledged that securing housing was the critical first step toward improved health and wellness.
- Participants emphasized that housing ends “houselessness,” but much more is needed to support health, wellness and social inclusion.
- Participants are struggling to find “home” in their housing, their communities and in the broader society.
- Participants did not perceive themselves as “settled” or “retired” or “old.” “Transitioning” emerged as a theme in many different areas: transitioning from housing to “home;” transitioning toward health, wellness and social inclusion; and transitioning out of poverty.
- Significant barriers limited participants’ ability to transition, such as limited age-appropriate, affordable housing and support options; persistent “homeless effects” and accelerated “aging effects;” “poverty or welfare walls” imposed by inadequate income and employment supports; and ageism, particularly the special class of ageism identified as the “gap” (the 50-65 demographic falling between general population and senior services).

Focus Group Key Findings

- More affordable and age-appropriate rental housing is needed that includes a broad menu of housing and support options situated in mixed housing sites with market rent and rent geared to income (RGI) units.
- Enhanced funding is required to ensure that supports are accessible to everyone, particularly in the areas of life skills, therapeutic, personal support and housekeeping services.
- Integrated service delivery (e.g., coordinated mental health, health and personal care), policy frameworks, and funding mechanisms are necessary to ensure seamless and coordinated housing and supports to health and well-being of formerly homeless older adults.
- Networks of support must extend to and institutionalize partnerships with off-site agencies, informal community networks, peer support programs and families.
- Training, education and other employment supports, as well as volunteer opportunities, based on long-term commitment and investment in people's capacity are necessary to ensure that formerly homeless older adults are meaningfully engaged and valued.
- The current service paradigm does not represent a “goodness of fit” with the service delivery needs of formerly homeless older adults (i.e., currently waiting days or months to see a service provider). Service delivery must shift to reflect the realities of these individuals' lives.
- There is a need for more housing professionals; staff who are knowledgeable about the range of programs, services and housing options available to formerly homeless older adults and whose time may be solely dedicated to serving this population.

Overall Significance of the Findings to Practice, Program and Policy Development

- Health, support and housing programs should be sensitive to “homeless effects” and accelerated “aging effects” by recognizing and supporting recovery from these effects to prevent formerly homeless older adults from cycling back to homelessness. Rapid intervention is crucial. Support must travel with people as they transition and is particularly critical during the first years of housing.
- Developing and evaluating age-appropriate affordable housing and supports are of primary importance. However, development of housing and supports must consider

social inclusion so that community integration, belonging, participation, overcoming discrimination and stigma, and other measures of quality of life can also be addressed.

- Assumptions around income support and employment support for this group need to be revisited. There is a significant disconnect between expectations embedded in these programs and the severe barriers experienced by formerly homeless older adults.
- Homelessness and former homelessness should be situated within the broader context of poverty so that they are not treated as discrete nor disconnected from issues impacting other socio-economically marginalized groups.

Recommendations

Policy Recommendations

1. Develop more permanent, age-appropriate, and affordable rental housing.
 - Federal:* Develop a national housing policy; renew and expand the National Homelessness Initiative's (NHI) Supporting Community Partnership Initiative (SCPI).
 - Provincial:* Address the significant shortfall in the number of affordable housing units promised in the Affordable Housing Agreement Framework; expand Housing Allowance programs and sanction municipalities to use shelter per diems.
 - Municipal:* Expand private sector partnering in the development of social housing; Ensure that municipal planning and zoning by-laws protect existing and promote new development of affordable rental housing stock.
2. Develop more supports for older adults to "age in place" and to promote health and well-being.
 - Federal:* Evaluate the need for a clearer policy framework to prevent "undue institutionalization" and to promote community-based care.
 - Provincial:* Recognize that housing and community-based supports contribute to the sustainability of the health care system and may moderate demand on more costly acute and institutional care.
3. Increase income support for older adults.
 - Federal:* Re-establish federal standards for income assistance.
 - Provincial:* Reform income support programs and raise minimum wage to reflect the real cost of living.
 - Municipal:* Ensure that administration of income support and application processes are accessible, transparent and timely.

4. Housing ends 'houselessness,' but much more is needed to foster social inclusion for older adults who have been homeless.
 - Federal:* Government leadership at all levels is crucial to eliminate discriminatory practices, policies and terminology against formerly homeless older adults, and other marginalized groups.
 - Provincial:* Expand and enhance employment support programs to ensure that individual capacity is considered and supported.
 - Municipal:* Foster, support, and value long term volunteerism; fund and support peer programs and resources that incorporate and value the lived experience of homeless and formerly homeless older adults.

Program Recommendations

1. Incorporate generic guiding principles into the development of models of service delivery.
2. Design new housing that accommodates the needs of older homeless adults to make "aging in place" possible.
3. Enhance mental health and addiction services.
4. Create flexibility in housing and service delivery.
5. Make more use of case management services.
6. Programming should address the "age-gap."
7. Programming must include attention to transportation systems.
8. Programming should monitoring financial abuse.
9. Early intervention to prevent eviction is required.
10. Provide education for service providers about "accelerated aging effects" and "homeless effects" to counter discrimination.
11. Programming must use and value peer resources.
12. Enhance public awareness of homelessness and aging.