Sheltering Homeless Seniors

Literature Review

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Introduction

In 1991, Kutza and Keigher wrote that a senior's physical capacity to withstand living on the streets or in shelters is limited. Their research suggested that homeless seniors' numbers would grow in the next few decades (Kutza & Keigher 1991 p.1). Eleven years later, this growth forecast was supported by the Government of Canada's (2002) report to the United Nations on aging in Canada. In addition, the Greater Vancouver Regional Steering Committee on Homelessness between 2005 and 2008 (RSCH) found both an increase in the average age of the homeless to over 40 as well as a significant increase in the number of individuals over 45 years of age amongst the homeless. The increase in the number of seniors within the homeless population presents unique challenges with Canada's aging population as well as for health, housing, and community services providers.

Definition and prevalence of homelessness in Canada

According to the Canadian Homeless Research Network (2012, p.1), "homelessness describes the situation of an individual or family without stable, permanent, appropriate housing; or the immediate prospect, means, and ability of acquiring it. It is the result of systematic or societal barriers, a lack of affordable and appropriate housing, the individual household's financial, mental, cognitive, behavioural or physical challenges, and/or racism and discrimination."

A 2013 study conducted by Gaetz, Donaldson, Richter, and Gulliver, found that 200,000 Canadians experience homelessness in a given year, 30,000 experience it on a given night, and 50,000 experience hidden homelessness on a given night. Hidden homelessness refers to those who have no prospect of housing and are staying with relatives or friends. Gaetz et al (2013), suggest that certain national statistics indicate increase in the number of people at risk of becoming homeless in Canada's future. Canadians are currently spending a higher percentage of their income on housing, with 380,000 Canadian's living in poverty and spending at least 50% of their income on housing. Combined with a decrease in rental housing, income, and available social benefits, many Canadians housing situation is becoming less stable. This risk is even higher for older adults, who may experience a decline in income due to forced retirement; ageism in the job market; limited pension benefits, and reduced retirement savings (Waldbrook, 2013). Difficulties maintaining the home environment due to physical disabilities, Alzheimer's disease, dementia, or other mental health problems may exacerbate this risk, especially when there is a lack of coping skills to adjust to life changes (Waldbrook, 2013).

Purpose of literature review

The purpose of this literature review is to inform discussions about best practices for sheltering homeless seniors and moving them towards appropriate housing. Many papers are interrelated and some historical findings are still relevant. At the start of this review, the committee acknowledged the lack of available research concerning homeless seniors. Of the existing literature, many articles present the need for more information about the homeless senior population. This review recognizes a continuum of research and learning that provides a sound foundation. The readings selected for this review are organized to highlight common interlinking threads.

This review will follow the common themes presented in the readings, which break down the issues of homeless seniors in the following contexts:

➢ Challenges and Characteristics of Homeless Seniors

➢ Physical and Mental Health Issues

➢ Best Practices

How the literature was compiled

The papers that make up the literature review are a combination of published research, grey literature, and government documents. Qualitative and quantitative research papers were included. Service provider input was a mixture of both perspectives. The readings arc across a broad range of learning around homeless seniors and their challenges. University databases and Academic Search Premier were used to gather the articles. Grey literature came from web based government documents and non-profit publications, which were found by using Academic Search Booleans.

The 2008 Greater Vancouver Regional Steering Committee on Homelessness count report was used instead of the newer 2011 report. This choice was made because the method of the 2011 count had changed and this was the first year it was being used. The 2008 count methods were consistent with the counts prior to 2008. All were done by the same organization and used the same methods of scrutiny. It was felt that the data in the 2008 report would be more consistent.

Common Themes, Challenges, and Characteristics of Homeless Seniors

Bottomley, Bissonnette, & Snekvik (2001) argue that the great majority of homeless older adults have not had an easy life. Their lives have often been punishing and painful. They came into homelessness by many different paths, almost all of which, one way or another, stem from being poor and marginalized.

Kutz and Keigher's 1991 study identified two subgroups of homeless seniors: the newly homeless and chronic homeless. This typology is augmented with an understanding of Gaetz and colleagues' (2013) three patterns of homelessness: transitional, episodic, and chronic. Transitional homelessness refers to those who enter the shelter system for one month or less and usually for only one stay. Aubrey and colleagues (2013) found that within the homeless population, 88-94% experience transitional homelessness and that they are usually younger with less complex issues. Episodic homelessness refers to those who move in and out of homelessness over a period of at least three years (Gaetz et al, 2013). Episodic homelessness makes up 3-11% of the population (Aubrey et al, 2013). Chronic homelessness refers to long-term homelessness. This subgroup represents 2-4% of the population but has a greater range of needs. The longer one experiences homelessness, the more likely that pre-existing and emergent health problem will worsen. In addition, they are at greater risk of criminal victimization, sexual exploitation, trauma, and involvement in the judicial system (Gaetz et al, 2013).

An older adult's pattern of homelessness influences the issues he or she faces and the needs service providers should address. For example, Bottomley, Bissonnette, and Snekvik (2001) found a large portion of the newly homeless become so after a lifelong contribution to society. They feel there is a need to provide services specific to the fresh trauma resulting from ending up newly homeless. These suggested services should address people's feelings of status loss, dignity, and self -esteem. In addition, a number of papers in this literature review found that older homeless people are more likely than younger people to have a steady income source and that this source was usually some form of government assistance (Kutza and Keigher, 1991). Zlotnick and Robertson (2001) looked at this issue through a human capital lens and came to the same conclusion. They found that rent supplements were frequently used. Zlotnick and Robertson (2001) stated that there was a need for stable and consistent income support to help seniors exiting from homelessness.

McDonald, Dergal, and Cleghorn (2004) looked at seniors' homelessness while participating in the Toronto Homeless Older Adults Research Project. A substantial quantity of the literature reviewed uncovered similar themes in the populations they studied across the world. The Toronto report learned that almost 70% of older homeless people become homeless between

the ages of 41 to 60 (McDonald et al, 2004). Older people at risk of homelessness have been homeless at one point in their lives (McDonald et al, 2004).   McDonald, Dergal, and Cleghorn (2004) confirmed what other readings observed about women being more likely to have lower incomes.

Financial and social status is more likely to predict homelessness in men and social stability is more likely to predict homelessness for women. Women become homeless at an older age than men. Homeless women have fewer but longer homeless episodes than homeless men (McDonald et al, 2004).

Homeless older adults rate their health as lower than average (McDonald et al, 2004). For instance, about half the people in the Toronto study had probable depression (McDonald et al, 2004). Homeless women were found to have more arthritis and bladder control problems, while homeless men were found to have more back problems and skin ailments (McDonald et al, 2004). Women were also found to have more mental health issues than men. When compared to the general older population, homeless seniors demonstrate an increased incidence of drug and alcohol use problems (McDonald et al, 2004). Fifty percent of homeless seniors have alcohol abuse issues (McDonald et al, 2004). These health problems are exacerbated on the streets where family is no longer considered a reliable support system. Issues concerning accessing basic care, being able to pay for the cost of medication, and obtaining adequate nutrition influence senior homelessness; however, the circumstances surrounding homelessness within certain subgroups also impact experiences of homelessness and the avenues of addressing these issues (McDonald et al, 2004).

Older women and homelessness

The most at risk for becoming homeless were women with low income (Waldbrook, 2013). Eviction, loss of a spouse, and loss of income are common reasons for older women becoming homeless. Homelessness for older women likely stems from family crises, while homelessness for older men is often related to challenges around job loss (McDonald et al, 2004). Burcycha and Cotter (2011) conducted a one-time count of women in a shelter society and found that 71% reported abuse as the cause of homelessness. Older women experience homelessness differently than men. When compared to older homeless men, they report higher incidences of back problems, anxiety disorder, migraines, bipolar disorders, diabetes, and asthma, and fewer incidences of substance abuse and criminal history (Waldbrook, 2013).

Older men and homelessness

University of British Columbia researchers Coren and Hewitt (1999) examined sex differences in elderly suicide rates in the United States. Their paper suggests that achievement, autonomy, and social concerns may be highly relevant to suicide rates. They argue that any stresses or interruptions of these concerns may be precipitants of suicide (Coren and Hewitt, 1999).

Coren and Hewitt (1999) reported that the rates of suicide are six times higher in older men than women. The data scan found marked differences in the 70 to 95 year old group. Male suicide rates continue to increase after age 65; however, female rates remain stable or decrease. Financial and social wellbeing and social factors in the environment were found to predict suicide rates for older men and women. Male suicide rates were tied to financial and social wellbeing, and female suicide rates were tied to social factors and social stability in the environment (Coren and Hewitt, 1999,).

Coren and Hewitt (1999) argued that the findings may be explainable by psychological theories which speak of sex differences in the personality domains known as agency and communion. Similar considerations may help to explain why the suicide rate for men tends to increase in old age, while for women it remains relatively constant. Agency and communion theory seems to be a common theme in the research even though it is not named. Agency refers to dominance, social power and autonomy. Communion refers to nurturance and social interests. They stated these concepts have long been recognized as important in understanding human behaviour; however, they extended the concepts to issues in psychopathology, including depression and suicide (Coren and Hewitt, 1999).

The report highlighted that the impact of the two sets of variables, agency and communion, differ for older men and women. They suggest that retirement factors concerned with financial and social status are agency-related variables that mostly pertain to older males (Coren and Hewitt, 1999). It is assumed that "agency suffers the greatest reduction in old age", which may "explain why the rate of suicides shows such a marked increase for men above the age of 65 years" (Coren and Hewitt, 1999, p.117). According to this theory, women are associated with communion-related variables, which are somewhat protected from change in old age (Coren and Hewitt, 1999). Therefore, "women are less stressed in old age, resulting in little change in their suicide rates after age 65" (Coren and Hewitt, 1999, p.117). Coren and Hewitt's report (1999) was conducted five years prior to the Toronto initiative. The findings support gender variables that the Toronto Homeless Older Adults Research Project (2004) discussed. Reflecting on both reports it seems a good practice for shelter workers to be aware of the heightened suicide risk for elderly males who have just faced job loss between the ages of 60 and 65. Their

research indicates that shelter workers need to be aware of the risk factors associated with disruptions in social stability networks when looking at senior homeless women.

Aboriginal older adults and homelessness

Lange (2010) looked at elderly people of Aboriginal origin in Winnipeg. She stated that many elderly people of Aboriginal origin are displaced when they move from rural reserves into unfamiliar urban settings. These seniors are forced to relocate to cities for medical purposes and fall between the cracks of an already fragile support system (Lange, 2010). They could be prone to the issues Coren and Hewitt (1999) discussed due to the stress of being dislocated from their rural communities.

Beatty and Berdahl (2011) assert that Aboriginal seniors are among the most neglected societal class because of their increasing multiple physical and mental health problems. Aboriginal seniors have progressively poor socio-economic supports. This has forced them into even more challenging and dependent situations at an age when they should expect to be well treated and taken care of by both their families and governments (Beatty and Berdahl, 2011).

The paper pointed out that the number of Aboriginal seniors is growing more rapidly than the non-Aboriginal senior population. Beatty and Berdahl (2011) present Statistics Canada projections, which show that seniors will make up 6.5% of the total Aboriginal population, 8% of the Métis population; 6% of the First Nation population; and 4% of the Inuit population by 2017 (p. 2).

Beatty and Berdahl (2011) found there is poorer self-reported health status within the senior Aboriginal population. The researchers observed faster increases of the Aboriginal senior populations in Winnipeg, Saskatoon and Regina. Aboriginal seniors were more likely to report higher rates of drinking and smoking. These seniors had lower income levels, are more likely to live in overcrowded or unsuitable housing, and have lower levels of education and literacy. Their report supports Lange's (2010) study, which points to the same characteristics and concerns.

Looking at both papers, the findings in the Aboriginal discussions carry joint themes that other papers in this review also explore. It appears the challenges in the Aboriginal community are magnified for this group of older people. Both papers suggest that responsibility for their needs, particularly in relation to housing, is not clearly assigned to brand organizations or governments. This causes jurisdictional barriers which obstruct service delivery to Aboriginal seniors. These jurisdictional barriers also hinder Aboriginal seniors' ability to access health services.

The risk of homelessness among older adults

The Out of Sight, Out of Mind (2003) report prepared by the Seniors Housing Information Program (SHIP) examined the situations of homeless and 'at risk' seniors and vulnerable adults in the Lower Mainland (Hightower, Hightower, and Smith, 2003). Their writings share similar characteristics to other papers in this review.

SHIP's report connects with other research in areas which underline poverty as a path into homelessness (Hightower et al, 2003). Other overlaps include: housing, health problems, physical, emotional, and financial abuse concerns faced by homeless seniors. The report found seniors' homelessness was essentially about social exclusion. This can be attributed to a lack of friends, contact with family, breakdown of a marriage, death of a spouse, poverty, disabilities, and isolation (Hightower, Hightower, and Smith, 2003). This position supports Coren and Hewitt's (1999) discussion about locating the concepts of agency and communion when examining suicide risk predictors.

Gibeau (2002) contends that the effects of gentrification on communities, rising rents, and severe shortages in affordable housing has been felt mostly by older adults. Their incomes have not kept pace with escalating rents, the cost of medications, and the cost of health care in general (Gibeau, 2002). The "at risk" status for seniors has manifested itself in many ways, but evictions and elder homelessness rates continue to rise (Gibeau, 2022, p.25).

Accessing shelters seems to be problematic for seniors and the issues appear in a number of the documents. The SHIP (2003) report, Kutza and Krieger (1991) and Bottomley (2001) discovered over the course of their research that homeless seniors do not access shelters because they are scared of them. Seniors appear to be worried about:

- overcrowding
- noise
- theft
- violence
- shelter location in areas they feel unsafe to be in

A number of papers in this review have discussed a web of factors that potentially cause seniors to be homeless. They appear to fall into the areas of poverty, access to housing, and physical and mental health issues. These issues all seem to be linked with each other and need to be worked with at the same time. This connection of issues bridges the gap between the common themes and the physical and mental health challenges faced by elderly homeless people.

Physical and Mental Health Issues

Homeless seniors experience accelerated aging (Waldbrook, 2013). They are physically older than their chronological age indicates, and they are in worse physical health than the general older population. There are higher mortality rates in the older homeless population. Their shorter life spans may be attributed to: poor nutrition; disturbed sleep patterns; extreme weather exposure; social stigma; history of drug and alcohol use; and various barriers to primary care (Waldbrook, 2013). Since homeless seniors have unique challenges, better service coordination as well as updated shelter and housing options are required in order to meet their complex needs (McDonald, L., et al., 2004).

Bottomley (2001) maintains that the rates of chronic and acute health problems are extremely high among the homeless population. Homeless people are more likely to suffer from every category of chronic health problems. Obesity, strokes, and cancer are the only areas where homeless seniors do not outstrip the general population (Bottomley, 2001). She goes on to say that conditions that require regular, uninterrupted treatment, such as diabetes and tuberculosis, are extremely difficult to treat or control among seniors without adequate shelter. (Bottomley, 2001))

When people reported their ages during the RSCH (2008) count, 38% of the people were between 45 to 65 years old. This is largest segment in the count. They found the number of homeless people with two or more health conditions increased by 81% between 2005 and 2008 (GVRD, 2008, p. 12). Their data shows that 74% of the people counted in the Metro Vancouver region that day suffer from one or more health conditions (RSCH, 2008, p.34). Over 60% of the homeless people talked to on the day of the count were reported to have an addiction problem (RSCH, 2008).

During the homeless count people were asked about their use of health services in the past year. Health clinics were used by 53% of the homeless who responded to the question. This was followed by hospital emergency department use at 44%. Addictions services were used by about one quarter of the respondents and about one fifth reported using no health services at all. Ambulances were used by 27% of the people who were interviewed in the homeless count (RSCH, 2008).

Abdul-Hamid (1997) looked at elderly homeless men using hostels in Britain. His shelter sample found more people had psychiatric illnesses. The older group in the sample showed more chronic physical illness and disability. They had less psychotic illness and drug abuse compared to the younger population. Abdul-Hamid's (1997) data showed depression was detected in 40% of the older population and that a third of this group reported suicidal thoughts. This paper did

not report on the age of the seniors who had suicidal thoughts. The data would be good to look at through the Coren and Hewitt (1999) agency and communion concept lens.

Thomas (2011) investigated homeless mortality in England. His data reveals that a majority of deaths are from diseases. Cardiovascular disease and cancer account for nearly two thirds of deaths (Thomas, 2011). The cancer rates Thomas (2011) found may contradict Bottomley's (2001) paper. He discovered that causes of death for the homeless population are very different from that of the general population. Homeless people are more likely to die from external factors with deaths due to drugs and alcohol accounting for over a third of all homeless deaths (Thomas, 2011). Suicide rates were found to be nine times higher among the homeless population than the general population (Thomas, 2011).

Thomas (2011) found that there are much higher incidences of suicide and deaths as a result of traffic accidents among the homeless. Infections and falls are also more common amongst the homeless population. Bottomley's (2001) paper confirms the issue around fall injuries being problematic for homeless seniors. Bottomley (2001) found that frequently falls are the result of environmental obstacles, which homeless seniors encounter on a routine basis. Fall prevention programs are difficult to implement on the street.

Bottomley has similar findings to Thomas's (2011) research results. Bottomley (2001) addressed the health of homeless older adults. She describes common medical problems encountered by members of this population. Her practical perspective is worth looking at because she is able to list a number of issues shelter workers need to be aware of in order to provide appropriate responses to seniors.

She states many homeless people have multiple health problems frostbite, leg ulcers, and upper respiratory infections are frequent; they are often the direct result of homelessness and constant exposure to the elements. Homeless people are also at greater risk of trauma resulting from being hit by passing vehicles, muggings, beatings, and rape (Bottomley, 2001). Homelessness precludes good nutrition, good personal hygiene, and basic first aid (Bottomley, 2001).

This adds to the complex health needs of homeless people. In addition, some homeless people suffering from mental illness may use drugs or alcohol to self-medicate, and those with addiction disorders are prone to self-medication (Bottomley, 2001). Minor medical problems that require rest and proper hygiene become major medical emergencies for people who have no permanent domicile or access to sanitary facilities (Bottomley, 2001, p.3).

Bottomley (2001) asserts homeless seniors are more likely than the general population to suffer from neurologic disorders like epilepsy, peripheral neuropathies, and cognitive disorders. Seniors also face gastrointestinal problems, musculoskeletal disorders and respiratory disorders

such as pneumonia, chronic obstructive airway diseases, and tuberculosis (Bottomley, 2001). Working closely with homeless seniors, Bottomley (2001) found that hypothermia is more common than any other pathology among older homeless persons. It often occurs in association with other pre-existing conditions such as cardiac disease, diabetes mellitus, and alcoholism (Bottomley, 2001).

Based on her experiences amongst homeless seniors Bottomley (2001) states that sleep deprivation is ranked second in frequency of pathologies. Sleep deprivation compromises the immune system and leads to a whole range of diseases. Severe stress diminishes the quality of sleep and also exacerbates other medical conditions, such as hypertension. Noisy environmental conditions in the shelters and on the street often prevent long, deep periods of sleep. Bottomley (2001) states that sleep deprivation can exacerbate the aging process for homeless seniors (p.4).

Poor sleep frequently accompanies fibrositis and other musculoskeletal problems, which prevents people from finding comfortable sleeping positions (Bottomley, 2001). Older adults with osteoarthritis may awaken with stiffness and pain and have difficulty falling asleep again (Bottomley, 2001, p.4). Shelter workers need to be aware of this, because it could lead to avoidable confrontations during over-night shifts.

Bottomley (2001) states that homeless older adults suffering from sleep deprivation, often present with drowsiness, have a tendency to nod off for brief moments and confusion. Their lack of sleep leads to irritability and difficulty coping with even simple problems. Many older adults in shelter clinics suffered from chronic sleep deprivation and the resulting behavioural consequences (Bottomley, 2001, p.5).

Bottomley (2001) found that a diagnosis of urinary incontinence rarely occurs in this population, despite this its prevalence. Problems associated with urinary incontinence among homeless seniors include excoriated, emaciated skin that is chronically wet or damp. She has seen skin breakdown and lack of skin integrity from friction because of loose clothing. Foot ulcers are common from constantly soggy shoes, socks and dehydration (Bottomley, 2001).

The most common uncontrolled medical condition among homeless individuals is diabetes mellitus (Bottomley, 2001). She claims the prevalence of diabetes is highest in the older adult homeless population. Carrying prescription drugs often places homeless older adults at a higher risk for assault, and they opt not to carry them on their person, which makes diabetes treatment problematic (Bottomley, 2001).

Thomas (2011) asserts that mental illness should be considered to be a cause and a consequence of homelessness. Bottomley (2001) finds that mental illness is one of the most challenging problems encountered in the homeless senior population. Her experiences indicate

the most prevalent psychiatric disorders found in homeless seniors are substance use disorders associated with alcoholism (Bottomley, 2001).

Drake, Osher and Wallach (1991) studied people who were dually diagnosed with severe mental illness and substance use disorders. They found this group was vulnerable and had complex needs. Mentally ill substance abusers face multiple barriers. The problematic barriers happen for them because of:

- health issues

- legal problems

- behavioural issues

- skill deficits

- length of the engagement process to build trust

Research found that services separate mental health and addictions. This makes the study of this group difficult. Drake et al. (1991) feel effective programs need to focus on developing trusting relationships, comprehensive assessments, intensive case management, supportive housing and other support services. They say service providers working with this group should have an expectation that relapse will occur. Their research found housing is indispensable and housing options need to be designed around a continuum of care for this group.

Looking back at the information authors shared in their papers, a body of work that has been done over the years about homeless seniors emerges. The homeless seniors issue has been researched and written about for a least the last twenty years. Readings indicate problems are interconnected, complex, and difficult to partition in separate silos. Newer research has built on previous learning or complemented research which could be called dated. This highlights some of the best practice recommendations that have remained relevant for years.

Best Practices

Reflecting on the literature available, some common themes emerge as best practices for service providers. The following is a summary of best practice themes found in this review.

An important emergency service need for senior homeless people is the need for better access to temporary emergency shelters. Providing access to an emergency shelter is considered a best practice (Kutza & Keigher, 1991). Participants in the SHIP (2003) study and the Kutza and Krieger (1991) paper advocate the need for senior specific shelters. This theme resonates throughout a quantity of the documents in the literature review.

A number of articles agree that the best emergency assessment services occur when they are administered in place. These assessment services must come to the people who need the services. This practice compares with the premises that act as touchstones for the Homeless Integration Program in British Columbia.

Christensen and Vintner (2005) looked at the homeless exits for people with substance abuse or mental health problems. They touched on the context of the Danish welfare system in their research and highlighted some practices. Rent supplement and subsidy programs are used extensively in Denmark. People are granted housing, which includes social and health related supports. Municipal authorities have the right to allot rental housing to people incapable of finding a home. Municipal authorities allot 20% of the dwellings in the non-profit sector in order to reduce the scope of homelessness.

Outreach services as a best practice was supported in quite a few documents. The importance of mobile outreach to go out and engage people was emphasized numerous times. The Homeless Voices (2010) project and Gibeau (2001) are two of the papers which support outreach as a best practice. Cost effectiveness of the outreach services was discussed in a number of papers as well.

Hecht and Coyle (2001) recommend that it's more useful to provide housing with supported living arrangements for homeless seniors than it is to rely on service delivery models, which rely on moving people into employment to foster self-sufficiency. It is not realistic for seniors who are moving out or have moved out of their working years to be looking for work (Hecht and Coyle, 2001).

A central body that has integrated policy management authority in government and prevents the fragmentation of services that addressing homeless senior issues and needs was consistently addressed in the research papers. Koodratatas (1991) specifically argued for a central authority when discussing policy challenges. He stated it required unprecedented cooperation among federal, state, and local governments and non-profits.

Beatty and Berdahl (2011) recommend the establishment of Aboriginal long-term care facilities in major cities and First Nation long-term care facilities on-reserve. They say there is a need to ensure coordinated elderly care funding initiatives for Aboriginal caregivers. Ensuring Aboriginal elderly access to all health benefits, culturally responsive programming, and employment in healthcare systems were practices they felt would help Aboriginal seniors.

Medical assessment for seniors shortly after intake at the shelters is a practice supported by researchers working with geriatric clients. Bottomley (2001) states it is important to include a rehabilitation therapist on the assessment team. Allowing people choice in seeing the medical professional they feel comfortable with was also highlighted.

Bottomley (2001) states that fall prevention programs are difficult to implement on the street. It may be best to deliver it at shelter sites.

Rapid re-housing, where possible for the newly homeless seniors, emerges as a best practice. This mitigates risk factors of depression and suicide amongst this group.

Program successes often occur as a reflection of the value systems and practices guiding the team structures, which integrate housing, health, social, and medical services. The literature supports service provider skill development and enhancement as a best practice.

Access to enhanced services such as, health care, case management, clarification of benefits, and referrals to housing sources were considered strategic approaches by Bottomley (2001). Relationship building and making connections with homeless seniors were core processes for both outreach and shelter workers. This supports the view that professional development for service providers is a key practice.

Most practices in the literature review have been common themes in many discourses about homelessness. Some are universal and can be used with most populations who are homeless; other approaches take into account the toll aging takes on people and are senior specific.

Future Research and Closing Summary

This literature review examined a number of papers concerned with seniors and homelessness from various lenses. The papers were a mixture of current and past research. Much of the older information is still useful and can provide a strong foundation for current and future research. There were some areas this review was not able to loot at fully

The relationship dynamics between homeless seniors and service providers should be further studied. Out Of Sight, Out of Mind (2003), Homeless Voices (2010) and Home Free (2001) highlight that service providers need to make connections with homeless seniors in the context of relationship building. Future research should focus on how to foster such connections.

In addition, the limited amount of literature specific to the Aboriginal senior homeless population hinders service providers' ability to accommodate their needs. Available literature on this issue tends to use a prairie perspective; however, research suggests that the British Columbian Aboriginal senior population is growing significantly in urban centres (Beatty and Berdahl, 2011). Vancouver is ranked third in the number of urban Aboriginal people living in cities across Canada (Jantzen, 2004). The lack of Aboriginal specific literature points to a need for further research in this area. Future research should examine the experiences within this community and how they relate to issues for homeless seniors.

There is a lack of research concerned with the processes behind facilitating senior learning, the characteristics of elderly learners, or how to transfer information to homeless seniors. This is an area that needs to be explored. Service providers need to help people learn new ways to approach issues and solve problems. Older learners have different learning styles and challenges because of the aging process and life experiences. A European Union (EU) report stated that the older adult population has a lower level of formal education than the rest of the population, is composed largely of females, has changing social interaction patterns, and suffers from a number of health problems (Grundtvig, 2009). Themes presented in the EU (2009) report echo demographics and challenges faced by homeless seniors in Canada, which other papers in this review discuss. None of the authors focussed on how to help older people learn or reflect in ways that supports critical thinking and problem solving skills; therefore, further exploration and fusing of information about senior learning has the potential to provide an empowering avenue to addressing homelessness within the older population.

Much of the knowledge presented in this literature review is transferable to front line workers. It should be made available to front line workers with the intention of stimulating discussions to help raise awareness, bolster program approaches, and foster communities of practice through discourse.

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Acknowledgements

Members of the Homeless Seniors Community of Practice Steering Committee

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