IN FOCUS

Aging and Housing Instability: Homelessness among Older and Elderly Adults

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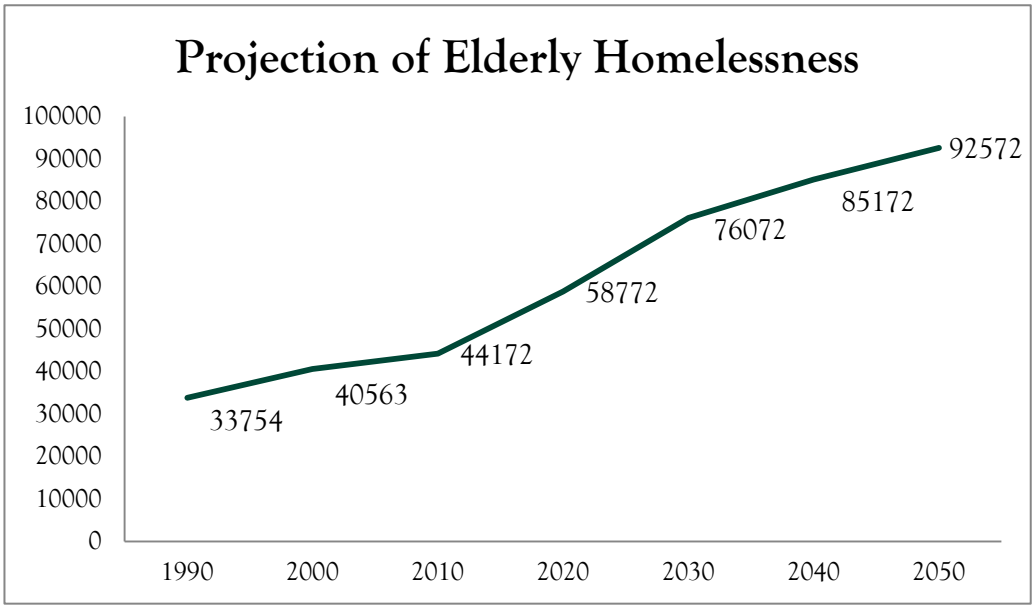
The September issue of *In Focus* provides a synthesis of recent literature on homelessness among older (age 50-64) and elderly (age 65 and older) adults in the United States. Much of the recent literature and policy focus has been placed on the plight of unstably housed youth and families. However, strong demographic trends, economic insecurity, and lack of affordable senior living have contributed to increased housing instability among those over age 50. Differences in pathways into homelessness, health care utilization, and age-specific clinical issues necessitate further consideration of the graying homeless population and will be discussed in this publication.

Aging Demographics

The homeless population in the United States is aging, mirroring general population trends.[1-6] The U.S. Census Bureau projects that the current elderly population will double by 2050, resulting in approximately 89 million people over the age of 65.[5] Similar trends are expected for those experiencing homelessness, according to projections by the Homeless Research Institute.[5] It is estimated that elderly homelessness will increase by 33% in 2020 (44,172 in 2010 to 58,772 in 2020). By 2050, the elderly homeless population is projected to more than double, with 95,000 elderly persons expected to be living without stable housing. The age composition of the homeless population has shifted significantly over the past two decades, with the median age of single adults increasing from 35 years in 1990 to 50 years in 2010.[7, 8] Still, the majority of unstably housed adults over 50 are between 50 and 64 years old, with only 5% age 65 and over. Looking specifically at sheltered individuals from 2007 to 2011, the age distribution has experienced an increase in individuals age 51 to 61 (from 19% to 23%); in total, 27% of sheltered individuals were age 51 or older in 2011.[6]



Data Source: Sermons, M.W., & Henry, M. *Demographics of Homelessness Series: The Rising Elderly Population.* Washington, D.C.: Homelessness Research Institute; 2010.

Pathways into Elder Homelessness

Although a number of safety net programs exist for the elderly, those between ages 50 and 64 often fall through the cracks despite having similar physical health to those much older due to daily stress, poor nutrition, and living

conditions.[9] In 2011, almost one-quarter of U.S. individuals below the poverty level were over the age of 62, demonstrating the financial instability of older and elderly adults.[6]

Existing research has established two predominant pathways into homelessness for this population: the aging of chronically homeless adults and first-time homelessness among older/elderly adults.[5, 10-12] In the first pathway, the aging trends affecting the general population are mirrored among those experiencing chronic homelessness. Unable to break the cycle of homelessness due to a myriad of issues, these individuals continue to age beyond 50 without stable housing. This pathway was confirmed in a study of the Los Angeles area's largest shelter, which revealed that the majority of older and elderly adults came to their current shelter from the streets or other shelters, not stable housing.[12]

In the second pathway, older and elderly individuals with a history of housing stability experience a first-time period of homelessness. Living on limited, fixed incomes—including Social Security and/or Supplemental Security Income—elderly persons experience severe housing cost burden more frequently than the general population, potentially resulting in housing loss (26% of elderly households were "severely cost-burdened" versus 20% of all households in 2007).[5] Compounding this, access to affordable senior living can be challenging, with an average wait time lasting approximately three to five years.[9] Two prominent studies have confirmed the prevalence of first-time homelessness among older and elderly adults.[10, 11] The first, a study of three international cities (including Boston), found the majority of elderly participants to be newly homeless with a history of stable adult employment and private living accommodations. Among these individuals, common causes of homelessness included: financial problems, mental health problems, relationship breakdown, physical health problems, and issues related to work.[10] A second study in Chicago reiterated this pathway into homelessness and identified three non-overlapping reasons for homelessness: "36% said they lost a job and could not find another and/or had problems with drinking; 39% reported discontinued or inadequate public assistance and/or a disagreement with family or friends with whom they were staying; and 25% reported inadequate income and/or illness."[11]

Health Care Utilization

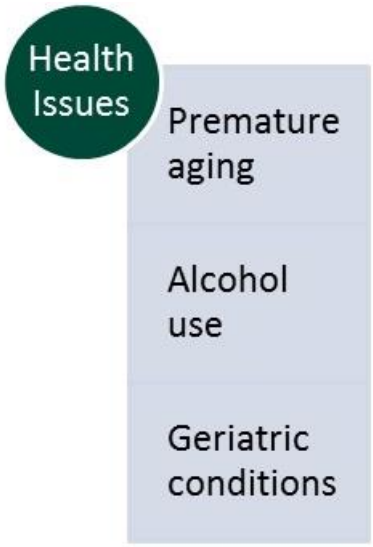
Lack of stable housing has been associated with increased Emergency Department (ED) utilization.[13] Compounded with older age and the burden of health conditions associated with aging, unstably housed adults over 50 use the ED at rates nearly four times the general population.[3, 14-16] A study comparing older and younger ED patients without stable housing found that older patients accounted for more than a third of the visits by all homeless adults and were more likely to arrive by an ambulance and be admitted to the hospital following an ED visit.[3] Another study of 250 unstably housed adults age 50 or older in 8 Boston shelters found that 64% had at least one ED visit in the past 12 months, 29% had at least four ED visits in the past 12 months, and 34% were hospitalized in the past 12 months.[17] Additionally, certain factors among these older patients were associated with making at least four ED visits in the past 12 months: female sex, white race, no usual source of primary care, at least one outpatient visit during the past year, alcohol problem, at least one fall during past year, executive dysfunction, and sensory impairment.

Health Issues

Due to prolonged exposure to stress, those living in poverty often experience weathering, or premature aging.[1, 18] Weathering has been shown to dramatically impact those without stable housing, causing individuals to age prematurely by 10 to 20 years beyond their chronological age.[1, 19] In addition to premature aging, the stress of homelessness affects morbidity and mortality. In a study comparing 40 homeless individuals with stress-related disorders and 40 housed controls in Madrid, the homeless participants had an altered immune function, which the authors stated could contribute to increased morbidity and mortality in this population.[20]

The consequences of weathering on health status emerge with age. Unstably housed adults over 50 experience higher rates of geriatric syndromes at younger ages than the general population of older adults, such as falls and memory loss.[3, 21] Geriatric syndromes are "conditions that occur in older adults and across discrete disease

categories;" examples include falls, cognitive impairment, frailty, major depression, sensory impairment, and urinary incontinence.[2] Factors associated with geriatric syndromes among older unstably housed adults include having less than a high school education, medical comorbidities (especially diabetes and arthritis), alcohol and drug use, and difficulty performing one or more daily living activities.[2]



A major geriatric condition, frailty is defined as the "...accumulation of deficits in physical, psychological, and social domains leading to adverse outcomes such as disability and mortality."[1] Factors that are significantly correlated with frailty in the older homeless population include chronological age, being female, increased health care utilization, and poorer nutrition scores.[1] Additionally, adverse life events including trauma, drug and alcohol use, and incarceration are other factors that can place those without stable housing at greater risk for hospitalizations, falls, and premature mortality.[1]

Alcohol use is another health concern among the older homeless population.[3, 4] In a study comparing ED use among older and younger homeless adults, the older population more frequently received alcohol-related diagnoses, while drug-related diagnoses were less common.[3] Older adults often experience more severe intoxication due to age-related changes in the metabolism of alcohol[4], but those in the study were still unlikely to request detoxification services.[3] The same study found that older adults were less likely than their younger counterparts to have psychiatric complaints or receive a psychiatric diagnosis discharge. Another age comparison study examined mental health, substance use, physical health, and social support among young, middle-aged, and older homeless adults before and after participation in intensive case management services.[4] At the baseline, older adults had fewer severe mental health and substance abuse problems than the other age groups, though their score improvement was slower or did not change after the intervention. Meanwhile, the youngest age group had the lowest scores for the substance use and psychiatric variables after the intervention, demonstrating a greater capacity for change.

End-of-Life Planning

Advance care planning is important at any age, but is especially vital for older and elderly adults. It allows individuals to document their end-of-life preferences with their social support systems and health care professionals in case they are unable to make decisions in the future.[22] For unstably housed adults, advance care planning can be challenging due to a lack of personal, social, and structural resources including poor health, limited medical access, high risk behaviors, and lack of social/family support.[22] To explore perceptions, needs, and concerns regarding advance care planning in the older homeless population, Ko et al. conducted a qualitative study of 21 older adults residing at a transitional housing facility.[22] The study found that end-of-life planning was an uncomfortable topic for participants to discuss, and the spirituality/religiosity of many defined and controlled perceptions of life and death, making advance care planning less relevant for them to consider. Physicians were largely the preferred decision-makers for end-of-life matters due to trust in their expertise and a lack of family/social support available for the surrogate decision-maker role. Finally, end-of-life planning was not a priority for participants in comparison to pressing basic needs.

To explore ways to improve end-of-life care and advance care planning among older adults without stable housing, Song et al. conducted a randomized trial comparing self-guided completion of an advance directive with professionally assisted advance care planning among 262 participants.[23] An advance directive is a legal document that allows patients to document what medical treatment they want to receive in different situations. The study found that one-on-one counseling and assistance significantly increased the completion rate of advance directives

(counseling completion rate of 38% versus self-guided completion rate of 13%), demonstrating that planning for end-of-life care can be accomplished more effectively if counseling and assistance are provided.

Implications and Recommendations

If demographic trends follow current projections, older and elderly homelessness will increase dramatically.[5] In addition to major prevention efforts, systems of care must be improved to accommodate the unique needs of older and elderly adults without stable housing. The research identifies a number of clinical implications that can be considered. First, focus should be placed on modifiable factors prevalent among this population, including alcohol use and common geriatric conditions.[17] To reduce avoidable ED utilization and improve health status, Brown et al. recommended routine screening and counseling on alcohol abuse, addressing common risk factors for falls, increasing access to eye glasses and hearing aids, and connecting patients with housing to decrease acute care use.[17] Salem et al. proposed three models of care to consider for this population, including having frontline geriatric nursing triage, shelter-based convalescence or medical respite facilities, and nurse case management utilizing a chronic disease self-management program.[1] With regard to end-of-life planning and care, Song et al. recommended counseling and assistance completing advance directives to improve the completion rate among the elderly homeless population. Due to negative perceptions of advance care planning, staff should approach clients with great sensitivity and assess their unique views of death and dying, while also addressing their basic and immediate needs.[22]

From a policy standpoint, Sermons et al. emphasized the need for an increased supply of subsidized affordable housing set aside for seniors.[5] With limited fixed incomes, housing cost burden can lead to first-time homelessness, one of two major pathways among older and elderly adults. For the second pathway, those who are above 50 and chronically homeless, Sermons et al. recommended permanent supportive housing to address intensive housing and service needs to break the cycle of long-term homelessness.

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