Original Research

Old and Homeless: A Review and Survey of Older Adults Who Use Shelters in an Urban Setting

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Objectives: Research on the mental health and service needs of homeless seniors has been scant. This paper reviews the available literature and presents findings of a Toronto survey in an effort to describe the demographics of homeless seniors, their level of impairment, and their mental and physical health needs.

Methods: We searched the Medline, AgeLine, and PsycINFO databases, using the following key words: elderly homeless, elderly hostel users, and urban geriatrics. To better describe the service needs of the elderly homeless, we obtained demographic data from the Community and Neighbourhood Services Department and distributed a survey questionnaire to 11 Toronto hostel directors. The questionnaire elicited data relating to reasons for shelter use, problem behaviours, and mental health needs of those over age 65 years.

Results: Although seniors represent a small percentage of the homeless population, their numbers are growing. The available literature suggests a high prevalence of psychiatric disorders and cognitive impairment in this population, with a greater proportion of older women than men having severe mental illness. Further, our survey suggests that the service needs of elderly hostel users in Toronto differ from those of their younger counterparts.

Conclusion: The homeless elderly are the most vulnerable of this impoverished population. Although more research is needed to define their mental and physical health needs and ways of meeting them, their characteristics appear to be unique. Geriatric psychiatrists could play a significant role in evaluating and treating this population more comprehensively.

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Clinical Implications

- The available literature indicates a high prevalence of mood and psychotic disorders and cognitive impairment among elderly homeless people.
- The characteristics and health needs of older homeless people are different from those of younger homeless individuals.
- In Toronto, 2% of single adult hostel users are over age 65 years.

Limitations

- The studies reviewed vary in the setting used, in their research methods, and in the age limit used to define the elderly homeless, making comparisons difficult.
- A small number of hostels were surveyed in Toronto.
- Elderly hostel users in Toronto may not represent the total elderly homeless population.

Key Words: *elderly homeless, elderly hostel users, urban psychiatry*

Homelessness is not an easily defined concept. Some conceptualize homelessness strictly in terms of housing (1,2). Others focus on sociological and psychological dimensions, arguing that the hallmark of the homeless person is "extreme disaffiliation and disconnection from supportive relationships and traditional systems that are designed to help" (3). Even among those investigators who focus on the housing dimension, no consensus exists as to what type of

accommodations provide for homeless people and what type provide for housed people, making study comparisons, especially cross-national comparisons, very challenging.

Just as there has been debate over the definition of homelessness, there has been debate over the age limit used to study the elderly homeless. In a study of "old homeless men" living on the street and in shelters in the Bowery, New York, Cohen and others used a sample of subjects aged 50 years and over (4–6). They argued that such a definition is meaningful because homeless men biologically resemble those in the community who are 10 to 20 years older. Kutza and Keigher used a minimum age of 55 years when reviewing the case files of "elderly people" in Chicago referred for emergency-shelter services (7), while Crane reported on those aged 60 years and over sleeping on the streets in central London, UK (8–10). Finally, Abdul-Hamid used an age limit of 65 years in assessing the need for services among elderly hostel users (11). To further highlight the challenges in studying this group, it should be emphasized that, despite the stereotypes, the elderly homeless are extremely heterogeneous, comprising different subpopulations with different characteristics and different needs (12–14).

Methods

To review the literature on the service needs of the homeless elderly, we completed a search of the Medline, AgeLine, and PsycINFO databases, using the following key words: elderly homeless, elderly hostel users, and urban geriatrics. We manually cross-referenced review articles and potential papers for additional articles. Appropriate studies were critically reviewed and summarized.

We obtained demographic data from the Toronto Community and Neighbourhood Services Department (personal communication), which compiles annual statistics on over 4500 "beds." Data on the age distribution of single adult hostel users were provided for the year 2000, and the patterns of use by those over age 65 years were obtained for the period January 1, 1988, to December 31, 2000. In addition, we designed a 21-item service-needs questionnaire, with input from hostel administrators and frontline staff. It elicited demographic data based on hostel records, as well as staff perceptions of met and unmet client needs. Questions specifically targeted mental health, physical health, social activity, self-care, and mobility needs, as described by the Camberwell Assessment of Need for the Elderly (15). Further, staff were asked to rank perceived reasons for homelessness and the most frequent problem behaviours encountered, based on their intake data. Information on available on-site health services and opportunities for education or training was also elicited.

We forwarded the questionnaire to 11 hostel directors responsible for 25% of the city's adult hostel beds. They were asked to complete it based on staff observations over a 1-month period and on intake information obtained from their clients over the same time period. The questionnaire placed clients in 2 age categories: those over age 65 years and those under age 65 years. Staff were asked to compare the 2 groups in terms of their met and unmet service needs and problem behaviours. Our geographic scope originally targeted Southeast Toronto, the "inner city," but was expanded to include a sufficient number of women's hostels, which are underrepresented in this area. Because the the study was exploratory and the sample size was small, we only used descriptive statistics.

Literature Review

The Extent of Homelessness Among the Elderly

Estimating the number of homeless elderly is a great challenge. In most studies in the US, seniors are underrepresented among the homeless, compared with the general population. This is felt to be owing in part to higher mortality rates (16–20). Although the elderly constitute a small percentage of the total homeless population in North America, their absolute numbers are increasing (6,21). Using shelter reports from 8 cities, the Aging Health Policy Center estimated that between 14.5% and 28% of the homeless are aged 50 years or over (22). Reports from cities such as Oregon, St Louis, Los Angeles, San Francisco, and New York estimated that 3% to 8% of the homeless in these cities are over aged 60 years (23); an Institute of Medicine analysis of 12 studies determined that persons over age 60 years comprise 2.5% to 9% of the homeless (24). In 1988, the US Department of Housing and Urban Development reported that those over age 65 years comprised approximately 3% of all hostel users nationwide (21). These numbers have been criticized as underestimates, because many elderly stay away from public shelters for fear of muggings or insensitive treatment (5,6). Indeed, street surveys and outreach programs in the US have reported a higher percentage of older people among the homeless—ranging as high as 30% (25,26). In the UK, investigators report that over one fifth of those surveyed in hostels and temporary accommodations in Sheffield, in Nottingham, and in London are in the "older" age groups (8,27). Other surveys in London have found a higher proportion of older people among those sleeping on the streets, highlighting the difficulty inherent in detecting the "hidden homeless" and in obtaining accurate estimates of the elderly homeless (8).

In Canada, even though a small literature exists on homelessness (28–35), the characteristics and needs of homeless seniors have thus far been overlooked, leading to a lack of relevant local planning data. In Calgary, Alberta, a recent report estimated that among 250 emergency-shelter users, 6% were aged 55 years and over (35).

Table 1 Proportion of younger and older homeless people with active psychiatric symptoms

City	Sample size	Older (%)	Younger (%)
New York (24)	Total: 8061 Older (≥ 60 years): 353	14	20
Los Angeles (44)	Total: 521 Older (≥ 50 years): 61	19	19
London (11)	Total: 101 Older (≥ 65 years): 37	24	35

Pathways Into Homelessness for the Elderly

The homeless elderly are heterogeneous. Doolin claims 3 common categories of homeless elderly: the chronic or traditional homeless, the deinstitutionalized, and the dishoused or temporarily homeless (12). Other classification systems have also been proposed (13,14,36) in an effort to better characterize this vulnerable group, whose members have been homeless for variable lengths of time (7,8). The pathway into homelessness for the elderly is multifactorial, as it is for younger homeless people, and includes deinstitutionalization, poverty, and lack of affordable housing (8,12,21,36,37). Risk factors or triggering events in this group include evictions; the death of a spouse, relative or significant other; and loss of income (8,37). The immediate precipitants of homelessness differ between sexes, with family dysfunction and gradual loss of social supports more likely to underlie homelessness in older women (38). Among 353 shelter users over age 60 years in New York, 60% cited eviction from previous housing because of lack of adequate funds as the reason for hostel stay, while 9% were released to a shelter from a hospital or other institution (23). In a Chicago study of older people with housing problems, homelessness was associated with low income, dementia, living alone, and an unstable residential history (39). Previous work in Chicago identified elderly women as a new group at risk for experiencing homelessness in late life (7).

In a study of 75 people over age 60 years sleeping on London streets, 29% had been homeless for less than a year and more than 50% for less than 5 years (10). Reasons for homelessness varied in this study but included mental health problems (45%), relationship breakdown (22%), loss of accommodation (15%), loss of employment (12%), and alcohol-related problems (3%).

In Toronto, qualitative research by 2 local community agencies on the impact of homelessness on women's health reveals that women over age 55 years are more likely to live in small and inadequate housing, experiencing "hidden homelessness" subject to abuse and violence (40).

Physical Health

Being homeless is associated with greater incidence of morbidity and mortality and a lifestyle that negates the pursuit of disease-prevention practices and interferes with attempts to treat health problems (41,42). The homeless elderly face the conditions associated with aging, magnified by their living conditions. Among the most frequently reported problems are dental problems, arthritis, hypertension, circulatory problems, lung disease, stomach ailments, glaucoma, asthma, anemia, diabetes, and sensory impairment (4,7,37,43). In addition, the homeless elderly face problems stemming directly from homelessness, such as the consequences of trauma or criminal assault, infestations with scabies or lice, peripheral vascular disease, cellulitis and leg ulcers, frostbite, and communicable diseases such as tuberculosis and HIV (41,44). Not surprisingly, they are more likely than their younger counterparts to report active medical problems (23,43,45) or a chronic illness or functional disability (7,23,43), and their health status is worse than that of elderly people in the general population (4,43). In studies that focus on older homeless people, more than one-half of those sampled have active medical problems (4,7,9,23). Thirty-three percent of the street sample of older homeless men in New York had been hospitalized for physical reasons in the previous year, compared with only 12% of the community sample (4).

Mental Health

Although early estimates of the prevalence of mental illness among homeless persons in the US varied widely (3,46), most experts now accept that approximately one-third of single homeless adults have a severe mental illness and that the prevalence of mental disorders among homeless single women is higher than it is among men (47,48).

Research on the mental health of older homeless persons is very scant. The major exceptions are studies from New York (5,6,23), Chicago (7,26), Detroit (49), Los Angeles (43), and London, UK (8–11). These studies have used different sampling strategies and interview sites, as well as research methods that varied from observational techniques to self-reported data to standardized diagnostic assessments by trained clinicians. However, significant psychiatric morbidity has been consistently demonstrated in this population, despite the methodological differences. Some of the studies compared the mental health needs of older homeless people with their younger counterparts (Table 1). In 4 Inner London hostels, 24% of those over age 65 years were in need of a psychiatric assessment, compared with 35% in the younger age groups (11). Gelberg and others compared 61 homeless people over

Table 2 Mental health difficulties among elderly homeless people

	%
Past psychiatric hospitalization (24,27,49,50)	14–33
Depressive symptoms (5,6,8,50)	15–66
Psychotic symptoms (6,8,44)	9–66
Alcohol abuse (5,6,11,24,44)	13–50
Cognitive impairment (6,8,44)	5–55

Table 3 Older clients among adult hostel users aged 18 to 85 years in Toronto

Age (years)[a]	Male hostel users (%)	Female hostel users (%)	Total hostel users (%)
> 50	12.5	11.5	12.3
> 60	3.8	2.9	3.6
> 65	2.2	1.5	2.0

[a]Age distribution count, first quarter of year 2000. Community and Neighbourhood Services Department.

age 50 years with 460 younger homeless people in 2 beach communities in Los Angeles. The older group reported fewer psychotic symptoms (25% vs 42%) and drug abuse (15% vs 55%) than did the younger group. There were no differences, however, in observed psychiatric symptoms or reported past psychiatric hospitalization (43). Finally, 14% of New York City's public shelter clients over age 60 years reported an active psychiatric problem, compared with 20% of the younger clients (23).

In many of the studies, a high proportion of older homeless people, ranging from 14% (23) to 33% (49), reported at least a single prior psychiatric admission. Prior psychiatric admissions are particularly prevalent among older homeless women (26,38,49). Depression, psychosis, and cognitive impairment are the specific psychiatric disorders cited most frequently (Table 2). Moreover, compared with men, a greater proportion of older homeless women have poor mental status (7,8,26). Depression is thought to be more common among older homeless men (8,49).

Of older homeless men in Detroit, 65% reported having depression (49), and of men living on the streets in New York, 40% were considered "pervasively depressed." The New York study included 281 men over age 50 years living on the streets and in shelters in the Bowery (the skid row area); it found high intercorrelation among depressive features, physical illness, stress, and unfulfilled needs (5,6). Finally, a study of 130 people over age 60 years sleeping on the streets in central London, UK, found that 45% of the men and 15% of the women reported depression (8). In addition, 65% of the women and 17% of the men in the London study showed signs of a psychotic illness (8). Psychotic symptoms were documented in approximately 25% of older homeless people in Los Angeles (43) and New York (6).

A review of 157 case files of people in Chicago who were referred for emergency-shelter service revealed that 45% of the women and 31% of the men displayed confusion, disorientation, or paranoia (7). Similarly, 43% of the men in New York living on skid row reported memory difficulties, with 9% classified as having mild-to-moderate dementia and 5% classified as having moderate-to-severe dementia (6). In London, 55% of the women and 34% of the men had moderate or severe memory problems (8). In contrast, however, Gelberg and others found that older homeless adults were no more likely than younger adults to have memory loss. This finding is perhaps attributable to a relatively young cohort of older adults: the overwhelming majority were aged 50 to 65 years (43). Estimates of the proportion of older homeless men who drink alcohol depend on the group sampled. One-half of the men living on skid row in New York drank daily (5,6), yet only 13% of older shelter users in New York drank regularly (23). In Los Angeles, 19% of older homeless people drank daily (43), and in London, UK, only 8% of hostel users over age 65 years needed alcohol and drug services (11). Older homeless people appear no more likely to drink than do younger homeless people (23,43), and in one study in London, they were significantly less likely to drink than were younger homeless people (11). Older homeless women are less likely to drink than are their male counterparts (10,23). Illicit drug use is low among the homeless elderly (11,23,43).

Survey Results

The shelter-use data for Toronto, Ontario, revealed that, of the total number of shelter users every year since 1997, 2% were over age 65 years (that is, about 450 individuals yearly). Men over age 65 years outnumbered women over age 65 years by 3 to 1. This ratio is similar to the ratio for other North American cities (23,34,35). In addition, among adult hostel users aged 18 to 85 years in 2000, 12.3% were over age 50 years and 3.6% were over age 60 years (personal communication) (Table 3). Community and Neighbourhood Services Department analysis of shelter-use data, taken over a 13-year period ending in 2000, has also revealed that adult hostel users aged over 65 years have unique characteristics: they tend to stay in the system longer, their exit into stable housing has been lower than expected, most are men and repeat users, and they are more likely to be from Toronto, compared with younger hostel clients.

Eight of the 11 hostel directors contacted completed our survey. Review of the completed surveys revealed that younger and older hostel clients in Toronto have different perceptions of the reasons for homelessness (Table 4). Those over age 65 years are more likely to have cognitive impairment, family breakdown, elder abuse, and hospital referrals precipitate their need for emergency shelter, compared with the younger clients. Evictions commonly precipitate homelessness in both age groups.

Table 4 Most common reasons for hostel use reported by hostel staff

Men ≥ 65 years	Men ≤ 64 years	Women ≥ 65 years	Women ≤ 64 years
Family breakdown	Unemployment	Elder abuse	Family violence
Eviction	Eviction	Family breakdown	Eviction
Cogntive impairment	Mental illness	Eviction	Mental illness
Alcohol abuse	Substance abuse	Hospital referrals	Substance abuse

Table 5 Client symptoms or behaviours ranked according to concern they cause for hostel staff

Men ≥ 65 years	Men ≤ 64 years	Women ≥ 65 years	Women ≤ 64 years
Alcohol abuse	Alcohol abuse	Depression	Verbal aggression
Cogntive impairment	Substance abuse	Paranoia	Alcohol abuse
Verbal aggression	Physical aggression	Cognitive impairment	Substance abuse

Although most hostel directors reported equal rates of behavioural problems among younger (under age 65 years) and older (over age 65 years) clients, the problem behaviours differed between the 2 groups (Table 5).

For men over age 65 years, problems most likely to concern staff included memory impairment, verbal aggression, and alcohol abuse. Women over age 65 years were more likely to present with memory impairment, paranoia, and depression. Problem behaviours identified in the younger clients included alcohol and other substance use and physical and verbal aggression. Direct comparison of the 2 groups confirmed that clients under age 65 years are more likely to drink and use street drugs and, further, revealed that those over age 65 years are more likely to have memory difficulties, a concurrent physical illness, restricted mobility, difficulty with self-care, and difficulty planning daytime activities. One-half of the hostel directors identified a need for additional psychiatric services on-site. Further, education regarding the needs of seniors was only available to 2 of the 8 hostels that participated in our survey, in the form of yearly inservices.

Discussion

Bachrach has emphasized the importance of recognizing that "each cluster of homeless individuals has its own distinctive demography, epidemiology and history, as well as its own treatment needs" (50). In Toronto, the number of homeless people continues to rise, with 30 000 people using emergency shelters in 1999 (51). Most of those staying in Toronto's emergency-shelter system are single men, with increasing numbers of youth and families using the system. With respect to the city's demographics, racial minorities are overrepresented as they are in other cities (23,33,35). Seniors in the system have thus far been overlooked. The finding that 2% of adult hostel users in Toronto are over age 65 years and 3.6% are over age 60 years is comparable with other North American cities (21,23,24) but much lower than reports from the UK (8,27). Although these numbers were derived from shelter-use data and therefore reflect homeless seniors using emergency shelters, previous work in Toronto and in the US suggests that most homeless people use available shelter services at some point (33,47). The extent to which this holds true for the elderly homeless is unclear, given their fear of violence from their younger counterparts (12). Shelter-use data also revealed that the elderly homeless in Toronto may be more disadvantaged: they tend to stay in the system longer than do younger homeless people, and their exit into stable housing has been lower than expected. Although this may be owing to lack of supportive housing, strict nursing-home admission criteria, and their fear of institutionalization, it may also reflect greater disability and unmet needs, especially among the chronically homeless and the chronically mentally ill elderly. The reviewed literature supports significant psychiatric morbidity in this population, and other studies have demonstrated that homeless people with mental illness tend to be homeless longer and spend more time in shelters, compared with their homeless counterparts who are not mentally ill (35,52).

The pathway to homelessness for the elderly is multifactorial (21,37), and our survey supports the hypothesis that diverse events precipitate homelessness in seniors, compared with younger people. Better knowledge of risk factors, antecedents, and triggering events in this age group may help define a prehomeless state and inform preventive measures (8,42). In the interim, more responsive hospital-discharge planning and

the establishment of different levels of care (such as infirmaries and longer-term beds) after hospital discharge have been suggested by local agencies (40,51). The literature reviewed suggests that elderly homeless people have multiple needs extending beyond the lack of housing: they face physical and mental health problems and "lack a social margin at a time of life when most people expect to draw on that set of resources and relationships" (12). Our own survey in Toronto raises concerns about age-specific unmet physical and mental health needs among homeless seniors, particularly among those with mobility and memory problems. Hostel staff indicate that seniors often have difficulty accessing shelters as a result of mobility needs and physical limitations that compromise their ability to climb stairs or sleep on the floor. Further, one-half of the shelters surveyed close during the day, leaving individuals who need help with self-care and with planning daytime activities on the street. As older homeless people stay in the system longer and are less likely to be housed successfully, it becomes paramount to adapt and improve shelters to suit elderly client needs. Traditional community-based health service programs for the elderly are not designed to serve the elderly homeless population. For the elderly homeless, several barriers impede access to such services. These include a lifestyle that interferes with preventive measures and treatment of acute or chronic conditions; language and cultural barriers; lack of health card identification; and dissatisfaction with. and perceived discrimination in, existing services (8,40). In response to these barriers, which are faced by all homeless people, the provincial government has funded homeless health services in targeted community health centres, as well as "shared care teams" that provide health services within the shelters (51). These teams comprise a psychiatrist, a primary care physician, a nurse or social worker, and a mental heath outreach worker. Assessing homeless people of all ages, they currently only partly address the need for mental health services, as evidenced by the need for additional on-site psychiatric services identified by one-half of the hostels surveyed and by the lack of staff training regarding clients' age-specific needs.

To conclude, our survey aimed to draw attention to the people in this vulnerable group and to highlight their need for services. We require more research to document the health needs of this population systematically and reliably. Future surveys should include seniors in drop-in centres, in food banks, and in out-of-the-cold programs, as well as those who congregate in various parts of the city. Because of the methodological challenges in studying this group (1,10,52), a comprehensive needs assessment may help policy makers and service providers more than do detailed diagnostic assessments (15,55). Such an assessment should include patient and staff views regarding services, given the importance of consumer perspectives in designing and delivering mental health services (15,35,56). Finally, given the growing numbers of homeless people in Toronto, there may be a role for day programs to engage the homeless elderly and those at risk. Centres designed specifically for older homeless individuals have been established in New York and in Boston and have been well used (12,53,54). Gelberg has argued that geriatricians may have a unique advantage in helping other providers assess the homeless elderly, owing to their experience with community care, outreach, and comprehensive health assessments (43). The same arguments could well apply to geriatric psychiatrists, who, through direct assessments and indirect consultation, could assist multidisciplinary teams to assess and treat elderly homeless people in a more comprehensive way.

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References

1. Susser E, Conover S, Struening E. Mental illness in the homeless: problems of epidemiologic method in surveys of the 1980s. Community Ment Health J 1990;26:391–414.
2. Stewart B McKinney Homeless Assistance Act, P. L. 1987; 100–77.
3. Bassuk EL, Rubin L, Lauriat A. Is homelessness a mental health problem? Am J Psychiatry 1984;141:1546–50.
4. Cohen CI, Teresi JA, Holmes D. The physical well being of old homeless men. J Gerontol 1988; 43:S121–S128.
5. Cohen CI, Teresi J, Holmes D, Roth E. Survival strategies of older homeless men. Gerontologist 1988;28:58–65.
6. Cohen CI, Teresi J, Holmes D. The mental health of old homeless men. J Am Geriatr Soc 1988;36:492–501.
7. Kutza EA, Keigher SM. The elderly "new homeless": an emerging population at risk. Social Work 1991;36:288–93.
8. Crane M. The situation of older homeless people. Rev Clin Gerontol 1996;6:389–98.
9. Crane M. Elderly, homeless and mentally ill: a study. Nurs Stand 1992;7(13):35–8.
10. Crane M. The mental health problems of elderly people living on London's streets. Int J Geriatr Psychiatry 1994;9:87–95.
11. Abdul-Hamid W. The elderly homeless men in Bloomsbury hostels: their need for services. Int J Geriatr Psychiatry 1997;12:724–7.
12. Doolin J. Planning for the special needs of the homeless elderly. Gerontologist 1986;26:229–31.
13. Fischer P, Breaky W. Homelessness and mental health: an overview. Int J Ment Health 1986;14(4):6–41.
14. Belcher JR. Defining the service needs of homeless mentally ill persons. Hosp Community Psychiatry 1988;39:1203–5.
15. Reynolds T, Thornicroft G, Abas M, Woods B, Hoe J, Leese M, and others. Camberwell assessment of need for the elderly. Br J Psychiatry 2000;176:444–52.
16. Freeman R, Hall B. Permanent homelessness in America? Popul Res Policy Rev 1987;6(1):3–27.
17. Hibbs JR, Benner L, Klugman L, Spencer R, Macchia I, Mellinger A, Fife DK. Mortality in a cohort of homeless adults in Philadelphia. N Engl J Med 1994;331:304–9.

18. Hwang SW, Orav EJ, O'Connell JJ, Lebow JM, Brennan TA. Causes of death in homeless adults in Boston. Ann Intern Med 1997;126:625–8.
19. Barrow SM, Herman DB, Cordova P, Struening EL. Mortality among homeless shelter residents in New York City. Am J Public Health 1999;89:529–34.
20. Hwang SW. Mortality among men using homeless shelters in Toronto, Ontario. JAMA 2000;283:2152–7.
21. Tully CT, Jacobson S. The homeless elderly: America's forgotten population. J Gerontol Soc Work 1994;22(3/4):61–81.
22. Aging Health Policy Center. The homeless mentally ill elderly. Working paper. San Francisco (CA): University of California; 1985.
23. Ladner S. The elderly homeless. In: Robertson M, Greenblatt M, editors. Homelessness: a national perspective. New York: Plenum Press; 1992. p 221–6.
24. Institute of Medicine, Committee on Health Care for Homeless People. Homelessness, health and human needs. Washington (DC): National Academic Press; 1988.
25. Coalition for the homeless. Crowded out: homelessness and the elderly poor in New York City. New York: The Coalition for the Homeless; 1984.
26. Rossi PH, Fisher G, Willis G. The condition of the homeless in Chicago. Chicago (IL): University of Chicago; 1986.
27. George SL, Shanks NJ, Westlake L. Census of single homeless people in Sheffield. BMJ 1991;302:1387–9.
28. Goering P, Paduchak D, Durbin J. Housing homeless women: a consumer preference study. Hosp Community Psychiatry 1990;41:790–4.
29. Goering P,Wasylenki D, Onge MS, Paduchak D, Lancee W. Gender differences among clients of a case management program for the homeless. Hosp Community Psychiatry 1992;43:160–5.
30. Wasylenki DA, Goering PN, Lemire D, Lindsay S, Lancee W. The hostel outreach program: assertive case management for homeless mentally ill persons. Hosp Community Psychiatry 1993;44:848–53.
31. Raynault MF, Battista RN, Joseph L, Fournier L. Reasons for the hospitalization and length of stay of a homeless population in Montreal. Can J Public Health 1994;85:274–7.
32. Zapf PA, Roesch R, Hart SD. An examination of the relationship of homelessness to mental disorder, criminal behavior, and health care in a pretrial jail population. Can J Psychiatry 1996;41:435–40.
33. Tolomiczenko GS, Goering PN. Pathways into homelessness. Broadening the perspective. Psychiatry Rounds 1998;2(8):1–5.
34. Acorn S. Mental and physical health of homeless persons who use emergency shelters in Vancouver. Hosp Community Psychiatry 1993;44:854–7.
35. Stuart HL, Arboleda-Florez J. Homeless shelter users in the postdeinstitutionalization era. Can J Psychiatry 2000;45:55–62.
36. Roth D, Bean GJ. New perspectives on homelessness: findings from a statewide epidemiological study. Hosp Community Psychiatry 1986;37:712–9.
37. Cohen CI. Aging and homelessness. Gerontologist 111;39(1):5–14.
38. Adams Sullivan M. The homeless older women in context: alienation, cutoff and reconnection. J Women Aging 1991;3(2):3–24.
39. Keigher SM, Greenblatt S. Housing emergencies and the etiology of homelessness among the urban elderly. Gerontologist 1992;32:457–65.
40. Kappel Ramji Consulting Group. Common occurrence: the impact of homelessness on women's health. Phase II: community based action research-final report. Toronto: Sistering/Toronto Community Care Access Centre; 2002.
41. Brickner P, Filardo T, Iseman M, Green R, Conanan B, Elvy A. Medical aspects of homelessness. In: Lamb HR, editor. The homeless mentally ill. Washington (DC): American Psychiatric Association; 1984.
42. Robertson M, Cousineau M. Health status and access to health services among the urban homeless. Am J Public Health 1986;76:561–3.
43. Gelberg L, Linn LS, Mayer-Oakes SA. Differences in health status between older and younger homeless adults. J Am Geriatr Soc 1990;38:1220–9.
44. Gelberg L, Linn LS. Demographic differences in health status of homeless adults. J Gen Intern Med 1992;7:601–8.
45. Ropers RH, Boyer R. Perceived health status among the new urban homeless. Soc Sci Med 1987;24:669.
46. Snow D, Baker S, Anderson L, Martin M. The myth of pervasive mental illness among the homeless. Soc Problems 1986;33:407–23.
47. Fischer PJ, Breakley WR. The epidemiology of alcohol, drug and mental disorders among homeless persons. Am Psychol 1991;46:1115–28.
48. Koegel P, Burnam M. Problems in the assessment of mental illness among the homeless. In: Robertson M, Greenblatt M, editors. Homelessness: a national perspective. New York: Plenum Press; 1992.
49. Douglass RL, Atchison BJ, Lofton WJ, Hodgkins BJ, Kotowski K, Morris J. Aged, adrift and alone: Detroit's elderly homeless. Final report to the Detroit Area Agency on Ageing. Ypsilanti (MI): Department of Associated Health Professions; 1988.
50. Bachrach LL. Interpreting research on the homeless mentally ill: some caveats. Hosp Community Psychiatry 1983;35:914–7.
51. City of Toronto 2001. The Toronto report card on homelessness. Toronto: City of Toronto; 2001.
52. Haugland G, Siegel C, Hopper K, Alexander MJ. Mental illness among homeless individuals in a suburban county. Psychiatr Serv 1997;48:504–9.
53. Cohen CI, Onserud H, Monaco C. Project rescue: serving the homeless and marginally housed elderly. Gerontologist 1992;32:466–71.
54. Cohen C, Onserud H, Monaco C. Outcomes for the mentally ill in a program for older homeless persons. Hosp Community Psychiatry 1993;44:650–6.
55. Abdul-Hamid W, Howard R, Silverman M. Needs assessment in old age psychiatry: a need for standardization. Int J Geriatr Psychiatry 1995;10:533–40.
56. Herman DB, Streuning EL, Barrow SM. Self assessed need for mental health services among homeless adults. Hosp Community Psychiatry 1993;44:1181–3.

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Résumé : Âgé et sans abri : une étude et un sondage des adultes âgés qui utilisent les refuges dans un cadre urbain

Objectifs : La recherche sur la santé mentale et les besoins de services des personnes âgées sans abri est faible. Cet article examine la documentation disponible et présente les résultats d'une étude menée à Toronto en vue de décrire les données démographiques des personnes âgées sans abri, leur niveau d'invalidité ainsi que leurs besoins en matière de santé mentale et physique.

Méthodes : Nous avons effectué une recherche dans les bases de données Medline, AgeLine, et PsycINFO à l'aide des mots clés personnes âgées sans abri, utilisateurs de refuges pour personnes âgées, et gériatrie urbaine. Pour mieux décrire les besoins de services des personnes âgées sans abri, nous avons obtenu les données démographiques du ministère des Services à la collectivité, à la famille et à l'enfance et avons distribué un questionnaire à 11 directeurs de refuges de Toronto. Le questionnaire visait à obtenir des données relatives aux raisons de l'utilisation des refuges, aux comportements problématiques et aux besoins en matière de santé mentale des personnes de plus de 65 ans.

Résultats : Bien que les personnes âgées représentent un modeste pourcentage de la population itinérante, leur nombre est en croissance. La documentation existante indique une prévalence élevée de troubles psychiatriques et de déficience intellectuelle dans cette population, la proportion de grave maladie mentale étant plus forte chez les femmes que les hommes. En outre, notre sondage indique que les besoins de services des personnes âgées qui ont recours aux refuges à Toronto diffèrent de ceux des itinérants plus jeunes.

Conclusion : Les personnes âgées sans abri sont les plus vulnérables de cette population démunie. Il faut plus de recherche pour définir leurs besoins en matière de santé mentale et physique ainsi que la façon d'y répondre, mais leurs caractéristiques semblent uniques. Les gérontopsychiatres pourraient jouer un rôle de premier plan dans l'évaluation et le traitement plus complets de cette population.