Moving Past The Barriers And Hidden Realities Older Homeless Adult Males Experience In Their Attempt To Access Supportive Services In The Toronto Area

By

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ABSTRACT

This is a qualitative research study which seeks to uncover barriers that prevent homeless older men from accessing support programs and services in Toronto, Ontario. This study involved five men who are fifty years of age and older and are currently homeless in Toronto. The recruitment process for this study was conducted in a drop-in centre located in the downtown Toronto area. The lived experiences of the research participants is critically relevant to this qualitative study, since the information the men provided has been used to amplify participant demands, challenge oppressive relations and structures, and create awareness at the legal and political level.

Key Words: Barriers, Anti-Oppression, Oppression, Structuralism, Critical Social Theory, Narrative, Marginalization, Oppression, Homeless Shelters, Stigmatization, Victimization
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Dedication

I would like to dedicate this research study to the abovementioned participants who generously offered their valuable efforts, time and energy, and expert knowledge, to make this qualitative social research study on homeless older adult males a memorable and successful experience.
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Part 1: Introduction

This research study examines the structural barriers and hidden realities homeless older adult males experience in their attempt to access support programs and services in Toronto, Ontario, Canada. Homeless men fifty years old or older were included in this research study. Empirical research indicates that homelessness is one of the most complex social and political problems facing society today (Hulchanski, Campsie, Chau, Hwang & Paradis 2009, as cited in Gaetz, 2010; Frankish, Hwang, & Quantz, 2005; McDonald, Dergal, & Cleghorn, 2004; Cohen et al, 1988 as cited in Stergiopoulos & Hermann, 2003; The Alliance To End Homelessness, 2011; The Toronto Report Card on Housing and Homelessness, 2003; Crane & Warnes, 2010). Literature, however, does not provide a single definition for homelessness. For the purposes of this research study, the term homeless will refer to conditions that comprise living outdoors or in abandoned buildings, vehicles and garages, as well as staying in shelters (Frankish et al, 2005; Speak & Tipple, 2006; McDonald et al, 2004; Ploeg, Hayward, Woodward, & Johnston, 2008; Kutza & Keigher, 1991; Hwang, 2001; Gaetz, 2004; Stergiopoulos & Herrmann, 2003; REACH, 2010).

According to Frankish et al (2005), 1987 was the first year that the Canadian Council on Social Development began efforts to provide estimates with respect to the number of homeless people in Canada. The problem of homelessness has become a more conspicuous problem as a growing homeless population occupies park benches, shopping malls, and other public spaces (Gaetz, 2010). The visibility of the situation has led many to acknowledge that the problem of homelessness is a “crisis,” and “national disaster” (Gaetz, 2010; Frankish et al, 2005; Turnbull, Muckle, & Masters, 2007; Ploeg et al, 2008). Unfortunately, however, the plight of homeless older men has been largely ignored and continues to be a growing and difficult social issue.
Homeless elderly persons have been described as the ‘new homeless’ ‘forgotten’ and the ‘hidden’ (Kutza & Keigher, 1991; Crane 1994a, Tully & Jacobson, 1994 as cited in Ploeg et al, 2008, p. 593). This ‘invisible’ non-status of the older, homeless population creates enormous barriers in accessing community supports in Canada and this will be the focal point of my research (McDonald et al, 2004).

The issue of homelessness among “older adults” is a serious and growing problem (Hulchanski, Campsie, Chau, Hwang, & Paradis 2009, as cited in Gatez, 2010; Frankish et al, 2005; The Alliance to End Homelessness, 2011; The Toronto Report Card on Housing and Homelessness, 2003; Crane & Warnes, 2010; Kutza & Keigher, 1991). There is, however, little doubt that the older, homeless population will increase as the baby boomer generation ages. For example, a common concern among researchers is that as the Canadian population ages, homeless seniors will undoubtedly increase significantly in Canada, due to the rising cost of living, the lack of affordable housing, and other declining resources (Gaetz, 2010; Ploeg et al, 2008; Turnbull et al, 2007; Frankish et al, 2005; McDonald et al, 2004; Stergiopoulos & Herrmann, 2003; Kutza & Keigher, 1991). It is expected that the social implications of this growing pandemic will be severe because of the “special attention older, homeless adults require” (McDonald et al, 2004, p. 8). This population is an extremely vulnerable sector of the homeless population and presents considerable future challenges due to the increased risk of chronic diseases, suicides, victimization, and mortality (Frankish et al, 2005; Hwang, 2001; Kutza & Keigher, 1991; Hoch, Dewa, Hwang, & Goering, 2008; McDonald et al, 2004; Ploeg et al, 2008). Therefore, urgent attention to this matter is required and that is why I have chosen to study the structural barriers and hidden realities older, homeless men experience in their attempt
to access vitally needed resources in Toronto, Ontario, Canada. It is my intention to use the principles of anti-oppression research to work collaboratively with my research participants so that their life experiences and knowledge might contribute to social change in this area of need.
Part 2: Researcher’s Positionality

I am especially aware that power dynamics can easily influence my relationship with the research participants. Therefore, I place great importance on understanding and critically examining my positionality as an anti-oppressive researcher. In this way, considering my social location and rigorously addressing issues that may contribute to power differentials are essential aspects of this emancipatory social research on homeless older adult males.

This brings me to a discussion of my social location and identity. I am male and bi-racial. My father suddenly died when I was three months old. Due to his untimely death, my mother raised my brother and me as a single parent. I spent most of my adolescence and much of my adult years addicted to alcohol and drugs. Over a period of approximately eight years my situation deteriorated to the point where I became destitute, homeless, and disengaged from reality. In my stupor, prison became my revolving door to shelters. During these years my experience with service providers was often negative and demeaning. My own lived experiences as a member of the homeless population has influenced me to explore relations of dominance and subordination with the explicit political goal of benefitting this community. I consider that both the research process and the outcome are crucial aspects of my research. In this way, maintaining a relationship of trust with the research participants throughout the study and offering a respectful representation of the community have been of paramount importance to me. Giving a voice to older homeless men has been an essential goal of this emancipatory social research study. The years I spent homeless on the streets of Toronto have led me to investigate the structural barriers that older, homeless males face as they attempt to access social services in the Greater Toronto Area.
Part 3: LITERATURE REVIEW ON HOMELESSNESS

3.1 Statistics on Homelessness

Various efforts have been made to gain a “clear understanding of the nature and extent of homelessness in Canada” (Frankish et al, 2005, p. S24). Given the transient nature of the homeless population, it has been difficult to compile an accurate national or local estimate of the number of homeless people living in Canada (Hoch et al, 2008; Peressinin, 2007; Kutza & Keigher, 1991; Steriopoulos & Herman, 2003; Turnbull et al, 2007). However, some urban centres have attempted to monitor the crisis and provide recommendations to address this social problem (The Great Vancouver Region, City of Calgary Homeless Count, as cited in Frankish et al, 2005; The Toronto Report Card on Housing and Homelessness, 2003; The Alliance to End Homelessness, 2011).

In 1999, “The Homeless Action Task Force” recommended that the City of Toronto develop a “report card” to assess whether government is addressing the problem of homelessness in a satisfactory manner (The Toronto Report Card on Housing and Homelessness, 2003). Unfortunately, The Toronto Report Card on Housing and Homelessness (2003) was discontinued after 2003. In 2009, The Alliance to End Homelessness in Ottawa (ATEH) was established to produce report cards on homelessness in Ottawa (The Alliance to End Homelessness, 2011). Between the years 2004-2011, statistical data collected by The Alliance to End Homelessness (2011) reported that Ottawa experienced a significant jump in homelessness by 31.6% (The Alliance to End Homelessness, 2011).

Toronto, Ontario has the largest population of homeless people in the nation (Hwang, 2001). It was estimated that shelter occupancy in Toronto on a nightly basis had risen from 1,902
individuals to 3,790 individuals between the years 1990 and 1998 (Hwang, 2001). The Toronto Report Card on Homelessness (2003) found a 21% increase in homelessness as compared to the previous two years. Statistical data suggests that, in 2002, about 4,200 homeless utilized the shelter system on a nightly basis in Toronto (Hwang, 2001; The Toronto Report Card on Housing and Homelessness 2003; as cited in Hoch et al, 2008). In a later study, the number of homeless people in Toronto needing nightly help from the emergency shelter system jumped significantly from anywhere between 5,000-6,500 individuals (St. Michael’s Hospital, 2007). Literature establishes that the Canadian shelter system is unable to provide the help needed (The Toronto report Card on Housing and Homelessness, 2003; The Alliance to End Homelessness, 2011; Gaetz, 2010; McDonald et al, 2004).

Shelter-use statistics documenting the elderly is sparse. It has been estimated that between 14% and 28% of adult male shelter users are fifty years of age or older, 3.6% are older than sixty years of age, and 2% (roughly 450 individuals annually) of adult male shelter users are older than sixty-five years of age (Stergiopoulos & Herrmann, 2003). According to Stuart & Arboleda-Florez (2000) 6% of shelter users were fifty-five years of age or older (as cited in Ploeg et al, 2008). Although, these statistics are without question quite staggering, these figures are mere estimates of the actual total number of homeless older adults in the city of Toronto.

3.2 Homeless people and The Health Care System

The literature confirms that older homeless men do not receive equitable health care (Kutza & Keigher, 1991). Homeless people are often restricted to the fringes of society because they are perceived to be violating societal norms and public sensibilities (Speak & Tipple, 2006). The service delivery model in the health care system is based on a narrow hegemonic perspective
that stigmatizes and marginalizes people (Williams, 2002). In this way, professionals in the medical sector often expect individuals to act, look, talk, and behave in ways that are commonly upheld as socially acceptable behaviours (Williams, 2001). Negative judgements erect barriers that exclude patients who are homeless from receiving quality treatment in hospitals. These derogatory, stereotypical views often present themselves in the conduct of service providers’ who perpetuate oppression (Phelan et al, 1997). Studies show that health care professionals often act in a socially distant manner (Phelan et al, 1997). This form of discrimination often works to disempower the homeless population from obtaining medical attention, despite how desperately they may need it (Hwang & Dunn, 2005; Wen et al, 2007, as cited in Hoch et al, 2008). Turnbull et al (2004) state that, “older homeless people face a number of barriers to accessing health services such as: the fear of illness, mistrust of physicians, fear of being shunned by professionals, lack of recognition of the severity of the illness, not having a health card and the cost of medications” (p. 8).

Homeless people in their 40’s and 50’s “often develop health disabilities that are commonly seen in persons who are decades older” (Frankish et al, 2005, p. S25). Research suggests that in most cases the only medical care the homeless population receives is from a hospital emergency department, which is often very expensive and ineffective (Turnbull et al, 2007). Homeless patients, who are admitted to hospital, are frequently moved quickly through the health care system, discharged prematurely, and sent to neighbouring shelter systems despite their physical inability to cope under such unsafe conditions (Hwang, 2001). Research indicates that the homeless, “are discouraged by a system that works for others but that works against them” (Turnbull et al, 2007, p. 1065-66).
3.3 UNDERSTANDING HOMELESSNESS - ROOT CAUSES

The evident rise in the incidence of homelessness has led researchers to examine the causes of homelessness. Explanations for homelessness have generally been dichotomous and have either reflected a focus on socio-economic structures or individual causes. Individual factors leading to homelessness have included alcohol and substance abuse, various health problems, and family breakdowns (Kim, Ford, Howard, & Bradford, 2010; Tessler, Rosenheck, & Gamache, 2002, as cited in Barrett et al, 2011; Rossi, 1990, as cited in Hoch et al, 2008; Kutza & Keigher, 1991, Gaetz, 2010, Rickards, McGraw, Araki, Casey, High, Hombs, & Raysor, 2009). My study will center on structural inequalities that affect the design and delivery of community supports and make it particularly difficult for homeless older adults to access social services and programs (McDonald et al, 2004; Hoch et al, 2008; Stergiopoulos & Herrmann, 2003; Ploeg et al, 2008). Structural inequalities result in daily institutional practices that assemble barriers that perpetuate the marginalization and oppression of Canada’s older population (Kutza & Keigher, 1991; Frankish et al, 2005; Hoch et al, 2008; McDonald et al, 2004; Gaetz, 2010). Research findings suggest that unless change occurs at the institutional and governmental levels, homeless older adults will continue to face numerous structural barriers that reproduce oppression and lead to homelessness among an older adult population (Barrett et al, 2011; Apicello, 2010; The Alliance to End Homelessness, 2011; The Toronto Report Card on Housing and Homelessness, 2003).
Part 4: UNDERSTANDING HOMELESSNESS - STRUCTURAL BARRIERS

4.1 Lack of Age-Segregated Programs & Services

There are number of structural barriers which make accessing services in Toronto increasingly more difficult for the homeless older adult population. One area that researchers have observed as a legitimate barrier involves a lack of “age-segregated” shelters geared toward homeless older adults (McDonald et al, 2004, Frankish et al, 2005; Gaetz, 2010; Kutza & Keigher, 1991). Public policy does discriminate between young homeless adults and older homeless adults, which suggests that there are little or no age appropriate services that best address the needs of an older adult homeless population (Kutza & Keigher, 1991; McDonald et al, 2004). Older homeless adults generally avoid going to homeless shelters for fear that shelters are inadequately equipped to address their complex needs (Kutza & Keigher, 1991). The needs of an older homeless generation often include the need for special accommodations to assist with physical limitations and mobility issues. These are not offered in homeless shelters (Ploeg et al, 2008; Kutza & Keigher, 1991). Comparing empirical research studies, between the late 20th C in relation to subsequent studies that have been conducted during the early 21st C, it appears that policy and practices that regulate shelter systems has not improved their services to assist an ever increasing homeless older adult population.

4.2 Home-care and Homemaking Services

In previous years, home-care and homemaking services made it possible for greater numbers of vulnerable elderly Canadians to maintain their homes with assisted living services and programs. Assisted living programs helped to ensure that vulnerable, elderly individuals paid
their rent, took their daily dose of medication, ate healthy meals, attended medical appointments, and received help to shop for groceries. The list of other age-appropriate services that were readily available is extensive and even includes services to ensure that the homes of elderly citizens meet public health and safety standards to prevent eviction due to squalor conditions (Ploeg et al., 2008). Although, this resource is a vital community service to the elderly, a large number of senior citizens have been adversely impacted by major funding cuts to these programs. A group of research participants reported that funding cuts to home-care and homemaking services played a major role in their inability to live independently and eventually led to homelessness (Ploeg et al., 2008).

4.3 Unaffordable Housing

Canada is a prosperous nation with strong economic resources. Yet, despite Canada’s wealth, resources, and political might; marginalized groups of Canadians, including older, homeless male adults, are increasingly experiencing homelessness (Gaetz, 2010; Peressini, 2007; Hwang, 2001; Turnbull et al., 2007). An analysis of shelter data during a fifteen year period (1987-2002) confirmed that the number of homeless older adults is increasing in Toronto (McDonald et al., 2004). A lack of affordable housing has become an observable crisis in Canada’s large metropolitan cities. There is a “growing gap between the rich and poor, and a decrease in affordable housing and the social housing supply” (Shapcott, 2003, as cited in Gaetz, 2004, p. 11). Literature on housing security analyzes the problem from two distinct vantage points. One approach stresses employment problems associated with inadequate income and insufficient employment opportunities for many in Canada (The Toronto Report Card on Housing and Homelessness, 2003). The other perspective addresses the problem from supply
considerations maintaining that the shortage of affordable rental properties and government-subsidized housing is the decisive factor in the problem (Frankish et al, 2005; Kawash, 1998; Gaetz, 2010; Apicello, 2010).

It is undeniable, however, that there are few housing options for vulnerable groups of people who need rent-g geared-to-income (RGI) apartments, as is evidenced “by the lengthy waiting lists for low-rent housing” (Ploeg et al, 2008, p. 601). In 2003 there were 71, 000 families on the wait list for subsidized or RGI units and each year it is estimated that about 4,500 families will placed in a subsidized unit (The Toronto Report Card on Housing and Homelessness, 2003). In 2011, the number of households on waitlists in Ontario had risen to 156, 358 and this number has been steadily increasing each year (ONPHA Report, 2012). The number of elderly people on this waitlist has steadily grown since 2004 and by the end of 2011, it was reported that 39, 463 were waiting to get affordable housing (ONPHA Report, 2012). This means that individuals may wait anywhere from 2-10 years or longer for affordable housing (ONPHA Report, 2012).

It has been suggested that one reason for the lack of affordable housing options has been the growth of “programs of urban renewal” (Kawash, 1998, p. 320). The emergence of policies promoting the creation of gentrified spaces in major metropolitan centres has targeted those who are socially and economically vulnerable further perpetuating their oppression (Kawash, 1998; Peressini, 2007). The Regent Park Revitalization Project is a current example in Toronto that promotes gentrified spaces in the city. Regent Park was designed exclusively for low-income individuals and families. Government, land developers, and other stakeholders, however, are in the process of replacing the community’s social housing arrangement with new town houses and condominiums. Many low-income families and individuals have been displaced or are being
transferred to other areas of the City so that choice land in downtown Toronto might be made available to those able to pay market rent. This has led to a multi-million dollar project that largely ignores the situation of those who are in need of affordable housing.

4.4 Social Safety Net

The emergence of a neo-liberal political system in Canada has led to the systematic breakdown of our Canadian social safety net (Samuelson & Anthony, 2007). The Canadian social safety net was intended to provide adequate resources which prevent Canadian citizens from falling into homelessness (McDonald et al, 2004; Peressini, 2009). However, current neoliberal policies have restructured fiscal policy by placing greater focus on individual agency and by emphasizing competitiveness, free trade, deregulation, and by radically reducing government’s role in “managing economic life and guaranteeing social welfare and equality” (Samuelson & Anthony, 2007, p. 245). Many academics contend that the ‘system’ is not adequately meeting the needs of its citizens (Frankish et al, 2005; Turnbull et al, 2007; The Toronto report Card on Housing and Homelessness, 2003). Neoliberal policies have created large “gaps in the social safety net” (Turnbull et al, 2007, p. 1065) which have made it very difficult for many Canadians to receive much needed social supports (McDonald et al, 2004).

Many homeless older adults have “poor” physical and/or mental health conditions which typically prevent them from maintaining or accessing any form of employment (McDonald et al, 2004). According to McDonald et al (2004) homeless older adults develop conditions associated with aging 10 to 20 years earlier than the general population. This impacts their ability to work. As a result, many homeless older adults who can no longer work do not meet the age eligibility criteria (65) to access benefits such as Old Age Security (OAS) or Canadian Pension Plan (CPP)
(McDonald et al., 2004). Consequently, older adults who do not qualify for these entitlements have to wait until they meet the age eligibility criteria even if the wait leads to homelessness. Some older adults may qualify for Ontario Works (OW) or the Ontario Disability Support Program (ODSP) and others may be eligible for the Personal Needs Allowance (PNA) however, all these benefits are meagre. In addition, navigating through the application processes is difficult. The eligibility process for ODSP is extensive and many applicants are determined not to be suitable candidates. In Peressini’s (2009) study on homelessness, respondents reported that they believed Canada’s social safety net has failed them, since they were ineligible to receive financial support through “Social Assistance (OW), Unemployment Insurance (UI), and the Canada Pension Plan (CPP). This help would have otherwise mitigated the financial needs of this older generation (Barrett et al., 2011). Scholarly research suggests that such structural barriers can be eliminated if policy focuses on age appropriate programs and services to better address the financial needs of older homeless individuals (McDonald et al., 2004; Gaetz, 2010).

Research indicates that the problem of homelessness among an older adult population is not limited to Canada but has increased throughout North America (Stergiopoulos & Herrmann, 2003; Apicello, 2010; Barrett et al., 2011; Rickards et al., 2009). As cited in Barrett et al. (2011), “During the last decade, government, non-profit, faith-based, and other agencies that serve vulnerable, poor, marginalized individuals...have been faced with declining resources” (McNichol & Nicholas, 2009; National Coalition for the Homeless, 2009; U.S. Department of Labor, Bureau of Labour Statistics, 2009, p. 338). This has deeply disadvantaged special groups like homeless older adults.

Advocates for the homeless endorse restructuring at all levels of government (Ploeg et al., 2008; Belcher & Deforge, 2012; Turnbull et al., 2007; Apicello, 2010; Rickards et al., 2009;
Barrett et al., 2011; Hoch et al., 2008; McDonald et al., 2004). Social researchers suggest that new strategies must be developed to reduce barriers which limit access to resources and services in Toronto, Canada and abroad (Turnbull et al., 2007; Rickards et al., 2009; Barrett et al., 2011; Apicello, 2010; Ploeg et al., 2008; Belcher & Deforge, 2012). Greater investment in social programs and services that focus specifically on prevention strategies concerning elderly homelessness are being suggested (Gaetz, 2010). Developing a more comprehensive social safety net would involve creating new policies and program initiatives to include supplemented rent cost programs, in-home services to assist older individuals, and a system to monitor older adults who are at risk of losing their homes (Gaetz, 2010; Hwang, 2001; Turnbull et al., 2007; Peressini, 2007). These suggestions need to be ratified and implemented by all levels of government (Gaetz, 2010). Government policies, however, continue to be informed by Enlightenment theories with respect to the individual’s autonomy and responsibility for choices. This ideology informs public policy and limits the state’s intervention problems facing its citizens. In this way, a comprehensive policy addressing the issue of homelessness is not in operation and inadequate initiatives are the norm.

4.5 Dominant Discourse & Stigmatization

Discourses are “structures of knowledge, claims and practices through which we understand, explain, and decide things...they are frameworks or guides of social organizations that make some actions possible while precluding others” (Patron, 1994, p. 13; as cited in Healy, 2005, p. 8). Discourses shape our perceptions, actions, and even our identities and stigmatizing discourses have historically dominated societal views about homeless people.
Sociologist, Erving Goffman’s seminal work on the concept of stigma (2001) has given rise to numerous definitions of stigmatization (as cited in Phelan, Link, Moore, & Stueve, 1997). Goffman (1963) (as cited in Major, Laurie, & Brien, 2005) defines stigma as an attribute that creates a “gap” or “disappointment” between our perceived social identity and “stereotypes.” Dominant stereotypes define universally “acceptable” and “unacceptable” social categories. Thus, when a person’s attribute or physical appearance does not characteristically fit into an “acceptable” social category, almost inevitably, those individuals will experience stigmatization. Although stigma is a complex term, there are key markers or cues that signal stigmatization. Stigma is probably operating when a person or group is labelled by using ‘undesirable traits.’ This negative stereotyping separates the stigmatized from the dominant culture and places them in a position of lower status. This results in discrimination and the perpetuation of unequal power relations (Belcher & Deforge, 2012; Link & Phelan, 2001; Speak & Tipple, 2006).

Negative and judgmental language attached to the homeless has historically impacted this sector in society. There are many stigmatizing labels assigned to homeless people that reinforce disapproval, exclusion, and powerlessness. These labels construct the homeless in various derogatory ways that marginalize the group in society. The homeless are commonly viewed as alcoholics and addicts, or as unemployed thieves who are dirty and lazy beggars (Speak & Tipple, 2006). Those negative stereotypes condition and reinforce public perception that homeless men are dangerous, useless, and beyond society’s help (Belcher & Deforge, 2012).

The stigmatization of homeless people is associated with the notion that homelessness is caused by the individual pathology or weakness of homeless people (Clapham, 2003). The focus is on the individual’s negative traits. The underlying belief is that people are free to choose what they will become in life and if they become homeless; their trouble has resulted from their own
poor choices (Samuelson & Anthony, 2007; Kawash, 1998). This discourse tends to blame the perceived character of the homeless and raises the issue that homeless people are undeserving of society’s help because they are in some way at fault (Clapham, 2003). This reasoning supports public policy decisions that limit the implementation of broad solutions to homelessness and absolves the state of any real responsibility for homelessness, since individuals are responsible for their own life choices (Kawash, 1998; Speak & Tipple, 2006; Brym, 2004). Structural inequalities that oppress marginalized populations are regarded as ideologically acceptable by those in power. In this way, current initiatives concentrate on individual causes as opposed to structural causes of homelessness by not recognizing that homeless people should have equal rights to societal resources and services (Belcher & Deforge, 2012).

Knowledge is political and since knowledge is interconnected with power, it is constructed in the interests of the privileged, dominant groups in society (Potts & Brown, 2005). Knowledge is understood “as having an ideological function that is used to create a hegemonic—that is a dominant view of reality and social relations that is given the appearance of an authoritative version of truth” (Mitha, 2005, p. 49). Dominant discourse has operated to limit interest in seeking more ‘objective information’ to assist the homeless population (Phelan et al, 1997). In this way, research and academic analysis regarding older, homeless men is sparse (McDonald et al, 2004; Gaetz, 2010; Turnbull et al, 2007). “Older homeless adults have largely been ignored in both the gerontological and homeless literatures” (McDonald et al, 2004, p. 2). Ignoring the homeless older adult population not only maintains the dominant discourse, but also keeps this vulnerable group disadvantaged, powerless, and dominated in society.

This research study addresses the apparent gap in current knowledge concerning the barriers and hidden realities older homeless adult males experience in their attempts to access
supportive services in the Toronto Area. The obvious lack of research concerning older, homeless males demonstrates that that the needs of this group have been neglected and that knowledge is urgently needed. My intention is to create public awareness, advocate for political change, and amplify the experiences of older, homeless men by drawing attention to their stories in their voice. I would suggest that virtually all the themes raised in my research represent gaps that require further research because there is so little study of the unique realities impacting the older, homeless male population. Some of these themes include victimization, overcrowded shelters, imposed curfews, aging and health problems, and the social safety net. I developed a Demographic Information Form (DIF) which was used to guide the research and investigate the hidden realities and barriers that older homeless men experience. My questions were designed to encourage participants to speak and provide their own stories about being homeless. Therefore, the participant narrations have highlighted and exposed particular barriers and hidden realities experienced as homeless older adult males in Toronto.
Part 5: THEORETICAL FRAMEWORK

5.1 Critical Social Theory

Critical social theory has radically influenced the perspective of many social work theorists by changing the way in which individual problems are defined. Critical theory gained prominence in the 1970s and challenged core positivist assumptions (Healy, 2005). Several theoretical approaches, including structuralism and anti-oppressive practice (AOP) are subsumed under the rubric of critical social theory (Healy, 2005). These related social work approaches all emphasize that unjust social structures are the cause of individual problems. Central to critical social theory is the idea that personally-experienced problems are political, since they are the result of socio-economic structural inequalities. Therefore, helping the individual requires an examination of how society is organized and in particular how valued resources are allocated (Brym, 2004; Tew, 2006). In this way, solutions to individual problems must address the unjust social structures that oppress, dehumanize, and marginalize groups in society (Healy, 2005). A commitment to emancipatory goals and social change are foundational principles for critical social theorists.

5.2 Anti-Oppressive Practice (AOP)

Several dominant discourses have historically influenced social work. The formal professional base of social work has been informed by a therapeutic approach associated with psychology and psychiatry (Healy, 2005). In this way, social work has been individual centred and problems have been assessed as functions of individual or family pathologies (Sakomoto & Pinter, 2005). This micro-level perspective scrutinizes personal defects and weaknesses to
explain and resolve individual problems. Since people are seen as the source of their own problems; issues of judgement and blame also follow (Samuelson & Anthony, 2007).

“Enlightenment ideals of objectivity, rationality, individualism and a linear notion of process have also had far-reaching implications for social work” (Healy, 2005, p. 18). Positivist epistemology and scientific methodology have been foundational aspects of social work (Dietz & Thompson, 2004). The adherence to a scientific model of social work research is premised in the belief that human behaviour can be studied and understood objectively. Verifiable knowledge derived from value-free observations, data collection, and reproducible conclusions continue to be the hallmark of mainstream social work research (Strega, 2005). In addition, neo-liberal economic policies which stress fiscal accountability have contributed to the current resurgence in positivist ideology that privileges quantitatively verifiable research outcomes (Brown & Strega, 2005).

Central to social work’s positivist values is the positionality of the researcher. The social work profession has defined the worker as a neutral, objective expert and this has resulted in an orthodox elitism that is characterized by rigid formality and exclusivity (Moffat & Miels, 1999). “In positivism, the researcher is the expert and is seen as the primary and often only, person with the power and ability to create knowledge, to act on that knowledge, and to profit from its creation” (Potts & Brown, 2005, p. 262). The neutral social worker is constructed in a manner that separates the researcher from all that pertains to his/her individual identity. Subjective feelings, attitudes, beliefs, biases, political values, personal interests and life experiences are required to be suspended, since it is believed that competent judgements can only be made through objective, rational reasoning (Dietz & Thompson, 2004). It is presumed that an
apolitical, amoral, and emotionally detached stance must be maintained throughout the research process. All anti-oppressive approaches refute these basic assumptions.

AOP does not refer to a single social work approach. It is “instead an umbrella term for a number of social justice–oriented approaches to social work, including feminist, Marxist, postmodernist, and anti-colonial and anti-racist” (Baines, 2007, p. 4). Simply stated, all anti-oppressive approaches share a fundamental understanding that our social order is oppressive and oppression is the source of people’s problems (Danso, 2009). Anti-oppressive theory rejects the assumption that individual or family pathologies are the origin of personal problems and instead maintains that structural inequalities which create oppression should be the focal point of social work. Therefore, unequal power relations which cross social divisions identified in terms of race, class, gender, sexual orientation, disability, and age are assumed to cause oppression and represent the root of the problem. In this way, it is the social order and not the individual that needs to be “fixed” (McLaughlin, 2005). Anti-oppressive researchers interrogate the complex issue of power in social relationships beyond the structural level (political, economic and social) and include the personal level as well as cultural, institutional and, psychological (Clifford & Burke, as cited in Baines, 2007). I find that this approach makes a range of questions regarding privilege and domination much more accessible.

Oppression is defined as occurring “when a person is blocked from opportunities of self-development or is excluded from full participation in society or assigned a 2nd class citizenship, not because of individual talent, merit or failure but because of membership in a particular group or category of people” (Mullaly, 2007, p. 312). Anti-oppression theory recognizes that power operates at various levels in multiple forms that interconnect and overlap in different circumstances (Clyton & Burke, as cited in Baines, 2007). Generally, people occupy many social
locations simultaneously and AOP does not construct a hierarchy of oppression (Barnoff & Moffat, 2007). The interrogation of the multiple intersectionalities of oppression and privilege are a central feature in AOP analysis (Brown & Strega, 2005). The complexities involved in analyzing power when it is understood as relational are a major strength of anti-oppression theory.

Central to AOP theory is the examination of the power relations that exist between the social worker and the research participants. Self-reflection is key to anti-oppressive research because reflexive knowledge concerning the worker’s identity and positionality within the social order is critical (Danso, 2009). Since social workers occupy a position of privileged status in relation to research participants; it is essential that the anti-oppressive researcher examine her/his interactions with research participants to avoid the reproduction of oppression (Rossiter, 2001; Healy, 2005). “Critical self-reflection is a form of internal criticism, a never-ending questioning of our social, political and cultural beliefs” (Mullaly, 2002, p. 207). This critical perspective examines the creation of knowledge and the power relations that influence the process of knowledge construction. The objective, expert role of the professional social worker is challenged because knowledge is understood to be socially constructed and political (Brown & Strega, 2005). Since every human endeavour including social work research is produced through the interaction of people; acknowledging and articulating the social location of the researcher is fundamental to the integrity of the research process (Potts & Brown, 2005; Kimpson, 2005; Absolon & Willet, 2005).

Anti-oppressive research also re-defines the role of the participant in research. The hierarchical, authoritarian relationship between researcher and participant which oppresses and objectifies participants is radically transformed by anti-oppressive theory. The conventional role
of the participant whose history, lived experiences, values, and beliefs are disregarded by positivist research is replaced by an egalitarian approach that affirms the equal and collaborative role of the subject group (Potts & Brown, 2005). Anti-oppressive theory is committed to research that gives oppressed and marginalized groups real control over the research process and ownership over the production of knowledge (Strier, 2006). The issue of power factors into every aspect of a research project from whose interests are advanced by the research topic to who constructs meaning from the results (Strega, 2005). Mainstream research has secured the production and implementation of knowledge in the hands of the social worker and entirely excluded the participating community.

Strega (2005) posit three criteria grounded in anti-oppressive principles to replace traditional positivist standards of rigor and research validity. Firstly, the social justice validity of social work research should be evaluated by assessing the implications and benefits gained for the participating community. Secondly, the communication of the study results should be examined to determine that the results are culturally appropriate and understandable. Finally, the process of self-reflection should be investigated to assess whether the researcher has been complicit in systems of domination. These criteria afford the participating group a voice as a co-creator of meaning and knowledge by giving study participants a truly collaborative role in identifying research goals and conclusions.

Emancipatory social justice ideals are fundamental to anti-oppressive research. There is clear recognition that anti-oppressive research is not value-free or neutral but is politicized and transformative. This perspective acknowledges that everyday life involves a constant struggle over power, resources, and identities between competing socio-political groups (Baines, 2007). Therefore, social work research is inherently a political activity. Crucial research issues such as
what topics receive funding and who is responsible for funding decisions are political issues (Potts & Brown, 2005). In addition, the anti-oppressive approach grounds social work research in developing knowledge that supports people in gaining freedom from systemic subordination and oppression. This is a political goal that purposely addresses the needs of populations that have been marginalized and dominated in society. In order to hear silenced voices, “the study of the oppressed requires multiple strategies to connect these groups to research projects and to overcome barriers of mistrust and alienation” (Strier, 2006, p. 4). It should be noted, anti-oppressive theory is not focused on changing the individual to the exclusion of supporting macro-level societal changes. Research is committed to the development of actionable knowledge that resists oppression and creates opportunities for systemic changes through social activism and collective organizing (Strier, 2006).

I have chosen an anti-oppressive approach to guide my research on structural barriers older homeless men experience in accessing programs and services in Toronto. I acknowledge that my research has a distinct political purpose, since I hold that unjust social structures are the root causes of the problems facing homeless people. In this way, my research objectives are not neutral. From the outset, the aim of my study has been to collect evidence that supports my belief that the social order needs to be radically restructured.

In conducting my study of older, homeless men, I have rejected the notion that valid research necessitates that I separate myself from my life experiences, values, beliefs, and emotions. I believe that my experiences as a homeless adult in Toronto should not be dismissed as subjective factors that cloud my ability to make competent judgements. I have discovered that my lived experiences have helped me develop a collaborative relationship with the participants in my study. An important goal in my research design was to maintain a respectful relationship
with the participants so that their important role in this study is validated. Therefore, I have chosen to use a qualitative narrative approach to counter positivist ideals of objective data.

Critical self-reflection is an essential aspect of anti-oppressive practice. Critical reflection examines the privileged position I occupy as a researcher and the power relations embedded in knowledge construction. During the research process, I analyzed how dominant discourses about older homeless men have affected my thoughts, actions, and responses toward them. I asked myself uncomfortable questions. For instance, who or what has influenced my thoughts about the older homeless population, how do my ideas influence my interactions and judgments of them, and how will this influence the outcome of this research? This enabled me to honestly address aspects of my current and past social location that influence my work.

I agree with Strega (2005) that any test for research validity should include results that have a social justice component which both benefit the participating community and are understood by that community. Investigating the structural barriers that older homeless men face with the objective of effecting systemic change has been the focus of this study. Soliciting recommendations for change from the participants and using the narrative approach in arriving at the research findings have helped me maintain a truly collaborative role for the participating men concerning research goals and conclusions. I have found that applying anti-oppressive theory to my research design has enabled me to validate the voice of a marginalized and oppressed group in society.
Part 6: Research Design & Methodology

I used an exploratory qualitative research method to study the structural barriers older homeless men experience in their attempts to access support programs and services in Toronto. Qualitative researchers “study things in their natural settings, attempting to make sense of, or interpret phenomena in terms of the meanings people bring to them” (Denzin & Lincoln, 2011, p.3, as cited in Creswell, 2013, p. 44). Therefore gaining understanding through the meaning homeless older men provide concerning their day-to-day lived experiences is central to my study. The stories participants articulate is a fundamental aspect in this research study. My research will, therefore, be informed by the meaning my research participants ascribe to the problems they have encountered accessing resources.

Part 6.1: Narrative

The term ‘narrative’ has several meanings and is used in multiple ways by different disciplines, but is often used synonymously with the idea of telling a story (Larsson & Sjoblom, 2010). According to Josselson, 1995; Josselson & Lieblich, 1999; Lieblich, Tuval-Mashiach & Zilber, 1998; Riessman & Quinney, (2005) narrative research is a method designed to gain an in-depth understanding of people’s lives (as cited in Larsson & Sjoblom, 2010). A narrative approach allows participants to share the events of their story orally while the researcher takes careful field notes (Neuman & Robson, 2009). “Narrative accounts give us access to the identity construction of individuals and can be a good strategy for giving voice to minority and/or discriminated groups” (Elliott, 2005; Halberstam, 2005; Josselson & Lieblich 1995; Riessman, 2002, 2003, as cited in Larsson & Sjoblom, 2010, p. 274). In this way, the researcher’s voice is
not the dominant voice in the study, since the researcher must accommodate the knowledge that the participants bring to the research (Neuman & Robson, 2009).

Oral narratives are important to this research topic because they make room for the inclusion of a diverse range of participants who may have little education or are unable to read or write in English. A narrative approach affirms the uniqueness and importance of each individual’s story and provides the opportunity to explore alternative understandings that do not support the interests of the dominant groups in society. Narratives are an important source of knowledge production because they help to de-authenticate negative stereotypes which have been socially constructed through dominant discourses (Creswell, 2013). Using a narrative approach to research creates an environment for participants to play a fundamental role in debunking dominant discourses, which often assign blame to the homeless for their problems. Narratives are a valuable tool in amplifying the voice of marginalized groups, in shaping social policy, and enhancing future research of particular social phenomena (Creswell, 2013). This is an effective anti-oppression approach to social research because it recognizes the inherent value, dignity, and worth of individuals who have been relegated to marginalized and subjugated positions. In this way, the narrative approach is a good starting point for this social research, since it allows for “creative collaborative research” (Larsson & Sjoblom, 2010, p. 273) which is a necessary aspect for conducting anti-oppressive research.

6.2 Sample Population

As previously mentioned, the sample population involved five homeless older (50+) male adult participants. Participants were recruited from a drop-in centre located in the downtown Toronto area. This site was selected for the research study because it was viewed as a friendly
environment that homeless older male adults frequented on a regular basis. Participants were recruited for the qualitative research study through the use of recruitment flyers to avoid self-selecting participants for the purpose of this study.

6.3 Snowball Sampling

Since, it was not guaranteed that enough participants would be discovered through the recruitment flyer process, I used a snowball sampling technique by telling respondents to pass the information along to other homeless men. Snowball sampling is considered to be a type of network sampling (Neuman & Robson, 2009). This sampling method requires the researcher to relinquish control of the recruitment process by allowing the participants to tell others who may wish to participate in the study (Neuman & Robson, 2009). There were so many people interested in participating in my research that I was not able to accommodate all those who offered to participate.

6.4 Ethical Protocols

I am aware of the fact that vulnerable populations are frequently at risk of coercion and exploitation. One important aspect of my research was that all five participants engage in the study voluntarily. Prior to my obtaining informed consent, the participants were thoroughly informed about the purpose of my research and the types of questions that would be asked. I explained that the information being collected about their lived experiences may produce future changes regarding the barriers older, homeless men face accessing programs and services. However, I prefaced this by explaining that there was a possibility that no changes may happen as a result of this study. I was careful to ask whether they were still willing to participate.
Additionally, respondents were told about their rights as potential volunteer research participants. I explained that participants have the right to refuse to answer any questions, stop the interview process at any time, and withdraw their information at any stage without fear of reprisal, since the research study was in no way related to the drop-in centre. Therefore, withdrawing from the study, at any stage, would not affect the services they were receiving at the drop-in centre.

6.5 Informed Consent

Receiving informed consent from all participants is an essential requirement prior to conducting a research study involving human subjects. According to Neuman & Robson (2009), informed consent is a fundamental ethical principle for social research. It is incumbent upon the researcher to provide participants with information about their legal rights and a general overview of the nature and content of the research project, including any harm they may suffer as a result of the research. Participants were assured that all the information they provided, including their identity, would remain confidential. The face-to-face interview process was conducted in a private office in the drop-in centre so that each participant’s confidentiality was protected. Due to the vulnerability of this population of men, participants were assured that their names would be codified, by using a type of numbering or lettering system.

6.6 Data Collection

The data collection process included written notes from face-to-face interviews, participant narrations, a series of open-ended questions produced from the Demographic Information Form (DIF), as well as other responses from casual conversations. The DIF was
used to guide the research in relation to the barriers that homeless older male adults face in accessing programs and services in Toronto. Other forms of data collection also included the informed consent forms. The material collected from the DIF asked participants’ questions such as; in your opinion what contributed to homelessness in your life, describe your current living arrangements, describe your experiences accessing programs and services and have you consulted a physician for preventative health care services in the past 12 months and other questions? The collected material was then carefully documented, stored in a log book, and then transcribed into coded themes. Seven themes emerged out of the findings. Finally, the data that was collected and stored in a safe place to ensure that it was kept free from harm, damage, or loss (Neuman & Robson, 2009).

6.7 Compensation

Each participant was offered compensation for volunteering their time to assist in this research study. Each participant was offered compensation in the form of a meal voucher valued at ten dollars. A ten dollar meal voucher was selected as an appropriate form of compensation, since meals are often a need the homeless face on a day-to-day basis. Participants were made aware of compensation during the informed consent process, as it was incumbent upon the researcher to do so at that stage in the research process (Neuman & Robson, 2009). For that reason, no inducements were used to recruit participants at any point in the research process. As earlier noted, four of the five participants did not accept the compensatory gift because, as they stated, they were just happy someone was showing interest in homeless older adults and that they hoped their stories could make a difference.
Part 7: Participants

Once the recruitment process was successfully completed and all of the five participants signed the informed consent, the interview process began. Participants were asked a short series of open-ended questions to uncover the barriers that each have personally experienced in accessing services in Canada. The interviews were approximately one-point-five-hours in length, but due to a greater interest in uncovering barriers to services, two subsequent interviews took place, however those interview lasted approximately thirty to forty minutes in length.

7.1 General Participant Information

I would like to mention at the outset that each of the research participants were offered compensation for agreeing to participate in this research study by being provided with meal vouchers. Only one of the five participants accepted the compensatory gift. The four other participants refused to accept any compensation, since they stated they were just glad that someone was showing an interest in the lives of homeless older adult men. They each expressed their hope that their narratives could bring about future change to the way in which the shelter system and health care system are organized. The snowball sampling method generated more attention than I had anticipated and therefore a percentage of eligible candidates had to be turned away.

All of the five participants self-identified as being homeless and their ages varied, ranging from fifty-years-old to sixty-three-years-old. The following will introduce the profiles of each participant is greater detail.
7.2 Participant Profiles

“Daniel”

Daniel is a fifty-six-year-old male who has been chronically homeless for the past twelve years and is currently sleeping rough on the streets of Toronto. Daniel is an only child who was raised by his parents in Montreal, Quebec, Canada where he lived until 1982 before moving to Toronto, Ontario. Daniel explained that his mother developed a brain tumor at the age of twenty-nine and passed away when he was only ten-years-old. Due to alcohol addiction, Daniel’s father was unable to assume the responsibility of caring for his ten-year-old son. Consequently, at the age of thirteen, Daniel quit school and left his father’s home to go and live with his uncle (father’s brother).

Despite the constant turmoil in Daniel’s young life, he has never struggled with issues of drug or alcohol addictions. At age sixteen, Daniel obtained an AZ tractor trailer truck license and began his forty-two-year long career as a long-distance truck driver. In the 1990s, a series of tragic events began to unfold in Daniel’s life. Daniel’s marriage of sixteen years dissolved in 1990. In 1998 Daniel suffered a massive heart attack while operating a tractor trailer and two months after his heart attack, he was diagnosed with cancer. After Daniel’s cancer diagnosis his health has steadily declined. Daniel is presently in the terminal stages (level 4) of cancer.

“David”

David is a fifty-year-old male who has been chronically homeless for the past ten years and is reliant upon the shelter system for assistance. David is a native of Toronto, Ontario and was raised in a two-parent home with one sibling (brother). David reported having had a very ordinary childhood with no significant issues. However, David did draw attention to the fact that
his father was a functioning alcoholic who was gainfully employed as an engineer. David has struggled with issues of alcoholism and drug dependency throughout his adult life and this has affected his ability to maintain stable full-time employment.

“Ed”

Ed is a fifty-three-year old male, who has been homeless for over two-years and is currently seeking support from the shelter system. Ed was born and raised by his parents in Scarborough, Ontario. Ed’s father was employed as a full-time letter carrier and his mother was a full-time employee in the food services industry. Ed’s father struggled with issues of alcoholism. Ed’s father’s personality would dramatically change when he drank, which was frightening for Ed as a young child. Ed stated that he did not have a good childhood, so he eventually left the family home. Ed did not obtain a high school diploma and instead began to work. As young adult, Ed worked as a construction worker, got married, and had four children (two boys & two girls). Ed was recently released from the prison system without any community supports in place. Today, Ed feels a great sense of loss, since he is unable to work, have a home of his own, reconcile his relationship with his family, or even see them.

Sunil:

Sunil is a sixty-three-year-old man who has been homeless for over two years and is currently residing in a Toronto homeless shelter. Sunil was born in Jamnagar, India. Sunil was raised by his mother and father who are natives of Burma. Sunil describes his childhood as very good. Sunil completed his high school education in Karachi, Pakistan and subsequently went on to complete post-secondary education majoring in biochemistry. Sunil used his academic
credentials to obtain employment as a professional business salesman and later married. Since family is very important, in Sunil’s culture, Sunil and his wife remained in his parent’s home where they raised their two children (1 boy/1 girl).

At age twenty-five Sunil emigrated from Pakistan to Canada, leaving behind his wife and children in his parent’s home. Shortly after Sunil arrived in Canada, he discovered that he would not be able to obtain employment in his field. Sunil has been employed as a building maintenance worker for approximately thirty-five years. In 2008, Sunil was unable to continue working because he suddenly lost his vision. Sunil’s Employment Insurance (EI) was terminated, since he was no longer employable because of his health condition. Sunil currently remains wedded to his wife, although he has not seen any family members since his immigration to Canada.

*Gary:*

Gary was born in Toronto, Ontario and was the youngest of his three siblings. At three-years of age, Gary’s parent’s decided it was in the best interest of the family to relocate to a farm in Northern Ontario. Gary stated that his childhood was adversely affected by the sudden death of his mother, when he was nine-years-old. Gary explained that because of his “behavioural issues and unmanageability,” his father could not take care of him. By the age of twelve, Gary became a ward of the state and was sent to reform school. He was eventually transferred from one juvenile home to the next.

Gary developed issues of dependency on drugs and alcohol. Gary explained that he desperately sought help from his truancy officers, reform school staff members, and other services providers, but could not find the help he needed. Gary had been in-and-out of jails until
his early twenties. In Gary’s mid twenties, he committed an indictable offence which resulted in a conviction and a subsequent life sentence (25yrs). Gary served the full life sentence in several Canadian federal institutions and near the end of his life sentence he committed another indictable crime that resulted in an additional four year conviction. In total, Gary served twenty-nine-years before his release into the community. Gary has been homeless for approximately one year due to his recent release from Federal State Penitentiary. Gary left the penitentiary with a one-way bus ticket on route to downtown Toronto in search of a bed at a local homeless shelter.
Part 8: Findings

After carefully reading the interview transcripts, several compelling themes emerged. It was not possible to include all the themes that developed during the interview process. However, the following theme selections best capture the participants’ narratives. These include, Pathways to Homelessness During Illness, Pathways to Homelessness After Incarceration, The Shelter System - A Danger Zone, The Shelter System – Overcrowded, Homeless and Stigmatized.

8.1 Pathways To Homelessness During Illness

The use of the term ‘falling through the cracks’ was not initiated by the researcher, directly or indirectly, at any stage during the research process. Participants, however, frequently used this phrase to describe how their circumstances led to homelessness. All the participants explained that they had made numerous attempts to access emergency programs and services, however these efforts did not help them secure housing. Daniel explained:

“In 1998, my health issues increased, I had a heart attack and not long after I was diagnosed with cancer. I couldn’t work anymore, so I went on sick leave and when that ran out I applied for EI. After my financial supports ran out, I was told I couldn’t get them extended and that I had to apply for welfare even though it wasn’t enough money for me to keep on living in my apartment. I was hoping I could find help instead, so I asked hospital staff for help and I was told the same thing, to go to the welfare office, I went to a local drop-in for help and all I got there was a lot of paper work to fill out, but nothing that could help right away” (Daniel).
The serious health issues facing Daniel made it impossible for him to continue working. This led to a downward spiral.

With nothing else available, I applied for welfare and shortly after that I became homeless and have been ever since, for the last twelve years. All I wanted was someone who could direct me to a service that could help prevent me from losing my apartment, but now it’s too late, I have fallen through the cracks and it hurts” (Daniel).

The following is an example of Sunil’s experience prior to becoming a homeless older adult. Like Daniel, Sunil’s pathway into homelessness began when he suddenly developed serious health problems.

“In 2008, due to a cornea problem and cataracts that I developed, I needed surgery. I was forced to quit my job because I became legally blind. The benefits I received were temporary and when they ran out I didn’t qualify for anything else other than welfare” (Sunil).

Consequently, Sunil was unable to maintain his employment position so he reached out for help and found that he was ineligible for assistance.

“I did not receive the help I needed from the system when I reached out for help. The staff weren’t listening or paying attention to me. When I asked the hospital for help, they were quick to push me aside and tell me to go to the welfare office. I’ve never been on the welfare system
since being here for thirty-eight years. The welfare system requires too much information; there were too many hassles to get the help I needed. I eventually lost my place because all of the income benefits ran out. After that, I was living in Toronto Housing with a friend who later died and because I wasn’t on the lease, I had to leave and had nowhere to go and became homeless because I couldn’t afford to support myself and then I went to a homeless shelter, where I’ve been living for two years” (Sunil).

Loss of employment and the termination of financial supplements have contributed in large measure to participants’ homelessness. David’s information also highlights the problem of trying to find stable housing in Toronto as he explains he received very little support from the ‘systems’ he had looked to for help.

Once my work benefits ended and I couldn’t get another job, I couldn’t keep my place. All the workers I went to for help just told me to apply for welfare. All they did was give me lots of paper work and sent me out looking for myself. Having to go on welfare for help has really discouraged me and hasn’t been enough money for me to live on. Sometimes I lose confidence and motivation because the system has failed me. It’s very hard to get back on my feet when supports lack” (David).

David continues his narration by explaining how discouraging it has been to find workers who are genuinely concerned about his wellbeing.
“At times, I have felt very unhappy and depressed because there hasn’t been enough helpful systems or caring workers who would help me get off the streets or any that tried to prevent me from ending up on the streets. After ten years of living a homeless life, I’ve given up on looking to the system for help, the only one who’s going to get me off the streets is going to be me, but right now I don’t know how to do that” (David).

A common theme repeated throughout the interview process by all participants was the failure of the “system” to help despite numerous attempts to obtain help from many service providers and local agencies. During their interviews, it was apparent that the participants were familiar with commonly used social services language such as supports and falling through the cracks of the system as they used these terms throughout the research process.

8.2 Pathways To Homelessness After Incarceration

Homelessness and release from prison was not an anticipated research area however, this became an emerging theme that I could not omit because of Ed and Gary’s narratives. Gary stated that:

“In 2012, the federal prison system released me into a world that I haven’t known for twenty-nine-years and told me to figure my own life out now. I was very scared when I was leaving the prison because I had nowhere to go, couldn’t go to family, since I was disenfranchised by them a long time ago” (Gary).
Being released from prison was something Gary looked forward to over the years. However, the reality of leaving prison to go into a world he had been detached from for so many years was not what he imagined. Gary described how difficult it has been for him to start a new life after so many years in penitentiary because social supports prior to or following release from prison were not readily available. Gary was candid concerning his feelings about being let down by the system.

"Workers always treated me like I was garbage, so I fought for myself. I felt desperate to get help and a place to live before leaving prison, but none of the staff on the inside would help me. They just gave me a bus ticket and sarcastically told me don’t worry, I’d be back with them soon enough. I wanted to access the John Howard Society but there were too many hoops to go through like finding the right place to go, making appointments, getting a worker etc. It seemed too hard when I needed help right away, so now I’m homeless" (Gary).

Gary’s desire to obtain employment and experience a successful return to society has not happened and he is now homeless.

“Since my release, I was told that I get something called “Burnout Pension” from doing too much time. I get a little bit of money for that because I didn’t work all those years. I really want to work now, but I can’t function anymore and I need some help from the system. Most older homeless men are looking for a hand-up and not a hand-out. The system has always been part of my life and never helpful. Too many of us fall through the cracks” (Gary).
In the same vein, Ed explains that after his release from prison he was unable to pick up where he left off before his incarceration.

“Before I became homeless I had a job as a construction worker which was enough money to support me. Anyway, I got in a fight and ended up getting arrested, convicted, and sentenced to serve time in prison. As a result of losing my freedom, I had no job to return to or any financial benefits to claim even though I worked for so many years and no family that I could return to” (Ed).

When Ed sought after professional help through Corrections Canada, he too was unable to access any services to help him reintegrate into the community and find housing. Finding supportive agencies outside of the prison to help Ed has also been nearly impossible.

Upon my release, all I was told was to go and find a homeless shelter somewhere and since then I have been struggling to find help. I’ve been trying to get housing from the shelter, but they just pass my file from worker-to-worker and nothing gets done. Right now I’m on a housing list that is seven years long. If I wait for them to find me a home, I could wait a very long time” (Ed).

When Gary and Ed were released from prison, their immediate struggle was not knowing where to begin in a world they had been absent from for a long time. A major problem Gary and Ed reported was that they were both released into the community with nowhere to live, no employment opportunities to return to, and no family members with whom they could stay.
8.3 The Shelter System: A Danger Zone

Undeniably, homeless older people are far more susceptible to victimization by younger stronger males whom the participants often referred to as “young bucks.” The topic of victimization was one of the most troubling discussions that emerged through the research narratives. All the participants stated that they were not safe staying in shelters. All five participants personally witnessed and experienced real dangers in their shelters. Most participants have stated that sleeping on the streets is often safer than Toronto shelters. Gary who has been a federal inmate most of his life describes how dangerous homeless shelters are and how he fears for his own safety each night.

“For us older homeless men, sleeping in the shelter is very unsafe because the young gang members are controlling the shelter system, selling the drugs, and drinking on the property. People in the shelter, who cannot stand up for themselves, have to shut up and take orders from the young bucks and shelter staff turn a blind eye to this problem. This usually makes us want to sleep on the streets instead” (Gary).

Gary went on to explain that other fears also come into play because the shelter system is open to all persons, including individuals who suffer from severe mental health. Gary referred to individuals who are dangerous and unpredictable as “Wild Cards.”

“Another thing that makes the shelter system too dangerous is the people who are coming in off the streets after midnight. The shelter that I’m staying at just started a program that allows five
wild cards (people) to come in, off the streets each night and the people being let in are usually high, drunk, and mentally ill. I’m never sure if one of these people will stab me while I’m asleep. Although, sleeping in the shelter is something I do with one eye open” (Gary).

David has clearly reconciled himself to the fact that dangers are part of the shelter system and if he decides to sleep in a shelter; he is at risk of attack.

“A resident tried to steal my shoes and lots of other thefts have happened. There’re lots of threats and violence and I always have to watch my back. In the shelter people are out for themselves. The condition of homeless life is very stressful because I never know what will happen next, sometimes sleeping on the streets is a much easier decision to make” (David).

The following three narratives described a deeply disturbing picture of shelter conditions for older males. The constant fear of intimidation and attack by young gang members has kept Daniel living rough on the streets of Toronto, because he is physically powerless to defend himself against the constant threat of victimization.

“Toronto shelters are very dangerous because they house the mentally ill and violent criminals, drug addicts and alcoholics all together; to keep them from wandering the streets there’re placed in homeless shelters. There are high levels of drug and alcohol use in the shelters and fights break out and people who owe each other money create dangers for everyone. There are many dangers in the washroom and sleeping quarters, which I won’t get into” (Daniel).
Another extremely important issue that was raised by Daniel concerned his medical treatment plan. Daniel requires heavy doses of medication to treat his stage 4 cancer. He is required to administer some of this medication to himself with needles and this creates intense fear and danger for him in the shelter. Daniel explains the following:

“It also very dangerous for me to sleep in the shelter because I’m on morphine for my cancer and people would assault me to steal my meds and I can’t fight them off. No one can be trusted because everyone is in great need. Another danger for me to sleep in the shelter is that the meds I take are keeping me alive and can’t be given to me by shelter staff, like injections, and there’s no nurse there. I usually go to the hospital instead. Overall safety is scarce because there’s not enough shelter staff, not enough video surveillance, and not enough accountability for staff so anything goes” (Daniel).

Daniel disclosed that his cancer is “terminal” as he is in his final stage (Level 4) and he “expects to pass away anytime.” Despite how ill Daniel is, he feels his only safe place is the streets.

“I would sleep on the streets most of the time because I found the streets safer, cleaner, less germs, and less restriction. When I sleep on the streets I don’t worry so much about being attacked for my meds. I need my meds to live, but people, in the shelter, will hurt me for them so they can get high. Cancer is slowly destroying all of my internal functions and being around an
environment as dirty and dangerous as shelters are just isn't safe for me. I can get sick very easily and the germs that spread around the shelter could kill me” (Daniel).

Like Gary, David, and Daniel, Sunil explains that when he is confronted by dangerous shelter residents he is too frail and defenceless to challenge them. Therefore, Sunil complies with the demands of aggressors to spare his own life or he may choose to leave the shelter and sleep rough instead.

“I'm always scared, threatened, and not living the life I thought I'd ever be living when I came to Canada. Some shelter residents have broken my lock or locker to steal my money, clothes, shoes, and two of my cell phones and physical harm isn’t uncommon. People always tell me give me this or that or you’re dead and I can’t say no or they’ll kill me. I’m always harassed because I'm East Indian. If I'm alone in the shelter, it's very dangerous for me and I always feel very unsafe. If I choose to stay in a shelter this is what I have to deal with or I have to sleep on the streets instead” (Sunil).

Ed noted that the Toronto Police are often present, yet shelter residents usually do not feel safe because the police cannot be relied upon to help them in a moment of danger.

“The police presence is prevalent and yet, crime still happens, constantly. Thirty-eight people sleep in my dorm and I'm afraid of being attacked all the time. People who are involved with drugs and alcohol and have violent pasts make the environment very dangerous for me. People
are quick to start fights. There’s lots of yelling, shouting, and threatening going on in the shelter system. People have stolen my money, my shoes and clothing, and lots of people threaten me because they want my tobacco. It’s hard to defend myself against a younger generation who carry weapons” (Ed).

One surprisingly dangerous reality, Ed explains, is related to the violent threats and assaults against people who snore when they are asleep.

“Snoring is very dangerous in the shelter, they will threaten to kill people who snore and the shelter staff don’t care if they’re told. One man was snoring in my dorm and was warned to stop, but of course couldn’t and was assaulted. It’s survival of the fittest in this joint” (Ed).

8.4 The Shelter System: Overcrowded

Overcrowding in Shelters is another overwhelmingly common problem. Since homeless older adults comprise a smaller percentage of the general homeless population in shelters; participants explain that overcrowding exponentially increases their chances of being at risk of harm. The participants associate overcrowding with the increased risk of dangerous situations such as victimization and exposure to health hazards and communicable diseases. Gary described the prevalence of overcrowding in the shelters he has seen.

“Overcrowding and full shelters and no empty beds is a regular thing. Most of the shelters are full and overcrowded and that means the streets are my last choice. I couldn’t find a shelter to
sleep in. So right now, because no beds are available, I’m sleeping in a church basement that’s filled with many dangers” (Gary).

Sunil explained the shelter is always filled to capacity and overcrowded shelters are not uncommon. He explained how filthy a shelter becomes, since large numbers of people do whatever they want because there is not enough staff members employed in homeless shelters. There is inadequate supervision.

“The shelter is always full, sometimes I have to walk long distances looking to find a bed somewhere and sometimes I can’t find one anywhere. When the shelter is full of people it contributes to a very dirty environment. People spit on the walls, poo on the floors, smoke drugs and drink on the premise, and sell drugs. A place with so many germs like the shelter is no good for my health and I get sick easily from it” (Sunil).

Daniel also describes the shelter condition when it is full to capacity.

“It’s hard to get in the shelters because the shelters are always full and when the shelter is full I have to look for one that isn’t and it’s not easy to find one. The overcrowding makes shelters very dirty, there’re lots of germs, and no beds to sleep on. So many people in the shelter carry in so many germs that make shelters more dangerous for me. Having to look for other shelters also really affects my health, especially when I end up sleeping on the streets” (Daniel).
David expressed the difficulty he has encountered in attempting to secure a bed in a homeless shelter and explained that there is no guarantee he will have a bed to return to at night.

“Getting in the shelter can be hard because of overcrowding. When shelters don’t accept me, I sleep on the streets indefinitely, if there’re no other vacancies. Occupancy levels can be at full capacity for a long time and I could fall through the cracks, which often feels that way. No matter how hard things get, I try to remain confident but it’s very hard to feel hopeful” (David).

Daniel and David believe curfews may have been imposed on shelter residents because of the high volume of people needing a shelter bed. Imposed curfews have a significant impact on the resident’s ability to remain housed in a shelter, since a curfew breach often results in losing their bed. The issue of curfews is yet another emerging theme that I have not read in the literature. Both, Daniel and David made a connection between overcrowding and imposed curfews and its impact on shelter beds.

“Curfews are different everywhere, but usually residents have to leave the shelter early every morning, which means no sleeping in, but they must return to claim their bed by 4:00pm. If I don’t come back to the shelter by 4:00pm, I automatically lose my bed and this has happened many times in the past. My physical illness often prevents me from returning to my shelter bed on time. I would have a bed at a homeless shelter only till I would need to get medical attention, then I would usually lose my bed. I have to make frequent visits to the hospital (every two days) and that hurts my chances of keeping my bed. There’re so many people who need shelter beds
that they won’t hold mine if I’m not sleeping in it. If I get hit by a car, I still lose my bed. The system is so full that it’s constantly displacing us” (Daniel).

David informs that it is especially difficult for him to honor the curfew arrangement which is inflexible. David explains that curfew times place him at a disadvantage, when it comes to seeking employment.

“Getting into the shelter can be very hard because of the problem with overcrowding, but curfews make it even harder. I don’t want to stay in a shelter forever, so I go out looking for work. Getting a job isn’t easy for me because curfews make it hard to get a job because if I don’t return on time I lose my bed. It’s not very safe to stray too far from the shelter in case I can’t make it back in time” (David).

8.5 Older, Homeless and Stigmatized

Throughout the interview process, all the participants recounted the overwhelmingly demeaning treatment they experience when dealing with service providers. The negative impact of stigmatization has dissuaded many of the participants from seeking help even when medical treatment is urgently required. With much reluctance, Daniel attends hospital appointments for cancer treatments quite often.

“I have to make frequent visits (every two days) to the hospital and I’m not treated fairly in the hospital because too many homeless people go for drugs and because of my appearance medical
Daniel noted that the treatment he receives from health care providers and others deeply affected him. He prefers to remain in isolation and if he did not have terminal cancer, Daniel would not bother going to the hospital at all.

“This kind of treatment makes me feel isolated and cut-off from society. I prefer to be all alone because when I’m at the doctors I feel like everyone is staring at me and that makes me feel like I don’t belong here. Even though, I’ve lived in Toronto for thirty years, I’ve never fit in as a homeless person” (Daniel).

Ed described how especially frustrated he feels when he makes hospital visits, since he feels like the majority of health care providers treat him in a demeaning way.

“The system treats me like I’ve done something wrong and they seem reluctant to help when I request it. It feels like a personal attack against me” (Ed).

Gary also tells about the fears he faces when he has to attend medical appointments, which Gary explained is quite frequent and very frustrating.
“I don’t like to go to doctor appointments cause when they see my condition, they don’t want anything to do with me. I can’t get a family doctor cause when I tell them things about me, they tell me to go find a walk-in clinic instead, but I really need a family doctor. We need more caring doctors willing to accept new patients like me. I’m very overwhelmed cause I’m facing too many hoops to jump through out here. Wish I could get more help” (Gary).

Ed reported frequent issues of pain. However, he often chooses not to pursue medical attention because of the attitude he will encounter when he seeks medical help.

“I have all kinds of pain due to age, past injuries, fights, and attacks. I was attacked one night and I felt my knee crush, it was dislocated but I don’t like going to hospital because I don’t feel I can trust the doctors and nurses. They always look at me funny and leave me waiting forever anyway, so what’s the point. If I have to go to a doctor, I just go to a walk-in clinic, but it takes me eighty minutes to get there, when I’m in pain” (Ed).

Sunil expressed that there are numerous areas of pain throughout his entire body, but his fear of dealing with health care providers works to inhibit his seeking medical attention. Sunil also made mention of the fact that he is usually left in the waiting room of medical departments for a very long time and when he does see a doctor he does not receive appropriate care.

“I have lots of pain in my body, but whenever I go to emergency, I feel overwhelmed because of the extremely long waits. As a homeless man, when I’m seen, it’s always very quick, they tell me
I’m fine, and then they tell to go and take two Tylenols. I feel like I can’t overcome my difficulties because I don’t feel I’m getting the help I need. I’m unhappy about this cause things don’t look like they’re getting better or changing” (Sunil).

The majority of participants believe that medical professionals have negative views about them and this plays a major role in the treatment they receive.

8.6 Participant Recommendations

This research views the participants as co-creators of knowledge with a central role in the outcome of the study. Therefore, the participant’s recommendations are an essential aspect of my research. Participant recommendations validate the lived experiences of the participant and amplify the participant’s voice as they offer their meaning to the study. I asked the participants what changes they would recommend that would improve the services available to the older homeless population. The participants’ responses pointed to a more inclusive and egalitarian Canadian social safety net.

This section contains the recommendations for change proposed by the participants beginning with Sunil.

“The shelter should employ more compassionate workers who pay attention to the client’s needs. Some of the money used to run homeless shelters should be used to offer housing to the homeless and more money should be put into health care and educating staff to treat the homeless more sensitively” (Sunil).
Ed offers similar recommendations concerning the reformation of these two systems.

“More money should be used to house people, not paying the staff to wash our sheets, cook our food, pay for our toiletries, and pay for our water etc. There should be a system that reserves some of this money, just a little bit, so that people looking for housing can get a rental unit without years of waiting. It costs about two hundred dollars a day to house one homeless person and that money could be better used to house one homeless person at a time” (Ed).

According to Daniel, the system is inherently flawed and therefore, Daniel made several recommendations.

“Restructuring the shelter first requires removing curfews, not throwing residents out in the streets and expecting them to come back at a certain time, in order to keep their bed. The shelter system should employ people who actively look to house people. There needs to be access to more housing facilities. People are just parked in a shelter and forgotten. The cost for emergency services to the homeless is expensive and could be better used to help the homeless instead and heath care should open more facilities to house patients, instead of dropping them off at shelters. Too many shelter residents should be hospitalized, not sent to a place that can’t help them” (Daniel)
David argues that proposing change to the shelter system should involve increased funding to the housing sector, since removing the homeless from homeless shelters will first require having a home to assign to them.

“Getting rid of the curfew system would help. Increasing housing affordability, rent-geared-to-income units, and the need for more rental units would minimize the number of beds being used in homeless shelters. There needs to be employment equality because it’s hard for the homeless to get jobs. There needs to be more equality in providing mental health care needs to the disadvantaged and needy because they should get other care not sent to a homeless shelter” (David).

Gary states the system needs to be more liberal in its approach to help those who are at a severe disadvantage in society.

“People need a hand-up to get in their place. Recently, the start-up checks have been discontinued for both OW and ODSP. I have to live on street allowance which is between $200-$300 per month and try to get my own place with it. Rent is more than that. There needs to be more caring doctors willing to accept new patients like me” (Gary).
Part 9: Discussions

The findings of this qualitative research study have provided new knowledge concerning the barriers older homeless men face on a daily basis accessing programs and services. The narratives of the five participants in this study present valuable insights into the experience of being an older, homeless male however; these findings are limited because of the small sample size I have used for this research. Three major discussion points have emerged which include, The Administration of the Social Safety Net-Is It A Case of Discrimination Against Older Homeless Men? Shelters-Are They Acceptable Accommodations For Older Homeless Men? and The Social Safety Net - Who Is It Helping? These themes are discussed below.

9.1 The Administration of the Social Safety Net - Is It A Case of Discrimination Against Older Homeless Men?

One of the most disturbing aspects of my research was documenting the fact that Daniel who is battling 4th stage cancer and Sunil who is legally blind continue to be homeless on the streets of Toronto despite their severe health problems. Although, I have personally experienced homelessness in Toronto, I was not familiar with the extent to which older, homeless men suffer from oppression and marginalization on a daily basis. Daniel and Sunil’s narratives refute the commonly-held view that the homeless are in some way to blame for their situation. Daniel and Sunil were employed and were self-sufficient for decades until they were unable to work because of illness. Neither of these men struggled with addictions to drugs or alcohol at any point in their lives.

Although each research participant has a unique history and a different pathway into homelessness, all five participants raised their experience with service providers as a primary
factor in their situation. All of the participants emphasized that they made frequent attempts to access community supports before and after becoming homeless, but with no success. It is apparent from the narratives that whether they sought help from service providers at hospitals, prisons, local drop-in centres, shelters, community agencies or government offices; service providers did not provide the assistance that was urgently needed. This complaint was raised repeatedly throughout the interview process. Service providers showed no real interest in helping and routinely kept referring the men to other departments or agencies. Both Gary and Ed who were incarcerated before becoming homeless stated they sincerely sought help to reintegrate into the community, but found that there was no listening ear willing to address their needs. Although the narratives of Ed and Gary are not generalizable, literature confirms that individuals are being released from prisons and mental health institutions without adequate supports (Peressini, 2009). The experience all participants had with service providers is also supported by scholarly literature.

In McDonald et al (2004) participants reported that, “social service staff are often too busy, therefore are not always accessible...and there is no follow-up by service providers following the initial meeting (p. 7). Turnbull et al (2007) state that it is nearly impossible for the homeless to negotiate the complex system associated with social service assistance. Empirical research indicates that service interventions concerning the special needs of homeless elderly people are often overlooked (Hudson et al, 1990; Kutza & Keigher, 1991; Butler & Weatherley, 1995; Bruckner, 2001, as cited in Ploeg et al, 2008). Service providers are the front-line administrators of the social safety net. Their decisions often determine whether doors open or close for service users. The narratives of all five participants confirm the body of research which
indicates that older/elderly homeless men are generally neglected and disregarded by service providers.

In listening to the participants during the research process, I began to question what role stigma played in the handling of the participants’ case files. The men were very clear in their understanding that service providers communicated negative and at times even hostile attitudes towards them. They all expressed deep disappointment with the negative judgements that they believed were the source of the dismissive treatment they received. Stigmatizing labels have historically been assigned to homeless people. These negative stereotypes construct the homeless in derogatory ways that communicate they are worthless, morally blameworthy, and hopeless people who are beyond the help of society. This discourse appears to have been communicated to the participants by their service providers. The public’s stigmatization of the homeless has far-reaching, detrimental consequences for this population. However, if negative stereotyping of older, homeless men is also widespread among service providers; then discriminatory practices that construct barriers to programs and services and reinforce exclusion and disenfranchisement would be expected.

Empirical literature indicates that homeless, older men frequently have various health challenges that distinguish them from the general homeless population. According to McDonald et al, 2004 “Common health problems among older homeless people include: respiratory problems, stomach ulcers, and gastritis, circulatory problems, dental problems, eye problems, blood pressure and asthma or shortness of breath” (p. 4). The stigmatization of the homeless population in general by service providers in the health care system is well documented. “Homeless people face many barriers that impair their access to health care” (Hwang, 2001, p. 231) and stigmatization is one of the major barriers that homeless older adults face in hospital
settings. Daniel, Ed, Gary, and Sunil described how inadequate they felt in their attempts to access community supports, especially when it came to dealing with the attitudes of health care providers. Phelan et al (1997) explain that homeless people often experience significantly greater levels of stigmatization by medical providers. This discourages the homeless from accessing health care services except on an emergency basis. Sunil explained that despite the seriousness of his medical condition; the treatment he receives is often very quick and ineffective. This scenario repeats itself whenever medical issues arise in his life. Negative stereotypes regarding homeless older men have created inflexible barriers that perpetuate marginalization and oppression and leave these service users feeling inferior and powerless. Eventually giving-up has become the better alternative for the participants of this study.

9.2 Shelters – Are They Acceptable Accommodations For Older Homeless Men?

The theme that the shelter environment is extremely dangerous and that older homeless men are particularly vulnerable to victimization has emerged in this study as a predominant factor for the participants. Although there are no statistics available regarding assaults on the homeless older male population in shelters, the narratives of the participants indicate that because of their age and frailty they are constantly at risk of attack in shelters. Participants reported Toronto shelters are a dangerous environment because assaults and threats of assaults committed by younger shelter residents happen day-in-and-day-out. All five research participants provided graphic accounts of incidents of victimization. They explained that when they are confronted by potential attackers, they often comply with their demands to avoid being harmed or killed. “Men using homeless shelters in Toronto are two to eight times more likely to die than their counterparts in the general population” (Frankish et al, 2005, p. 25). Participants felt it
would be pointless to report assaults to shelter staff or the police because nothing would be done and it would place them in greater danger of being attacked or killed as punishment for making a report.

Another concern discussed by some of the participants was their need to take strong doses of medications on a daily basis. Daniel discussed the extreme fear he experienced bringing medication into the shelter system because of the likelihood that younger shelter residents would assault him and take his medication. Daniel explained that staff members at shelters do not administer medication to shelter residents and that the shelter system does not have a paid nurse onsite. That means Daniel is expected to find somewhere safe, out of harm's way in the shelter, where he can administer the medications on his own. Predictably, this puts Daniel in a precarious situation which increases the likelihood victimization. This information was shocking to discover, since I assumed that every shelter in Toronto offered nursing services to shelter residents. However, this information was later verified by staff at a reputable shelter who confirmed that the shelter program does not offer nursing or medical services to shelter residents and that residents who need to take medication are expected to keep and administer their own medications as needed. There is consensus within literature that older, homeless men should be regarded as being approximately 10-20 years older than their actual age because of health issues (McDonald et al, 2004; Frankish et al, 2005). They suffer from various chronic illnesses that require the use of prescription drugs. Housing older homeless men in shelters with the younger homeless population places them at increased risk of attack for several reasons; one of which is the danger of victimization because of prescription drugs in their possession. This reality has been clearly confirmed in the findings of this study.
Based on the information provided by all five participants concerning victimization; a phenomenon in the shelters emerged that has not been reported in the literature reviewed. A social dominance hierarchy exists in many shelters that Ed explained is maintained by a code that only the ‘strong survive.’ Individuals who are “respected” are generally perceived as being strong, aggressive, and fearless. They often terrorize and torment and impose their will on shelter residents who are viewed as weaker, less powerful, less aggressive residents. Respect usually operates in a covert, counterculture fashion, since respect is something that can only be earned by intimidating and disrespecting the weaker shelter residents. The older homeless men are not respected and are therefore at greater risk of being victimized than younger residents of shelters. Gary, Daniel, and Ed referred specifically to the dangers gang members and addicts presented in shelters.

All the participants discussed the difficulties and dangers they experienced as a result of overcrowded shelter conditions. Overcrowded and unsanitary shelter conditions made the participants feel especially vulnerable to disease. Research indicates that there is a high risk of being exposed to diseases like tuberculosis because of “crowding, large transient populations and inadequate ventilation” (Frankish et al, 2005, p. S25). It is not surprising that frail, older men are at even greater risk of contracting infection and illnesses because of these unsanitary shelter conditions. In order for the participants to gain a sense of control and safety, the participants (except Sunil) preferred “sleeping rough” on the streets of Toronto whenever possible instead of staying in homeless shelters.

Another issue the participants raised is shelter curfews. They saw overcrowding as the cause of the imposed curfews. Men using homeless shelters in the Toronto area are required to return to the shelter each day by 4:00pm in order to claim their bed for an additional night. With
shelter beds in such high demand, homeless men wait in extraordinarily long line-ups in hopes that a shelter resident will not return to claim his bed so they may get it. In David and Daniel’s situation it was very difficult for them to return to the shelter on time because of work related or health related issues. A late return to the shelter results in an automatic bed loss. Considered in its totality, the findings reflect a shelter system that is not an acceptable response to the emergency needs of homeless older men.

9.3 The Social Safety Net – Who Is It Keeping Safe?

A third theme that the research data presents is the issue of financial assistance. Neoliberal policies have resulted in reductions in Government support for Canadians in financial need. Transfers to Canadians through federal benefits which include family allowance, Old Age Security, and Employment Insurance Benefits were reduced from 6.3% of the Gross Domestic Product (GDP) in 1993 to 3.8% by 2008 (Gaetz, 2010). Welfare programs have also been drastically reduced, “The province of Ontario, for instance, slashed welfare rates by 22.5% in 1997, with only minor cost of living increases” (Gaetz, 2010, p. 22). At the same time, the overall reduction of the rental market and the shortage of low rental housing and government subsidized housing exacerbated housing problems for low income individuals and families. These realities have had a profound effect on the most vulnerable members of society. The narratives of participants tell the story with a poignancy that describes the human suffering which neoliberal ideology has driven.

As I documented earlier in this study, both Daniel and Sunil were employed for decades and were not dependent on government assistance until they became too ill to work. As a result, they were referred to the welfare office and later became homeless. When David’s Employment
Insurance benefits expired, he too was referred to the welfare office. He subsequently became homeless because he could no longer continue to support himself on financial assistance. Similarly, after serving twenty-nine years in federal penitentiary and hoping to receive help, Gary was sent to the welfare office and later became homeless like Ed. All participants were unable to obtain sufficient funds to prevent homelessness. Daniel, speaking out of hopeless resignation, said that he has reconciled himself to dying on the streets. A similar despair permeates the stories of each of the other men. All the participants expressed a hope that their contribution to this study could in some way change things for others in the future.

This research study has enhanced my capacity to better understand, analyze, and respond to the needs of the homeless older adult male population. I would argue that swift action is necessary to address the serious inequities that the participants in this study have experienced when attempting to access social supports. Firstly, I would argue that the Canadian government needs to formulate and implement policies that offer age appropriate programs and services designed specifically to address the needs of the older homeless population. This approach would facilitate a meaningful and timely response to the urgent problems facing a growing older homeless population. Secondly, there should be a national housing policy that offers greater access to subsidized housing units and reduces lengthy wait lists. My third and final recommendation would include the elimination of the many administrative barriers that prevent older homeless men from accessing community support programs. Addressing these matters will help this vulnerable population receive equitable treatment.
Part 10: Implications

As I reflect on the findings and discussion of this research study, there are a number of implications that arise. The impact of oppression on the lives of the five men who agreed to participate in this study is evident and profound. Without question, the living conditions of these men are unjust and unacceptable. This study reveals circumstances and barriers to assistance that are that are insurmountable without structural changes and are at crisis levels. Recommended changes that emerged from this study center on three topics, The Service Providers, The Shelter System, and The Social Safety Net. These will be discussed below.

10.1 The Service Providers

The participants’ interactions with service providers, whether through the shelter system, the health care system, the prison system or various social services departments, were uniformly negative. These encounters with service providers communicated a message to the men that caused them all to feel so debased, discounted, and hopeless to the point that they abandoned their efforts to get help.

The findings of this study suggest that dominant discourses stigmatizing the homeless and the elderly (ageism) influence service providers’ attitudes and decisions concerning older homeless men and inhibit their willingness to offer assistance to this group. It is imperative that we challenge dominant discourses that construct homeless, older people as hopeless cases who are at fault and therefore unworthy of receiving help. To advance this objective, research is needed to investigate how social stigma affects the decisions service providers make regarding older, homeless men seeking help. This research should include both older homeless men and service providers as well.
The findings of this study also imply that general retraining for service providers is necessary to raise awareness about the special circumstances and needs of homeless older men. Special attention should be given to topics dealing with health issues, homelessness, and aging. Empirical research indicates that health issues are primary factors impacting the daily life of older homeless adults. To foster understanding and support service providers, partnerships need to be developed between staff and managers in the social services, health care services, and community agencies about the older, homeless population. Training and support should also be provided to assist service providers to deal with frustrations and possible burnout that may arise from applying neoliberal policies and legislation to this population’s needs.

10. 2 The Shelter System

The findings of this study concerning the participants’ experiences in the shelters indicate that shelter conditions in Toronto are appalling. Participants stated that they were regularly in danger of intimidation and physical assaults from younger residents. The men also stated that overcrowded and unclean living conditions aggravated the many problems they faced on a daily basis.

A primary factor that has informed the implications arising from the research is the poor health of many older, homeless adults. Empirical research suggests that “almost 60% of the chronic homeless rate their health as poor or fair” (McDonald et al, 2004, p. 3). In addition, literature reports that, “homeless people are in their 40’s and 50’s often develop health disabilities that are commonly seen in persons who are decades older” (Frankish et al, 2005, p. S25). The shelter systems overcrowded and unclean environment places frail, older homeless men at increased risk of contracting infectious diseases. Additionally, Toronto shelters have no
staff to dispense or monitor the prescription drugs older homeless men may need to take. This heightens their risk of being assaulted by younger residents for their prescription drugs. These problems are even more serious because it appears shelters are being used to house men with serious health conditions on a long-term basis. This is evident from Sunil’s situation, since he has been a shelter resident for the past two years.

The overarching implication of this study is that Toronto’s current shelter system endangers the lives of older homeless residents. A new model of emergency shelters is urgently needed. Furthermore, a coordinated housing strategy that involves all three levels of government and sees beyond the emergency management of the homeless population is essential. Finally and most importantly, an ideological shift is needed to even begin addressing these issues. This requires an honest recognition of the devastating and unjust consequences that neoliberal policies have caused for the lives of the most vulnerable members of society.

10.3 The Social Safety Net

A primary concern pertaining to the social safety net is the issue of financial assistance available to people in need. As indicated in their narratives all participants of this study became homeless while dependent on a financial assistance program in Toronto. These meager payments were not adequate to secure housing in Toronto. Literature verifies the fact that low-rental housing is in short supply and wait lists for subsidized housing are extensive. Older citizens are significantly impacted by the realities of aging, health challenges, and loss of employment. Empirical research indicates that, “more than half of the new homeless are unemployed because of disability” (McDonald et al, 2004, p. 5).
Inequalities in income distribution have been compounded by the drastic reductions in social assistance benefits. A reversal of neoliberal economic policies must take place to begin the process of redistributing income to the needy. In addition, age-segregated programs and services, which are non-existent for older homeless people, are urgently required. Trained staff and sufficient resources and programs are needed to make prevention strategies available to those who are risk of becoming homeless. The social safety net is clearly failing older homeless people.
Part 11: Conclusion

In conclusion, this qualitative social research study examined the lived experiences of five homeless older adult men and the barriers that each has faced attempting to access community support programs and social services offered in Toronto, Ontario, Canada. The participants’ narratives have revealed multiple layers of oppression sustained on a daily basis. Domination, powerlessness and injustice define the experiences of these men as they live with chronic homelessness. The participant’s narratives have echoed a loud indictment against the absolute failure of neoliberal policies to service even the most basic emergency needs of this vulnerable population. The key findings of my study highlight the many structural barriers that perpetuate the oppression and marginalization of so many older homeless men in Toronto.

The education of service providers, program planners, and agency managers in critical social theory and anti oppressive practice is a beginning step toward social justice goals. However, it is clear that macro-systemic change is needed to meaningfully improve the lives of older homeless men. The problem is complex and requires a political willingness to genuinely address the root causes of homelessness among older people. Research with a social justice objective is critically needed. It is my hope the future research will contribute to the implementation of new initiatives that advance the interests of the older homeless population in Toronto.
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