



Chapter 2.5

Understanding the Health, Housing, and Social Inclusion of Formerly Homeless Older Adults

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Despite considerable research on the homeless population in Canada, relatively little is known about the characteristics, circumstances, health, housing and service needs of older homeless adults, especially after they have been housed. As the number of homeless older adults is expected to increase with the aging of the baby boomers, improving service delivery to reach this population is important. While the experience of homelessness impacts the health and well-being of older adults, aging adds a new dimension creating unique challenges for programming, policy and service provision.

We conducted a study in two cities, Toronto and Calgary, using a mixed-method approach drawing on data from 237 survey interviews with older adults in supportive and supported housing, 53 qualitative interviews with formerly homeless people, six focus groups with formerly homeless people and service providers, and Personal Health Information (that is, OHIP data released by the Ontario Ministry of Health

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and Long-term Care) from 136 consenting participants to investigate the health and housing outcomes of formerly homeless older adults. We also helped develop a working group of research participants who carried out dissemination of the results through a postcard campaign and a speakers' bureau.

Our findings suggest that housing is a critical determinant of health and that health care utilization after people have been housed is associated with improved health outcomes and more effective and cost-efficient use of health care services. We also found that this population can be appropriately and stably housed in a number of different forms of housing. Clearly, investment in age-appropriate, affordable housing and supports can help formerly homeless older adults find their way "in from the streets."

The survey group

Of the 237 participants who responded to the survey in Toronto and Calgary, the majority were male, which accurately reflects the proportion of men to women in the homeless population. The average age was 57 in both samples. Most of the participants were born in Canada and identified as "white," although Toronto had a larger percentage of immigrants and Calgary had a higher percentage of Aboriginal peoples. Most were single or divorced, over half in both samples had attended or completed high school and close to one third had attended college or university.

Over 60 percent of the participants in Toronto and 56 percent of the formerly homeless participants in Calgary had been homeless more than once, with men reporting significantly more homeless episodes than women in both cities.

In Toronto, 71 percent lived in supportive housing compared to 42 percent in Calgary and the remainder lived in supported housing with the help of community supports. In Toronto, about 50 percent had been housed for over five years compared to only eight percent for Calgary. The last episode of homelessness in Calgary was much shorter than for Toronto, suggesting a quicker turn-around in interventions that provided support and housing.

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Characteristics of the Formerly Homeless

The literature suggests that 50 is an appropriate demarcation of “old” in the homeless population. “Accelerated aging” was linked to “homeless effects,” which emerged as a central theme in both the qualitative and focus group analyses. Participants spoke of the stressful conditions of living without housing as having not only immediate adverse impacts on their health and well-being, but lingering effects that persisted once they were housed. Poor nutrition, trauma, and lack of access to health care while homeless left participants feeling considerably older than their chronological age.

Most of the participants were single, divorced, or widowed. Both male and female participants expressed considerable loneliness and disconnection and the trauma of not being able to trust and build relationships, as a result of the experience of homelessness. Another barrier to participants’ capacity to “get connected” was the internalized stigma and shame many participants felt due to their homeless experience, their receipt of income assistance, the depth of their poverty, and their residence in social housing.

In both the focus groups and the qualitative interviews, service providers and formerly homeless participants expressed frustration about the inappropriateness of the employment supports and the ageism that limits labour market participation. Recovery and employment programs were characterized as paternalistic and insensitive to individual needs and capacities. Ageism, coupled with episodic unemployment while homeless, constrained the employment options for many participants. Also, other “homeless effects,” such as poor health and mental health and ongoing challenges in adapting to “normal” schedules after years of chaotic living without permanent housing, made it extremely difficult for some participants to secure employment. These limitations were particularly salient, given that qualitative data revealed that the majority of participants did not see themselves as “retired” and were either actively looking for employment or were intending to do so in the near future.

Despite the desire for employment, only one quarter of the participants reported any income from employment in the previous six months and, of this group, the majority reported part-time or casual work. A lar-

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ger percentage of the Calgary sample was employed full-time, reflecting the robust nature of the Alberta economy that may override the barriers to employment as a result of the stigmatization of this population.

In both the qualitative and focus group analyses, participants highlighted the struggles they experienced “making ends meet.” Frequent descriptions of choosing between paying the rent or eating and the prohibitive luxury of new clothing or a fast food burger were a clear indication that participants had moved along—but not off—the poverty continuum. The high proportion of participants who relied on food banks and meal programs in both cities was a testimony to the challenges of securing enough to eat. Although most participants were getting enough to eat through the use of food banks, meal programs and the groceries they were able to purchase, the nutritional value of the food was poor.

The majority of participants in Toronto reported a yearly income for 2004 well below the current Low Income Cut-Off for a single individual in an urban centre. The average yearly incomes in Calgary were slightly higher, but still below the LICO for a city of this size. Not only were the levels of income available through assistance programs seen as inadequate in meeting basic needs, program policies were characterized as “welfare or poverty walls” that were difficult or impossible to transcend. Disincentives to work such as the clawback of earned income, the possibility of losing disability status, or the loss of health benefits were all described as formidable barriers to employment.

Health and Well-being of Formerly Homeless Older Adults

Overall the health and well-being of formerly homeless older adults were improving in comparison to the poorer scores reported for older homeless adults interviewed for the 2004 study. However, their health was lower than similar indicators reported in general population surveys. The double jeopardy of “homeless” and “accelerated aging” effects were limiting participants’ abilities to move toward better health and well-being. Nevertheless, formerly homeless participants, once stably housed, reported greater access to health care.

Results from the survey data indicated that the Calgary respondents scored considerably lower on the physical health scale, yet were much less likely to have visited a physician’s office in the previous six months

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than their Toronto counterparts. This may be attributable to a number of factors, including the fact that fewer had health cards and the shortage of physicians in Alberta as a result of rapid population growth there. Conditions that may have existed while they were homeless, but which remained undiagnosed, negatively influence measurements of health. In short, the identification and treatment of undiagnosed or latent conditions that occurred during homelessness affected health and well-being outcomes long after they had moved into housing. In both the qualitative interviews and the focus group analyses, participants stressed that recovery from the experience of homelessness was ongoing, and that one year of homeless experience required several years of stable housed experience to heal.

The data collected in the questionnaire on the mental health status of participants indicated poorer mental health than evidenced in similarly aged adults in the general population. However, some improvement was indicated by the higher mean score than that of the homeless older adults interviewed for the 2004 study. Analysis of the qualitative data revealed that for many participants, poor mental health was an ongoing struggle, but that they felt “less despairing” than they had when they were homeless. An important paradox raised by several participants was the flawed assumption that proximity and access to support would significantly improve their ability to seek help. A mental health crisis was described as “not rational,” a process and state where the crisis itself prevented participants from seeking help. However, participants did express greater confidence that being housed facilitated earlier identification of imminent crises that would allow them to seek support to forestall a health crisis.

Several participants described “homeless effects” as lingering trauma adversely affecting their mental health, using terms similar to those associated with Post Traumatic Stress Disorder. The magnitude of the trauma experienced during the homeless period also emerged as a key issue in the focus groups with service providers who spoke of isolation and exile as maladaptive responses to “homeless effects.” Service providers and formerly homeless participants spoke of the critical need for supports and services to be sensitive and responsive to the residual effects of the traumatic events experienced while homeless.

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Analyses from the service provider focus groups and from the survey interviews also revealed that Alzheimer's Disease and other forms of dementia were much less common than mood and schizophrenic disorders. This may be a sampling effect due to the relatively "young" average age and better health of those older adults who were willing and able to participate in the interviews. The focus group participants did, however, indicate that it was difficult to separate the effects of overlapping health issues such as cognitive impairment and alcoholism, as alcohol misuse remains a problem for some formerly homeless older adults.

Well-Being

Barely more than half of the formerly homeless participants in Toronto and slightly less than half in Calgary reported satisfaction with their lives. Perhaps more significant is the number of remaining participants who rated life satisfaction as "neutral" or "dissatisfied." A key theme emerging from the qualitative and focus group analyses is that housing ends "houselessness," but much more is needed to bring people into wellness, inclusion, and other positive dimensions associated with quality of life. Key areas participants identified as limiting quality of life were factors like isolation, loneliness, discrimination, internalized stigma, and lack of opportunities for meaningful participation (within and outside of the labour market).

Formerly homeless participants were at considerable risk of social isolation and continued to rely heavily on service providers for support. A significant difference was found between housing types and risk of social isolation in Toronto. Interestingly, those living in supportive housing were at significantly greater risk of social isolation than those in supported housing with the use of community supports. This finding is contrary to much of the literature (Lum et al., 2005; Pynoos et al., 2004; Cannuscio, 2003), which suggests that the presence of on-site staff exerts a positive effect on social connection and interaction. However, these studies sample from the general population of older adults living in supportive and supported housing. Consequently, as Ridgeway et al. (1994) suggest, formerly homeless persons may have a greater need for privacy and self-determination and find staff intervention intrusive, which may undermine social connections. Another factor influencing

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this unexpected outcome is the selection bias that may result in formerly homeless older adults with greater needs and challenges being placed in supportive rather than more independent housing settings.

Although qualitative analyses from the focus groups and qualitative interviews revealed that many formerly homeless persons were connecting and reconnecting with family and friends, a significant proportion remained disconnected from their housing and neighbourhood communities. Many factors limiting social support were cited, including discrimination (e.g., for having been homeless, for residing in social housing, for receiving income assistance, for being labelled “hard-to-house”), shame, distrust, lack of age-appropriate venues for social interaction, crime-ridden housing and neighbourhood environments, limited mobility, poor mental health, and prohibitive transportation costs. Many participants expressed frustration with funding and programming that undervalued social capital, commenting that the focus was on the measurable outcomes of employment supports and that supports to social inclusion and quality of life were neglected. Although feelings of insecurity and threat were frequently mentioned by participants, overall, the formerly homeless reported fewer violations of personal safety than the homeless older adults interviewed in 2004.

Use of Health Care Services

Analyses of the survey on the use of acute care (hospital emergency department visits) reported for the previous six months was similar for both the formerly homeless interviewed during this study and the homeless adults interviewed in 2004. However, analyses of the secondary OHIP data on the use of health care services by formerly homeless participants in Toronto before and after housing, indicated that the actual mean number of visits dropped significantly after being housed as did in-patient and day patient care.

These changes suggest that housing may contribute to more stable health care for the homeless once they are housed. The changes also imply reductions in the cost of care for this group as a result of being housed, since ambulatory care and inpatient care are expensive health services. Further, findings from the OHIP data analyses are consistent with the survey findings indicating that the overall health of the newly

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housed has improved compared to the health indicators for the earlier 2004 study of homeless older adults but below that for the general population.

Service, Support and Housing Needs of Formerly Homeless Older Adults

Just over half the participants reported finding out about and having received assistance in applying for their current housing from a social service worker. However, a significant minority located and secured their housing by themselves or with the assistance of informal supports such as family and friends. The analyses of the qualitative and focus group data found that some participants stressed that having professional “allies” or “advocates” was essential to navigating the social service and housing systems, while others stressed the power and value of informal networks and resources. Many participants suggested that resources should be directly accessible to users and that those resources should be informed by peer knowledge. Peer-based resources that incorporate the “lived experience” of the homeless and formerly homeless persons were seen as more responsive and more accurate.

The primary finding is that there is an acute shortage of affordable, age-appropriate housing and support options. This is an issue of supply, but also an issue of lack of variability in housing and support packages. Because of the very low vacancy rates in Calgary, respondents in supported housing were probably forced to live in very poor circumstances, which they indicated in the survey and confirmed in the focus groups and individual interviews. Participants stressed that a variety of housing and support options was critical to achieving a “good fit” between individual needs and preferences and living arrangements. Participants indicated that the degree to which a “good fit” was achieved influenced housing stability and health and well-being. No single model could adequately address the diversity of needs and preferences.

Another critical aspect of achieving a “good fit,” identified by both formerly homeless participants and service providers, was that the process must be client-directed. Self-determination and autonomy were highly valued by participants and were related to feelings of loss of trust

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and loss of control experienced while homeless. These “homeless effects” were best addressed by models of service that were client-centred and stressed relationship building.

Although the survey responses to questions about current housing and supports was, for the most part positive, a few areas emerged where needs were clearly not being met. When asked whether their housing was equipped to assist people with impaired mobility, the majority of participants in Toronto reported living in housing without accessibility accommodations. This finding has significant implications to formerly homeless older adults’ abilities to age in place. The Calgary data painted a very different picture, with the majority reporting that their housing was equipped to deal with the challenges faced by those with mobility issues. This is a reflection of the much newer housing stock available in Calgary.

Of those participants who indicated linked supports and services, the three most significant areas of unmet need identified were transportation supports, special services for older people, and skills development. Transportation issues were identified as particularly relevant in Calgary, a city that is more geographically dispersed and with a far less developed public transportation infrastructure than Toronto. In the qualitative interviews and focus groups, participants frequently reported that they could not afford transportation to health care facilities or meal programs and that many services were insensitive to the needs of older people (e.g., to slower mobility and diminished memory). For a great many participants identifying as “too old to be young and too young to be old” (the demographic “gap”), age-appropriate services were even more difficult to obtain.

Another area of concern was shared living arrangements. Almost two-thirds of participants shared accommodation, but the vast majority expressed a clear preference for self-contained units. The conflicts arising in shared living arrangements became especially troubling in housing sites where tenants were clustered according to similar health and mental health challenges. Although some participants felt that residing with tenants who shared similar challenges promoted greater understanding and acceptance, most felt that diversity of age, gender, ability, health and mental health status and of tenure (i.e., mixed subsidized and market

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rentals) prevented “ghettoization.” Participants spoke of cluster housing settings as creating dangerously vulnerable and disadvantaged housing communities.

A number of participants reported feeling unsafe in their housing, and identified criminal activity and inadequate security along with a fear of fellow tenants as reasons for feeling unsafe. Building safety and personal safety emerged as major themes in the qualitative data; participants said they wanted to have unregulated guest visits, but feared that not screening guests was dangerous. Both service providers and participants felt that more than any single policy or intervention, security and safety were best supported by “community building,” which emphasized participation, inclusion, and self-regulating tenant communities.

Recommendations for Effective Models that Support Health, Housing, and Inclusion

No single housing model was identified as most effective in supporting the health and well-being of formerly homeless adults. Although several models are identified below, the most significant theme was that a broad menu of housing, health and support options must be available to meet a diversity of needs and preferences of older homeless people.

Client-Centred Models

A primary theme emerging from the qualitative analyses was that the processes of finding and maintaining housing and supports should follow a client-centred model of delivery. Participants spoke of the necessity for relationship-building and establishing trust with housing and support workers. Sound client-worker relationships were described as critical to early intervention to prevent returns to homelessness. Client determination of housing/support packages was viewed by participants as central to securing a “good fit” without which housing instability might ensue.

Continuity Models

The theme of continuity of support was linked to relationship building. In some cases this meant continuity of support from shelter to housing,

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and in other cases, the focus was on continuity across moves to different types of housing. The former was contentious. Some participants described the link from the shelter to housing as effective, while others felt that it was undesirable, even traumatic, to maintain links to homeless services. However, almost all service providers and participants stressed that continuity across housing settings was critical to maintaining housing stability and health.

Several mechanisms for continuity were suggested, such as portable supports—for example, case management—that were de-linked from any single housing site or, alternatively, developing off-site partnerships with community-based agencies that would stay with a person and act as an adjunct to linked housing supports.

Integrated models

Integrated team models were championed as a means of providing layers of support in a coordinated seamless delivery. In this model, coordinated interdisciplinary teams provide a combination of care across a number of housing settings, which may or may not have on-site staff. Service providers emphasized the challenges to staff in supporting a diversity of needs in a single service setting, because of the scarcity of staff trained to support the mental health and personal care needs of aging formerly homeless tenants. Formerly homeless participants emphasized the challenges of negotiating fragmented, inaccessible service systems, where staff were either overwhelmed or inaccessible, a process exacerbated by the lack of support from a professional advocate.

“Housing First” Models

“Housing first” models, though typically associated with independent “low-demand” housing with client-determined, community-based support, do not necessarily imply the absence of on-site staff. The distinction made by service providers and formerly homeless participants was that the housing was not contingent on the tenant using any particular support or meeting any standard other than those demanded of all tenants (e.g., prohibition on criminal activities and on behaviours that interfere with reasonable enjoyment of other tenants). Both service providers and

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participants strongly endorsed a framework of universal rights and responsibilities as an appropriate tool for accessing housing and mediating conflict.

Harm Reduction Models

Harm reduction was seen by service providers and participants as an integral component of a “low-demand” “housing-first” model, which would ensure that active users, often the most vulnerable of homeless persons, were not excluded from housing. However, service providers expressed concern that housing sites formally adopting a harm reduction model might be subject to unfair scrutiny and stigma, despite substantial evidence-based research attesting to the effectiveness of harm reduction approaches (Hunt, 2004; Marlatt and Witkiewitz, 2002; Riley and O’Hare, 2001; MacPherson, 1999).

As an alternative, service providers felt that a rights and responsibilities framework subjects tenants to the same prohibitions on substance use enforced in the general population without the problems associated with formal sanction of harm reduction. However, such an “informal” model of harm reduction may mean that the supports associated with formal harm reduction are not available, such as service and supplies to support safer consumption.

Community Development Models that Stress Participation and Engagement

Formerly homeless participants spoke of the need to build healthy housing and neighbourhood communities. Community building was accomplished by programs that stressed participation in decision making. For example, participants and service providers spoke of tenant councils that addressed everything from social recreational programs to providing the first intervention in the event of risk of eviction. Self-regulating housing communities were valued for fostering social connections; enhancing feelings of security, safety and autonomy; and providing a mechanism for skill-building transferable to other settings. An extension of skill building was developing micro-enterprises within the housing community to support transitions to paid work and combat the ageism and

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other forms of discrimination confronting employment seeking formerly homeless older adults.

An integral component of community building models was that they engage and incorporate peer knowledge. Participants highly valued “lived experience” and spoke of “word on the street” (and in the drop-ins) as a vital and responsive resource. A central theme emerging in both the qualitative and focus group analyses was that formerly homeless older adults had a tremendous amount of knowledge and resources that could be integrated into programming, materials, and policies affecting the homeless community.

Models that Emphasize Diversity and are Integrated into the “Mainstream”

Although some participants expressed a preference for “clustered” settings (that is, living in facilities with people with similar mental health challenges), most endorsed diversity as desirable across age, rental status (subsidized and market rents) and health status. Clustering was perceived as dangerous and described as “ghettoization” that induced conflict and vulnerability to victimization. Service providers were less clear on the subject of diversity versus clustering. Many providers felt that diversity was an valuable principle, but difficult to implement—that is, selective placement may not always be possible and staffing to accommodate a diversity of needs was challenging.

A variant of the theme of diversity was that of “mainstreaming.” Many participants described the stigma and shame associated with using food banks and meal programs and residing in social housing clearly demarcated from the rest of the housing in a neighbourhood. Integrating service, supports, and housing into the mainstream was identified by many participants as a way to reduce the stigma. Participants suggested a number of examples, such as some sort of invisible proxy that could be used to buy food and meals in mainstream venues or community kitchens open to all members of the public with nominal or subsidized fees.

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Models that Support Transitions

Formerly homeless participants were adamant that models of services, supports, and housing must support transition and be flexible to shifts in need and preferences. Participants wished to move to different housing sites, toward better health, well-being and inclusion, and toward greater economic security. Many participants expressed frustration with models that assumed the status quo was sufficient and that “maintenance was progress.” However, participants were sensitive to the risk that models emphasizing transition may marginalize or adversely impact those persons who cannot or will not make those transitions, again suggesting that client-centred, flexible models would be able to accommodate both options.

Key Challenges to Effective Delivery of these Models

The focus group and qualitative interview analyses revealed limitations to the delivery of the above models to formerly homeless older adults: notably “homeless effects”; accelerated “aging effects”; ageism, especially that confronting those 50 to 65 years of age; classism; “poverty or welfare walls”; and a lack of affordable age-appropriate housing and supports.

“Homeless effects” and “accelerated aging effects” are clearly influencing the ability of formerly homeless older adults to recover and to improve health and well-being. Consequently, supports must be sensitive to these effects. For example, health interventions should stress the recovery of nutritional deficits incurred over the homeless period or accommodate, without pathologizing the lingering effects of trauma experienced while homeless.

The varied and pervasive forms of discrimination experienced by the older adults limited their ability to secure employment, and housing, and to realize meaningful social integration. Classism and all its variants, identified in the analyses by such phrases as “hard-to-house,” “welfare bum ” and “living in the projects” (social housing), are critical barriers that housing and support models must overcome. One way that housing and support models can address these stigmatizing labels is to avoid “clustering” and “naming” disadvantage whether through ensuring di-

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versity or ensuring that any disadvantage associated with a program is as invisible as possible.

Ageism, as is evident in the general population, seriously eroded the ability of formerly homeless older adults to secure employment. Ageism in employment-seeking was further exacerbated for this group by the “homeless effect,” which created significant breaks in their employment history or made skill sets obsolete. These limitations were particularly significant for those participants who saw themselves as members of the “demographic gap” between 50 to 65 years of age who were actively seeking employment and not ready to retire. Participants reported feeling caught between the conflicting assumptions that they were too old to find employment in a competitive and ageist labour market, yet were receiving income assistance–related employment support programs premised on the expectation of future employment and the cessation of income assistance.

Skill development, training, and employment support programs for formerly homeless older adults should be based on realistic assumptions of labour market participation and options to exercise skills in volunteer settings. The issue of the invisibility of the demographic “gap” extended to other areas of programming and was seen by participants as a serious limitation to appropriate service delivery. Service models should adapt and accommodate what participants refer to as a group that is “too old to be young and too young to be old.”

“Poverty or welfare walls” were a serious impediment to formerly homeless older adults achieving greater economic security. Participants, despite receiving income assistance and housing subsidies, were still living considerably below established Low-income Cut-offs (NCW, 2006). The reliance on food banks and meal programs reported by participants indicates the depth of poverty that many formerly homeless older adults experienced. As reported in the discussion of the socio-economic status of formerly homeless older adults, income assistance was not only inadequate, given the cost of living, but also presented formidable barriers to getting out of poverty (e.g., asset ceilings) and into employment (e.g., loss of health benefits). For formerly homeless older adults subject to discrimination and persistent “homeless effects” and “accelerating aging

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effects,” income support programs designed to be temporary and residual were inappropriate to their needs and challenges.

A final and significant limitation is housing and support models that assume a static level of support with no effective means for transition to other housing settings. Formerly homeless participants spoke of the desire to move to other housing settings; many were looking for settings with more independence and less support while some required higher levels of support and more accessible accommodations. Some formerly homeless participants and service providers spoke of the need to accommodate higher levels of support in the earlier stages of housing, which may no longer be necessary as greater health and housing stability is achieved.

Although the most formidable barrier to housing transition is the scarcity of affordable, age-appropriate housing and support options, any available transfers were reported to be problematic and inadequately supported. For example, both service providers and participants noted the vulnerability introduced in moving to new locations and establishing new supports. Portable or community-based supports were mentioned as mediating the risks to the social connections and housing stability associated with relocation. Other suggestions made by service providers were that transitions should be “trialed” and barriers removed so people could return to their original housing situation. For formerly homeless older adults, the risks to stability of health, well-being, and of housing associated with adapting to a new setting must be mediated by models that offer ongoing links to supports established prior to the move.

Conclusion

The most significant implications of these findings for practice, program development, and policy-making are fourfold. First, the findings emphasize that it is critical that health, support, and housing programs are sensitive to “homeless effects” and accelerated “aging effects.” Recognizing and supporting recovery from the persistent trauma induced by these effects is essential to preventing formerly homeless older adults from cycling back to homelessness. Rapid intervention is critical and must support people as they make transitions and during the first years of housing.

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Second, developing and evaluating age-appropriate affordable housing and supports are of primary importance. However, the findings highlight that policy, programming, and research must be premised on social inclusion so that issues such as community integration, belonging, participation, overcoming discrimination and stigma, and other measures of quality of life can be addressed.

Third, assumptions around income support and employment support for this group need to be revisited. There is a significant disconnect between expectations embedded in these programs and the significant barriers experienced by formerly homeless older adults.

Finally, the findings suggest that homelessness and former homelessness must be situated as points on the poverty continuum so that policy and programming do not address them as discrete or disconnect them from other socio-economically marginalized groups and from the general population of older adults.

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