Homelessness, Stable Housing, and Opportunities for Healthy Aging:

Exploring the Relationships

by

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ABSTRACT

This dissertation contributes to the existing literature on aging and health in human geography by exploring the relationship between homelessness, stable housing, and opportunities for healthy aging. Over the last 30 years, various social, economic, spatial, and political trends have reshaped Canadian society. These trends have resulted in a more complex, individualized life course in the 21st century, characterized by a greater number of delays and divergences as people adapt to the societal changes that have unfolded. Outcomes of such trends have been increasing rates of household financial problems, a greater incidence of absolute poverty, and growth in the homeless population. At the same time, Canada is undergoing demographic changes as the population ages and by 2030, it is estimated that approximately 25 percent of Canada’s population will be 65 years of age or older (Moore and Rosenberg, 2001). In this context, it is likely a greater proportion of the older population will have experienced homelessness in their life compared to previous generations (McDonald et al., 2006). Presently, academic research and public policy have failed to consider how people with histories of homelessness will fare in older age.

This dissertation addresses this unexplored area of research through the achievement of three broad objectives. First, the research contributes an original conceptualization of the long-term effects of homelessness on health and aging. Second, it explores how stable housing can improve homeless people’s opportunities for healthy aging. Third, the research provides a better understanding of how being homeless in earlier life can affect experiences of health and aging in later stages of the life course. The fieldwork to achieve these goals involved a structured survey (N=50) and interviews (n=29) with a sample of formerly homeless older people in Toronto, Canada. The findings reveal that older people with histories of homelessness are aging in a more disadvantaged context than the general older population. Various aspects of stable housing can improve health and offer a better opportunity for positive experiences of aging. However, formerly homeless people continue to face barriers to affordable, quality housing and other determinants of a healthy lifestyle in older age.
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CHAPTER ONE

Introduction

Setting the Research Context

Over the last 30 years, various social, economic, spatial, and political trends have reshaped Canadian society, alongside other westernized countries. These trends have included the changing nature of labour and employment, the way social welfare is delivered, and changes in the traditional structure of family and social life (Dear and Wolch, 1993; Dewilde, 2003; Bunting et al., 2004). These trends have profoundly transformed what was once considered a “normal” life course, marked by standardized ideals and transitions. From a normative perspective, the life course has traditionally been defined by events like leaving the parental home in young adulthood, pursuing education, marriage, childrearing, home ownership, the working years, retirement, and often changes in living environment in the elderly years (Elder, 1994). In recent years, social scientists have viewed the life course in the 21st century as a more complex and individualized process (Harper and Laws, 1995; Bailey, 2009). Today, the life course is characterized by a greater number of delays and divergences as people adapt to the structural and systemic changes that have unfolded in Canadian society. An outcome, or byproduct, of such trends has been increasing rates of financial problems among households, a greater incidence of absolute poverty, and ultimately growth in the homeless population (Bunting et al., 2004). In the post-war era through to the 1990s, homelessness was generally viewed as the outcome of personal problems like mental illness, chronic unemployment, alcoholism, and addiction (Rossi, 1990; Shlay and Rossi, 1992). In the 21st century, researchers are more critical of the social welfare system’s role in producing homelessness, blaming it for failing to ensure all people have adequate access to housing (Canadian Homelessness Research Network, 2013).
To complicate matters further, Canada is undergoing demographic changes as the population ages and the baby-boom generation moves into their retirement and elderly years. By 2030, it is estimated that approximately 25 percent of Canada’s population will be 65 years of age or older (Moore and Rosenberg, 2001; Hodge, 2008). The growing rates of poverty and homelessness in Canada have relevance to population aging in two major ways. First, it is likely a greater proportion of older people today will have experienced homelessness sometime during their life compared to previous generations (McDonald et al., 2006). Second, in response to population aging in Canada, the federal, provincial, and territorial governments are playing an increasing role in the decisions that older people make about housing and care (Keating and Cook, 2001; Northcott and Petruik, 2011). As public policy continues to promote the home as the ideal setting in which to age, unexplored questions are raised about the opportunity for formerly homeless people to age healthily and positively. To date, academic research and public policy have generally failed to consider how people with histories of homelessness and poverty will fare in older age. Based on the argument that homelessness is one of the greatest divergences away from a normative life course, this dissertation explores the linkages between homelessness, stable housing, and opportunities for healthy aging. To this end, the research presented in this dissertation seeks to achieve three broad objectives, as outlined below.

**Guiding Objectives and Research Questions**

The first objective is to contribute an original conceptualization of the long-term effects of homelessness on people’s experiences of health and aging. The second objective is to explore how stable housing can improve homeless persons’ opportunities for healthy, positive experiences in older age. The third objective is to understand better how being homeless in earlier life might affect experiences of health and aging in later stages of the life course. To
achieve these broad objectives, a series of six research questions will be answered in this dissertation: (1) Are formerly homeless older people aging in a different social, economic, and health context than the general older population in Canada? (2) What are formerly homeless older people’s experiences of health and health change since becoming stably re-housed? (3) What aspects of stable housing do they identify as having contributed to better health? (4) What types of barriers continue to limit formerly homeless older people’s opportunities for healthy aging even after they are housed? (5) How do formerly homeless older people perceive their past homelessness to be affecting their current health? (6) How do they envision their past homelessness will affect their health and experiences as they continue to age?

The answers to these questions will be reached by employing a combination of quantitative and qualitative methodologies. The first research question will be answered by data collected in the form of a structured survey, administered to a sample of 50 formerly homeless older people in Toronto, Canada. The specific parameters of the survey are outlined in Chapter Four, but it is useful to note that participants included people who were housed for six months (the minimum time frame) to nearly 30 years. The purpose of the survey was to collect background information on participants’ histories of homelessness, current housing situations, socioeconomic and demographic characteristics, and current health status. The remaining research questions are answered through qualitative data collected in semi-structured interviews with a subset (n=29) of the survey respondents.

The City of Toronto, Canada offers the most appropriate setting for this research. As the largest urban centre in Canada, Toronto contains a disproportionate share of the country’s homeless population, followed closely by Vancouver, Montreal, Ottawa, and Calgary. Although homelessness is a growing problem in smaller cities and towns across Canada, the sheer size of
Toronto’s population offers the greatest opportunity to recruit a sample of older people who have experiences of homelessness. Selecting Toronto as the study site also helps findings to be translatable and transferrable to other urban centres in Canada, and on an international scale.

Conceptual Premise of Research

The research presented in this dissertation is premised on three major conceptual points. First, the term “homelessness” not only reflects an absence of shelter, but is also conceived as the most severe form of social and economic marginalization. A definition by the Canadian Homelessness Research Network (2013) views homelessness as the “situation of an individual or family without stable, permanent, appropriate housing or without the immediate prospect, means, and ability to acquire it” (p.1). This definition considers the state of homelessness to include: living on the street or in a place not intended for human occupancy, an emergency overnight shelter, staying temporarily with family or friends, or in housing that does not meet public health and safety standards (The Canadian Homelessness Research Network, 2012). This research also adopts the view that homelessness is not a static or permanent state, and many people move back and forth along a continuum of housed-homeless throughout their life course (Watkins and Hosier, 2005; Scott, 2007).

The second premise is that homelessness poses serious, negative implications for physical health and mental wellbeing. Previous researchers have found homeless people to have poorer health, higher rates of chronic conditions, and a shorter life span than the housed population (Hwang et al., 1997; Hwang, 2000; 2001; Hwang et al., 2001; Kondro, 2007; Turnbull et al., 2007; Wen et al., 2007; Grinman et al., 2007; Frankish et al., 2009). From a life course perspective, homelessness is a health damaging process that puts people at a disadvantage with regards to health in the immediate and in later life (Blane et al., 2004; McDonough et al., 2005;
Pearlin et al., 2009). Accelerated aging is a common outcome of homelessness, meaning people who are homeless develop health problems at a younger age, resulting in an earlier death than the average person (Hwang, 2000; Crane et al., 2005; McDonald et al., 2006). The health differences found in the homeless population largely reflect an unfair distribution of key social determinants of health. In this research, housing is conceived as one of the most important determinants, encompassing both physical shelter and non-material resources that are crucial for psychosocial health (Dunn, 2000; Dunn and Hayes, 2000).

The third premise is that older persons with histories of homelessness are likely to age in a more disadvantaged context than the general population. The concept of “healthy aging” offers a useful framework for studying the complex relationship between homelessness, housing, health, and aging. Formulated by theories from health and social sciences, the concept of “healthy aging” is defined as encompassing physical health, mental wellbeing, satisfaction with life, independence, self-care, coping behaviours, access to support networks, and social participation (Rowe and Kahn, 1997; Bartlett and Peel, 2005). Some scholars also associate “successful aging” with economic achievement and the accumulation of income and assets in later life (Rowe and Kahn, 1997; Bartlett and Peel, 2005). A key critique is that “healthy aging” is deeply rooted in normative values, mainly based on upper-middle class ideals about the life course, the body, and personal wealth and resources (Bartlett and Peel, 2005). To date, the literature that seeks to conceptualize what healthy, successful aging means has overlooked the experiences and needs of formerly homeless older people.

**The Broader Theoretical Contributions**

The overall purpose of this study is not to develop recommendations for improving specific models of re-housing people who are homeless. Rather, the findings from this research
contribute to a stronger conceptualization of how stable housing can improve formerly homeless older people’s opportunities for healthy, positive experiences of aging. The uniqueness of this research is that it explores the experiences and perspectives of people who were once homeless, but currently housed in older age. Some participants had become homeless for the first time in older adulthood, but many had experienced homelessness in earlier life and had been living in stable housing for several years or decades. Bringing together these two common experiences from within the homeless population, the participants in this study offer valuable insight into the long-term outcomes of homelessness on health and aging. This dissertation is intended to offer a look “down the road” at what happens after homeless people are stably housed and as they grow older. As Canada’s population continues to age over the next 30 years, this research also offers a conceptual forecast for the types of challenges that people with low incomes and unstable housing histories will contend with in their senior and elderly years.

**Structure of the Dissertation**

The remainder of this dissertation is organized into seven chapters. Chapter Two reviews the theoretical and empirical studies in the existing literature as they relate to homelessness, health, aging, and the life course. The theories and concepts reviewed in Chapter Two emerge from human geography, and other related health and social sciences disciplines. The conceptual framework that guides this study is then articulated at the end of Chapter Two. Chapter Three sets the context for conducting this research in Toronto by reviewing current rates of homelessness, the prevalence of housing affordability problems, and recent policies and events that have shaped the city’s “homeless landscape”. The research design and methodological approaches are then outlined in Chapter Four, including the frameworks for analyzing the quantitative and qualitative data. The results from the survey are presented in Chapter Five with
the purpose of answering the first research question. The findings in Chapter Five emphasize that older persons with histories of homelessness are indeed aging in a more disadvantaged context than the general population in Canada. Chapter Six presents the qualitative findings from the interviews with the purpose of answering research questions two, three, and four. These findings reveal that the majority of the formerly homeless older adults in this study are experiencing better health since becoming re-housed. The various aspects of stable housing that have improved health and contributed to more positive experiences of aging are then identified. Chapter Seven explores the participants’ subjective views of the relationship between their past homelessness, current health, and expectations for aging, which addresses questions five and six. In Chapter Eight, the research objectives are revisited and conclusions are offered.
CHAPTER TWO
Literature Review

Introduction

The objective of this chapter is to review the existing literature on homelessness, housing, health, and aging in human geography, and related health and social science disciplines. The emphasis is that various social, economic, spatial, and political trends have transformed what was once considered a “normal” life course over the past 30 years. An outcome of such changing trends in Canada, and other westernized countries has been a growth in the rates of poverty and homelessness. In the context of the aging population, it is likely a greater proportion of older people will have experienced homelessness at some point in their life than in previous generations (McDonald et al., 2006; 2009). Yet, older people with histories of homelessness have received little attention within academic research and public policies on aging and housing. The theories reviewed in this chapter form the conceptual basis for studying the relationship between homelessness, stable housing, and experiences of health and aging.

The first part of this chapter reviews the existing research on housing and homelessness in human geography. The discussion then shifts to introduce theories of the life course and housing careers that have emerged from social science disciplines. In the second part of the chapter, housing and the life course are examined from a health sciences perspective. The research that has studied the health outcomes associated with homelessness is then reviewed, followed by recent debates about mental health. The third part of this chapter discusses homelessness in the context of the older population, including a review of the small body of literature that has specifically focused on formerly homeless older people. This chapter closes by situating this study within the literature that conceptualizes what it means to age healthily and
successfully. The overall emphasis of the chapter is that older people who have followed a non-normative life course are generally absent from the literature on housing and healthy aging.

**Housing and Homelessness in Human Geography**

The research on housing and homelessness in human geography has gone through various transformations over the past 60 years. In the post-war era, housing emerged as a major concern among human geographers with the evolution of national urban housing policies and various attempts to develop a social housing policy in Canada (Miron, 1988; Rose, 1980). More recently, human geographers who study housing have focused on the social, political, economic, and spatial trends that have contributed to a growth in the homeless population. This facet of research originally emerged in the 1980s from academic institutions in the United States, particularly in California where geography scholars drew attention to the increasing socioeconomic divide between social classes and racial groups in large cities (Dear and Wolch, 1987; Wolch et al., 1988; Dear and Wolch, 1993; Smith, 1996; Takahashi, 1996; Ruddick, 1998). Throughout the 1980s and 1990s, human geographers continued to address place-based concerns about homelessness, such as the gentrification of New York City’s housing stock (Smith, 1998) and homeless youth subcultures in California (Ruddick, 1998). This literature reveals a burgeoning social consciousness that homelessness was the outcome of more than just personal problems, but broader social, economic, spatial, and institutional changes were largely responsible. The recognition that homelessness was the byproduct of systemic or structural factors, and not just personal issues like mental illness and substance abuse, was a major conceptual turning point. In the early 1990s, Wolch and Dear (1993) advanced this research by arguing that three major trends were responsible for the growing rates of homelessness in American cities, and similar ways of thinking followed in Canada.
Dear and Wolch (1993) identified the changing structure of labour and employment in North America as the first trend. The shift away from an industrial to post-industrial mode of production brought higher levels of unemployment, deskilled occupations, and ultimately a greater reliance on low wage and contract-based jobs (Dear and Wolch, 1993; Takahashi, 1996). Competition in the labour market also increased as the baby-boomer generation created a bulge in the working-age population (Dear and Wolch, 1993). In the same era, the number of low income households in North America increased as the proportion of people in affluent, high-income professions grew. The overall outcome of these trends has been a deepening socioeconomic divide between the richest and poorest households.

Dear and Wolch (1993) identified the process of gentrification and urban renewal in large North American cities as the second major trend. From the late-1970s onward, the increase in the number of affluent households inspired gentrification in inner-city neighbourhoods, now commonly referred to as urban renewal (Bourne, 1981; Ley, 1983; 1986; Smith, 1998). In the post-war era, young couples aspired to live in outlying suburbs of cities, but in the 1980s the central city re-emerged as a desirable location for many young people (Dear and Wolch, 1993). The movement of high income households into inner-city neighbourhoods produced a competitive housing market (Dear and Wolch, 1993). The outcome is that households already living in the central city experience an increase in housing costs by raised rents, the high price of home ownership, and property taxes (Dear and Wolch, 1993). Urban renewal has also been blamed for the eviction and dislocation of groups who traditionally occupied inner-city neighbourhoods in the post-war era, including low-income households, minorities, elderly people, and immigrants (Smith, 1993; 1996). Processes of urban renewal also result in the destruction of single room occupancy hotels (SROs) and community opposition towards social
housing projects (Smith, 1993; 1996; 1998). The outcome of these trends are fewer affordable housing options and higher rates of homelessness in North American cities (Wolch et al., 1998; Smith, 1998).

The third trend that has contributed to a growth in homelessness, according to Dear and Wolch (1993), are changes to both the traditional welfare state and the nuclear family. The traditional family structure of the 1950s and 1960s has been transformed and characterized over the last three decades by higher rates of divorce, partner separation, an increase in female-led households, and delayed marriages among young people (Dear and Wolch, 1993). Changes in demographics and the normative family structure has also increased the demand for smaller and more affordable housing options, as well as other forms of social assistance (Dear and Wolch, 1993). At the same time as the demand for housing subsidies and financial assistance increased in North America, the traditional welfare state underwent a process of dismantling and reorganization. Since the early-1990s, a core focus of the research on poverty and homelessness has been to analyze the impact of welfare state policy reform (Dear and Wolch, 1993). Within this literature, a large share of scholars have blamed the growing rates of poverty and homelessness on reductions to provincial welfare assistance. In provinces like Ontario, social assistance payments and housing subsidies have been “clawed back” through cutbacks to government spending, program elimination, and reduced eligibility among recipients (Dear and Wolch, 1993). Welfare state reforms of this nature have had serious implications for many households and individuals, especially those already living in low-income situations.

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1 In 1998, the General Welfare Assistance program was replaced by the Ontario Works Act. The new Act was intended to provide temporary social assistance only to individuals who had exhausted every other financial option and could not find employment. The mandatory work-for-welfare program was introduced as part of the new Act, which required all recipients to be employed, except those who were disabled or single parents with young children (Ministry of Development and Economic Security, 2002).
Within their critique of welfare state restructuring, Dear and Wolch (1993) also point to the deinstitutionalization of mental health services as a factor in the growth of the homeless population. Beginning in the 1960s, legislation passed in countries like Canada, the United States, Britain, New Zealand, and Australia initiated the long-term process (and now current system of mental health care) that discharged people in institutionalized settings to independent living and care in the community (Dear and Wolch, 1987). Such movements originated in mental health institutions, but similar trends followed that shifted the care for persons with physical disabilities and elderly people to community settings (Dear and Wolch, 1987; 1993). While deinstitutionalization was intended to be a humane movement, most systems of government have failed to provide adequate support and care for these groups in the community (Dear and Wolch, 1993). Throughout the 1970s and 1980s, deinstitutionalization movements were considered largely responsible for the growing number of visibly homeless people on the streets in North American cities. In the 21st century, most scholars have shifted the blame away from deinstitutionalization movements and consider homelessness to be the outcome of limited affordable housing options and reduced welfare services.

The disappearance of government funding for social housing has received attention among human geographers (Bourne and Ley, 1993). In decades following the Second World War until the 1980s, social housing was governed at the federal level of government in Canada (Drummond et al., 2004). From the mid-1980s onward, federal support for public housing projects, non-profit cooperatives, and initiatives for private developers to build affordable housing began to decline (Drummond et al., 2004). By the end of the 1980s, the federal government was responsible for 60 percent of the support and funding for social housing, but the remainder had been devolved to the provincial level of government (The Ontario Human Rights
Commission, 2007). In 1995, the Ontario government cancelled support for social housing at the provincial level and downloaded the responsibility to the municipal level (The Ontario Human Rights Commission, 2007). By 1998, Ontario had lost 20 percent of its subsidized units in private buildings and waiting lists for social housing increased as competition in the private market grew (The Ontario Human Rights Commission, 2007). As an outcome, households have been forced to spend a larger share of financial resources on housing, and many people at the lowest end of the income spectrum have been pushed into a state of absolute homelessness. Since the beginning of the 21st century, the provincial government in Ontario has slowly begun to reinvest in social housing in response to rising levels of homelessness and housing affordability crises (Drummond et al., 2004). However, it remains generally unknown whether the amount of affordable housing construction in Ontario and other provinces will compensate for the erosion of support throughout the 1980s and 1990s (Drummond et al., 2004).

So far, this chapter has reviewed the literature on housing and homelessness in human geography through to the early 2000s. In 2004, Bunting et al. (2004) published a paper that argued homelessness in contemporary Canadian society is the outcome of an emergence of a “new poverty”. Bunting et al. (2004) argued that the homeless population has not only increased in sheer numbers, but has also become characterized by a broader range of social groups. The homeless population in the 21st century includes men, women, transgendered persons, youth, two-parent and single-parent families, couples, new immigrants, refugees, visible racialized minorities, and the elderly (Bunting et al., 2004). Similar to what Dear and Wolch (1993) argued a decade earlier, Bunting et al. (2004) consider the changing structure of family relations, an increase in single- person households, and the erosion of the family supportive wage to have contributed to growing rates of poverty and homelessness. Bunting et al. (2004) also argue that
the uneven, rapid population growth and development in major cities like Toronto, Vancouver, Ottawa, and Calgary has led to inflation in these urban housing markets. The rising cost of living in urban centres has forced households from all income levels to spend a larger share of income on housing (Bunting et al., 2004). In Figure 2.1, Bunting et al. (2004) offer a conceptualization of the contemporary factors that contribute to housing affordability crises and homelessness in Canadian cities.

**Figure 2.1**: The Bunting et al. (2004) conceptual framework for analyzing contemporary housing affordability stress and homelessness in Canadian cities

- **ECONOMIC CHANGES**
  - Polarized, post-industrial, occupational profile
  - Uneven metropolitan growth rates
  - Overheated real estate in fast growing CMAs

- **SOCIAL & DEMOGRAPHIC CHANGES**
  - Demise of family-supportive wage
  - More dual-earner households
  - More single-person households
  - More lone-parent, female-headed households
  - More immigrants

- **POLICY CHANGES**
  - Cut-back in social support
  - Elimination of rent controls
  - Demise of social housing

- Increased numbers of low-income households
- Increased rents and decreased supply of affordable housing.
- Increased housing affordability stress
Human geography scholars have noted other changing spatial patterns with regards to housing in Canada’s largest cities. A greater share of non-family and single person households are found in inner-city suburbs (Bunting et al., 2004). Some scholars have also raised concerns recently about the racial segregation and concentration of poverty among ethnically-diverse groups in Canadian cities (Walks and Bourne, 2006), particularly in the outlying suburbs (Preston et al., 2009). The literature reviewed above illustrates the important contributions that human geographers have made to research on housing, poverty, and homelessness. The next section reviews theories on the life course in human geography and related social disciplines.

**Reviewing Theories on the Life Course from the Social Sciences**

From a social sciences perspective, the life course is conceived of as a series of anticipated or expected events that unfold across a person’s lifetime (Elder, 1994). These events and transitions typically involve leaving the parental home, pursuing education, marriage, childrearing, purchasing a home, the working years, retirement, and death (Elder, 1994). In previous generations, the timing of such events and transitions was believed to be predicated mostly on age, biology, and demographic patterns (Elder, 1994; Harper and Laws, 1995; Bailey, 2009). More recently, the life course is seen as a complex, dynamic, highly individualized process. The life course is viewed as being shaped by both biological and social processes that intersect at various scales, ranging from the individual to the structural level, as well as across historical and temporal scales (Elder, 1994; Harper and Laws, 1995; Robinson and Moen, 2000; Bailey, 2009).

In the early 1990s, Elder (1994) outlined core principles that should be included in the conceptualization of the life course: lives and historical times; the timing of lives; linked lives and; human agency and structure. These principles emphasize that context is always important
when approaching topics from a life course perspective. According to Elder (1994; 2003), lives and historical times are important because differences in birth year means people are exposed to different historical contexts, each with its own unique constraints and options. The timing of lives should be considered because the sequence of events and transitions will shape future life courses (Elder, 1994; 2003). It is also important to recognize that human lives are embedded in social relationships and networks with others, such as family and friends throughout the life course, referred to as “linked lives” (Elder, 1994). And finally, human agency and social structure are crucial elements of life course theory because people make decisions within the constraints and opportunities that are available during their lives (Elder, 1994).

In the last decade, a small number of human geographers have incorporated principles of life course theory into their research (Dyck et al., 2001; Kobayashi and Preston, 2007; Bailey, 2009). In 2009, Bailey published a paper that argued “life course matters matter” to human geographers (p. 7). Based on the extensive review by Bailey (2009), human geographers have applied a life course perspective to study topics related to mobility, migration, employment, housing, childhood, changing families and social networks, health and disability. Along the same theoretical lines as Elder (1994), Bailey (2009) argues that biographies, transitions, events, synchronization, and contingency matter in how geographers theorize about the life course. Human geographers are concerned with patterns of everyday life and how people “organize their lives in relation to others, society, and its institutions” (Bailey, 2009; p3.). Bailey (2009) offers a useful definition of the life course from a human geography perspective:

[Life course scholarship] seeks to describe the structures and sequences of events and transitions through an individual’s life. Biographies help relate trajectories (or ‘careers’, including residential location, mobility, work, incarceration) to transitions (such as the demographic triumvirate of birth, death, and migration events, and nest-leaving, partnering, separating, retirement) and the spaces and times they flow through (p.1)
In recent years, social scientists have argued that generations now experience more delays and divergences away from what was once considered a “normal” life course. Dewilde (2003) and McDonough et al. (2005) suggest that trends in 21st century economics, politics, and social life have altered the traditional life course in profound ways. Much like the human geography scholars reviewed above, sociologist Dewilde (2003) argues that insecurity in the labour market, welfare state erosion, changing family structure, and population aging have played a critical role in complicating the traditional life course. Harper and Laws (1995) offer the following explanation for this process:

The fluid postmodern life course rejects the rigidities of a modernist life course which follows a linear sequence of youth and education, adulthood and work, and finally old age and retirement. Each of these modernist stages is associated with particular spaces: school, the workplace and residence, whether the family home, the poor house or a nursing home. People’s identities, changing as they do through the life course, are reflected in and formed by these spaces under modernism. Of particular interests is the effect of disruption to this linear sequencing: the taking of early retirement from one job only to take up part-time or volunteer work elsewhere; returning to school as adults and completing degrees alongside young students; and re-entrance into the labour force by women once their children have left the home (p. 213).

Over the last ten years, researchers have examined the societal trends and factors that are commonly responsible for interruptions and divergences in the life course of older people in particular. This literature is pieced together mainly from the disciplines of sociology, demography, gerontology, and psychology. The lives of older people are found to be intricately linked to younger generations, not only through family relations but across all sectors of everyday life. Studies on youth and their pathways into adulthood demonstrate how trends in one generation can have ripple effects in both young and older generations (Feijten and Mulder, 2005; Furlong and Cartmel, 2007; Settersten and Ray, 2010; Swartz et al., 2011). A common example is that recent generations of young people are encouraged to obtain some form of post-
secondary education or training in order to compete in an increasingly competitive labour market (Settersten and Ray, 2010). An emphasis on post-secondary education attainment, coupled with the restructuring of the labour market has led to a delay in traditional life course transitions among young people (Feijten and Mulder, 2005; Furlong and Cartmel, 2007; McDonald et al., 2011; Settersten and Ray, 2010; Swartz et al., 2011). Social and economic trends have particularly affected housing attainment among those in young adulthood, such as delaying home ownership and increasing the incidence of affordability problems (Feijten, 2003; Feijten and Mulder, 2005). Along with marriage and childbirth, the average age of first-time home ownership has also increased (Furlong and Cartmel, 2007). Many young people return to the parental home upon completion of their post-secondary education (Jacob and Kleinert, 2008; Swartz et al., 2011). An outcome of these trends is that many older people are bearing the financial burden of their own needs along with the needs of their adult children (Fingerman et al, 2009; 2009a). Research shows that people in middle age and older age often provide financial support to both their elderly parents and adult children (Remele, 2011; Fingerman et al., 2011).

Recent generations of older people also face challenges with regards to employment and retirement that have contributed to delays in the expected life course (von Bonsdorff et al., 2009; Hardy, 2011). The erosion of pension plans and diminished investments has meant that many older people face financial hardships at a life stage when previous generations have enjoyed a period of relative prosperity (Furlong and Cartmel, 2007). Since the early 2000s, growing rates of unemployment and lay-offs have required many older workers to retrain when previous generations were preparing to retire (von Bonsdorff et al., 2009). In Ontario, older worker initiatives and retraining programs have become part of political platforms in response to the 2008-2009 Global Recession (see policy example from Ontario Ministry of Training, Colleges,
Hardy (2011) argues that in past decades, people could afford to retire at the government mandated age of 65 years, but recent changes to pension plans and old age security benefits have extended the length of working careers in North America and many European countries. To cope with financial insecurity, many older adults only partially retire or even pursue second careers in later life (von Bonsdorff et al., 2009).

The literature reviewed above highlights the recent trends in research on the life course of the aging population in the social sciences. For the most part, the literature has focused on the experiences of older people who have followed a normal life course, marked by normative ideals and transitions. A normative view of the life course and aging assumes that everyone has followed a similar sequence of events with regards to childhood upbringing, educational attainment, employment and career, marriage and family, housing, social life, and retirement. A critique of this literature is that it excludes the perspectives of people, and entire social groups whose lifestyles, histories, and identities are not reflected in the ideals and values of a normative life course. To date, little attention has been given to the experiences of older people with histories of homelessness in the context of healthy aging (see McDonald et al., 2006; 2009; Shibusawa and Padgett, 2009 exceptions). In the next section, the existing literature specifically focused on housing careers and the life course is reviewed.

**Housing Careers and the Life Course**

Examining people’s housing careers offers some of the best insight in other aspects of the life course. The housing career reflects many aspects of people’s broader lives, such as their socioeconomic status, age, health status, employment, education level, and marriage status and family relations. From a life course perspective, housing is viewed as a life-long process that develops out of cumulative experiences beginning in infancy until the end of life (Watkins and
Hosier, 2005). For this reason, the meanings and definitions that each individual attaches to home are rooted in personal histories and experiences (Watkins and Hosier, 2005). While terms like “housing” and “home” tend to be used interchangeably, Watkins and Hosier (2006) argue there are important differences in their meaning within housing scholarship. The term “housing” typically refers to the physical structure, location, and quality of the building; while “home” is treated as a more subjective place, which ideally embodies feelings of comfort, safety, and security (Watkins and Hosier, 2005). Watkins and Hosier (2005) suggest a person’s concept of home is shaped “by relationships with place, embedded in a social context and stored in preparation for future life transitions and challenges” (p. 205). They go on to argue that perceptions of home are shaped by “complex influences across spatial scales, ranging from the person to broader society, across temporal scales from the historical to immediate, and on to the future (p. 205)

What is important to point out is that experiences of housing like other events in the life course are not shared equally by everyone in a society. From a normative perspective, a person’s housing history begins by leaving the parental home, followed by a state of independence in young adulthood (Watkins and Hosier, 2005). Life events like permanent employment and marriage put people on a trajectory for housing independence and security; however, unforeseen events like divorce, job loss, or illness can cause an unexpected interruption. Feijten and Mulder (2005) argue these types of unexpected life events do not just create emotional distress, but also cause a disruption in the accumulation of human and financial capital. An interruption can contribute to a loss or delay in homeownership and increase the likelihood that a person will experience housing affordability problems and even homelessness (Feijten and Mulder, 2005; Scott, 2007).
A small body of literature has examined homelessness from a life course perspective and this forms an important conceptual basis for this study. The “continuum of homelessness” model suggests safe, quality, affordable housing exists at one end of the continuum and the absolute state of homelessness is situated at the other (Lenon, 2000; Caragata, 2005; Scott, 2007). The continuum of homelessness represents the fluid nature of people’s living situations across their life course in response to their changing social, economic, health, and environmental context (Watkins and Hosier, 2005). One of the most important aspects of the continuum is its recognition that “housed” and “homeless” are not fixed or permanent states. A person might be housed at one point in life, but a missed paycheck, job loss, or illness can push them towards the insecure end of the housing spectrum (Scott, 2007). The continuum also emphasizes that life circumstances like domestic abuse or addiction can lead to precarious housing situations and increase the risk of repeated episodes of homelessness. The appropriateness of the continuum concept is that it allows for a consideration of both personal and macro-level factors that can influence housing security over a lifetime. A significant volume of research has explored the types of unwelcomed or unexpected events that can cause an interruption in, or divergence away from a normative life course. The factors most commonly identified include divorce and family breakdown (Cherlin et al., 1998; Ross and Mirowsky, 1999; Feijten and Mulder, 2010), widowhood (Williams and Umberson, 2004; Angel et al., 2007), incarceration (Huebner, 2007; London and Parker, 2009), mental illness (George, 1999; Mechanic and McAlpine, 2011), and physical illness (Braveman et al. 2011). Researchers have also pointed out the gendered (Moen, 2001; Williams and Umberson, 2004; Sered and Norton-Hawk, 2008; Venn et al., 2011), racialized (Foster and Hagan, 2008; Lynch, 2008; Mutchler and Burr, 2011), and unequal nature
of the life course (Walsemann et al., 2008; Shuey and Willson, 2008; Haas and Rohlfsen, 2009; Ferraro, 2011).

The research presented in this dissertation is informed by the literature reviewed above in three major ways. First, this study draws on theories like Watkins and Hosier’s (2005) to view housing careers as a life-long process. Second, this research adopts the view that homelessness exists on a continuum and is never a permanent state of being. Third, the literature reviewed so far helps to conceptualize how the intersection of personal problems, life events, and broader structural factors can interrupt the normative flow of events in a life course, and ultimately produce unstable housing situations.

**Health and the Life Course**

The research presented in this dissertation is also informed by theories from the health sciences. A health sciences perspective of the life course considers how circumstances in life have an accumulative effect on health, particularly events that are unwelcomed or traumatic in nature (Wadsworth, 1997; Kawachi et al., 2002; Blane et al., 2004; McDonough et al., 2005; Braveman and Barclay, 2009; Pearlin et al., 2009). While a developmental approach focuses on childhood and adolescence, a life course approach extends across multiple stages of life and into adulthood and older age (Braveman and Barclay, 2009). From a life course perspective, the body is viewed as a mechanism that stores both the benefits and dis-benefits of circumstances, environments, and human behaviours from earlier life (Blane et al., 200). This type of accumulative approach is concerned with how the intensity and duration of exposure to health damaging environments can adversely affect health in later life (Kawachi et al., 200). Much like studying other aspects of the life course, health is conceptually challenging because it is constructed through a complex, highly individualized process. Similar to social scientists, health
researchers have also applied core principles of life course theory to examine how the timing and sequencing of events, linked lives, and human agency and structure can shape health (Pearlin et al., 2005). Kawachi et al. (2003) offers one of the best explanations of this process:

The life course from a social epidemiological perspective refers to how health status at any given age reflects not only contemporary conditions, but embodiment of prior living circumstances in utero onwards. At issue are people’s development trajectories (both biological and social) over time, as shaped by the historical period in which they live—this is in reference to their society’s social, economic, political, technological, and ecological context (p. 695).

There is a vast body of literature on the relationship between health equalities and the life course (see Kuh et al., 2003; Kawachi et al., 2002 for full reviews). Evidence from existing research suggests that economic strain, repeated hardships, trauma, and discriminatory experiences can have long-lasting, negative effects on health (Dunn, 2000; Pearlin et al., 2005). The most damaging and traumatic kinds of stressors have been found to occur in major domains like family, housing, and employment (Pearlin et al., 2005). For example an unexpected event such as a job loss can lead to other stressors like family problems, financial troubles, and loss of a home, which ultimately puts people at risk of poorer physical and mental health (Pearlin et al., 2005). Research also suggests that people in lower socioeconomic positions typically experience more traumatic events than those of higher socioeconomic status (Pearlin et al., 2005). Generally speaking, people in lower socioeconomic positions also have fewer financial resources to deal with, or recover from unexpected life events (Pearlin et al., 2005).

Underlying much of the health sciences literature on the life course is the argument that social inequalities in health exist between different social groups (Braveman and Gruskin, 2003b). A large focus of the literature has been on the health inequalities that exist at different scales (Schuurman et al., 2007), such as between countries (Mackenbach et al., 2003; Marmot, 2005; Mackenbach et al., 2008), within countries (Kaplan et al., 1996; Kennedy et al., 1998;
Braveman and Tarimo, 2002), and at the neighbourhood level (Hou and Myles, 2004; Wilson et al., 2004). The research on health inequalities that exist between social groups is most relevant to this dissertation (Braveman and Gruskin, 2003b). It is important at this point to differentiate between the conceptual meanings of the common terms “health inequity” and “health inequality” (Kawachi et al., 2002; Braveman and Gruskin, 2003; 2003a; Braveman, 2006). Health inequality as a concept is considered value-neutral and refers to the measure of genetically-determined difference and disparities in health (Kawachi et al., 2002). Not all health inequalities are considered to be unfair or inequitable though, such as the health differences between women and men or the young and the old (Kawachi et al., 2002).

In contrast, “health inequity” refers to the inequalities in health that are considered unfair or embedded in some form of social injustice (Kawachi et al., 2002). Research that addresses inequities in health is usually deeply rooted in questions of fairness, ethics, and human rights (Braveman and Gruskin, 2003; 2003a). According to Kawachi et al., (2002), most inequalities in health that exist between social groups are unjust because they reflect an unfair distribution of crucial determinants of health, such as housing, nutritious food, access to educational opportunities, safe jobs, and health care. Health inequity systemically puts individuals and entire social groups who are already at a disadvantage at further risk with regards to their health and well-being (Braveman and Gruskin, 2003; 2003a; 2003b). Krieger et al. (2001) offers this useful definition of health inequities:

Social equity in health refers to an absence of unjust health disparities between social groups, within and between countries. Promoting equity and diminishing inequity entails reducing excess burden of ill health among groups most harmed by social inequities in health, thereby minimizing social inequalities in health and improving average levels of health overall (p. 698).
The social determinants of health is one of the most appropriate frameworks for exploring the relationship between health inequality and housing. The World Health Organization (WHO online) (2011) defines the social determinants of health as “the conditions in which people are born, grow, live, work, and age, including the health care system”. These circumstances are shaped by the distribution of wealth, power, and other material and non-material resources from the global to the local level (WHO, 2011). This comprehensive approach covers a wide range of factors from basic demographics, income inequality, health care, and the natural environment. More specifically, the social determinants include income, housing, social status, social support networks, education, literacy, including health literacy, employment, working conditions, social environment, physical environment, social capital, health and childhood development, biology and genetics, health services, gender, and culture (WHO, 2011). The overarching emphasis of this framework is that health is “sensitive” to social, economic, and cultural factors (Marmot and Wilkinson, 2006).

Dunn (2000) categorizes the existing research that emphasizes housing as a key social determinant of health into four major domains. First, a large focus of the research has been on the relationship between substandard housing conditions and poor health. Second, research has examined the connection between health status and access to health care, especially among disadvantaged groups like the homeless. Third, a significant share of the literature explores the pathological aspects of housing as the outcome of poor physical and mental health. And fourth, research has studied the relationship between stress, housing affordability problems, and health (p. 348). An overall objective of the literature cited above is to demonstrate that health is shaped by the cumulative effects of daily experiences and housing is a crucial determinant (Dunn, 2000; Dunn and Hayes, 2000). Research suggests that housing not only shapes health as a physical
structure, but it also affects people’s sense of control over life circumstances by offering safety and security (Dunn, 2000; Dunn and Hayes, 2000). The housing market plays a significant role in the distribution of wealth and other material and non-material resources, often referred to as psychosocial mechanisms (Dunn, 2000; and Dunn and Hayes, 2000). The housing market is also a place where power relations, social status, and social identity are reproduced (Dunn, 2000; Dunn and Hayes, 2000).

Principles of the life course combined with the concept that housing is a key social determinant of health forms an important part of the conceptual basis for this study. The melding of such theories offers a useful framework for studying how being homeless in earlier life might affect experiences of health and aging in later stages of life. Using the concepts outlined above as a point of theoretical departure, the following sections review the existing literature that studies the health outcomes of homelessness.

Homelessness and Physical Health

A relatively large body of research has studied the health outcomes associated with homelessness and its related lifestyles (Hwang et al., 1997; Hwang, 2000; 2001; Hwang et al., 2001; Kondro, 2007; Turnbull et al., 2007; Wen et al., 2007; Grinman et al., 2007; Frankish et al., 2009). In the Canadian context, most of these findings emerge from studies conducted on the homeless population in Toronto and Vancouver. Based on the evidence from these studies, the homeless population typically has poorer health and shorter life spans than the general, housed population (Hwang et al., 1997; Hwang, 2001; Hwang et al., 2001; Hwang et al., 2009; Hwang et al., 2010; Hwang et al., 2011). This process is commonly referred to as “accelerated aging”, meaning homeless people rarely live beyond the age of 70 years because they develop health problems at much younger ages than those who are housed (Hwang, 2000; Crane et al.,
In Canada and other developed countries, homeless people suffer from the same types of health problems as the housed population, but the frequency and risk of poor health is much greater (Turnbull et al., 2007). The physical health conditions that are most prevalent among the homeless population include diabetes, tuberculosis, respiratory tract infections (pneumonia, influenza), seizures, chronic obstructive pulmonary disease, arthritis, musculoskeletal disorders, anemia, reproductive problems, sexually transmitted infections, HIV/AIDS, hepatitis, skin and foot problems, and poor dental health (Hwang, 2001; Hoch et al., 2008; Kondro, 2007; Frankish et al., 2009; Khandor et al., 2011). Homeless people are at-risk of poorer health and an earlier death for a variety of factors, such as unfit living conditions and their exposure to dangerous lifestyles (Hwang, 2000). High rates of violence, injury, and sexual assault have also been found among the homeless population, as well as a greater risk of death caused by suicide and murder (Hwang, 2000; 2002).

Drug addictions and alcohol abuse tend to be prevalent in the homeless population (Grinman et al., 2010). Substance abuse is thought to increase the risk of homelessness by undermining social ties and economic stability, as well as leading to negative health effects like overdoses, psychiatric conditions, and infectious diseases (Grinman et al., 2010). The most common illegal substances used among Toronto’s homeless population include marijuana, cocaine, opiates, other sedatives, hallucinogens, stimulants, barbiturates, heroin, inhalants, and methadone (Grinman et al., 2010). Research suggests that people with drug addictions are more likely to become homeless at a younger age and will remain homeless for a longer duration than those without addictions (Grinman et al., 2010).

Sexually transmitted infections are also prevalent among the homeless population (Hwang, 2002; Frankish et al., 2009). Communicable diseases like HIV/AIDS and hepatitis are
common and often contracted through intravenous drug use and unsafe sex (Hwang, 2002; Frankish et al., 2009). In Canadian cities, hepatitis C is now recognized as a growing issue among the homeless and street-involved populations (Patrick et al., 2000; Fischer et al., 2006; Street Health Report, 2007; Csete et al., 2008). For example, a Toronto-based study by the Street Health (2007) organization found 25 percent of homeless participants (N=368) had hepatitis C, compared to less than one percent of the general population. Research also finds that homeless people with hepatitis C report higher rates of other serious health problems, like arthritis, rheumatism, inactive or latent TB, and hepatitis B. (Street Health Report, 2007). The complications associated with hepatitis C are projected to increase homeless people’s use of health care services in the future, as well as increase mortality rates among the street population (Street Health Report, 2007).

The homeless population has also been found to have poorer health as a result of barriers to accessing effective primary health care. In Canada, health and social care policy dictates that all citizens are entitled to care, but homeless people often experience a complex mix of internal and external barriers (Hwang et al., 1997; Plum, 2000; Turnbull et al., 2007; Wen et al., 2007; Frankish et al., 2009; Khandor et al., 2011). Internal barriers often include the denial of health problems, resistance to seeking care, pressures from competing needs, and the daily struggle to obtain shelter and food (Hwang et al., 1997; Plum, 2000; Frankish et al., 2009). The tasks associated with daily survival often take precedence over homeless people’s receipt of health care (Hwang et al., 1999; Frankish et al., 2009). Their access is also further complicated by external barriers like fragmentation in the health care system, having no regular family doctor, long waiting times at walk-in clinics, lost or stolen proof of health coverage and identity, a lack of transportation, and no health insurance or prescription coverage (Hwang, 2000; Hwang et al.,
Furthermore, prescription medications are difficult for homeless people to obtain and adhering to medical recommendations is often unrealistic without a home, especially if rest or dietary modifications are recommended (Frankish et al., 2009).

Research has found that prejudices and misconceptions among health care professionals can complicate homeless people’s access to care as well (Plum, 2000; Wen et al., 2007). Research suggests that the level of welcome felt by homeless people in health care settings is a large determinant of whether they seek care, as well as the quality of care that is received (Wen et al., 2007). There is evidence that homeless people receive the majority of health care services from walk-in clinics and hospital emergency rooms (Turnbull et al., 2007). Recent research has found that investing in social housing and other forms of social assistance is actually more cost-efficient than providing care in hospital emergency rooms (Pomeroy, 2005; Hoch et al., 2007; Canadian Housing Renewal Association, 2011). The existing research reviewed above demonstrates the complex relationship between homelessness and poor health. Frankish et al. (2009) argue that understanding this relationship is not straightforward, and both individual vulnerabilities and societal factors must be considered when studying homelessness, health, and quality of life (see Figure 2.2).
Figure 2.2: The Frankish et al. (2009) Conceptual framework: Causal pathways relating homelessness, health, and quality of life (p. S25).

Contemporary Debates About Mental Health and Homelessness

Much like physical health, mental health problems are also found to be more prevalent among the homeless population than the housed (Frankish et al., 2009). Research on mental health and homelessness in Canada, the U.S., Australia, and the U.K., has generally focused on six broad themes: the prevalence of mental illness (Fazel et al., 2008); risk factors or pathways to homelessness among the mentally ill (Folsom et al., 2005; Mojtabai, 2005); the social relationships and support networks among homeless people with mental illnesses (Padgett et al., 2010); their barriers to accessing health care (Hwang et al., 2010); issues related to substance abuse and addictions (Stein et al., 2008; Ginman et al., 2010); and social service models for re-housing homeless people with mental illnesses (Tsemberis et al., 2003; Padgett et al., 2011). Some studies have also compared the mental health status among different ethnicities (Austin et al., 2007) and between homeless men and women (Cohen et al., 1997). The findings from such studies suggest that older women tend to have higher levels of mental illness in comparison to homeless men and younger homeless women (Cohen et al., 1997; Crane and Warnes, 2010).
Homeless people with a history of substance abuse and alcoholism might also suffer from cognitive impairment and memory problems in older age (Crane and Warnes, 2007).

In a Toronto study, the most common mental health problems found among the homeless were depression, anxiety, bipolar affective disorder, schizophrenia, post-traumatic stress disorder, and addictions to drugs and alcohol (Khandor et al., 2011). Frankish et al. (2009) argues that a smaller proportion of the homeless population suffers from schizophrenia than commonly perceived by the general public and represented in media and news coverage on the homeless. In Toronto, it is estimated that only six percent of the homeless population has diagnosed schizophrenia, but these findings must be interpreted carefully as the number of undiagnosed cases is unknown (Frankish et al., 2009). Affective disorders refer to psychiatric or mental disorders that coincide with bipolar disorder or schizophrenia, and are found in 20 to 40 percent of Toronto’s homeless population (Frankish et al. 2009). These often include attention deficit or hyper activity disorder, eating disorders, fibromyalgia, general anxiety disorder, major depressive disorder, migraines, impulse control disorder, kleptomania, posttraumatic stress disorder, narcolepsy, and social phobia (Andrews et al., 2008; Graz et al., 2008).

Similar to physical health, understanding the relationship between mental illness and homelessness is not straightforward. As previously discussed, homelessness in the post-war era was usually viewed as the outcome of untreated or un-institutionalized mental illness (Rossi, 1990; Hoch et al., 2008; Cronley, 2010; Lee et al., 2010). In the 21st century, a different debate has emerged about mental illness and homelessness. On the one side, mental illness is considered to be a major contributing factor in the production of homeless situations (Warnes and Crane, 2010). This viewpoint dominates most studies on homelessness, especially those that seek to explain the causal variables and pathways into and out of homelessness (Crane et al., 2005).
These scholars typically view mental health as being present or existing *prior* to homelessness. Researchers on the other side of the debate argue that mental illnesses can be both a *cause* and an *outcome* of living in a state of homelessness (Cohen and Thompson, 1992; Martjin and Sharpe, 2006; Lee et al., 2010). In this second viewpoint, the crisis of becoming homeless can exacerbate any preexisting mental illnesses, as well as contribute to the emergence of new mental health problems (Prince et al., 2007; Taylor and Sharpe, 2008; Frankish et al., 2009; Lee et al., 2010). These researchers are not suggesting that mental illness is *never* a contributing factor in producing homelessness; rather, they argue that other factors are always at play, even among people with histories of mental illness.

The debates about mental health and homelessness remain generally unreconciled, but evidence has been published to support both sides of the argument. More research is needed into the timing and sequencing of events related to homelessness and the diagnosing of mental illnesses. Most studies on homelessness and mental health have relied on health data collected from surveys and interviews using self-reported data. Even with a clinical evaluation, it is often difficult to untangle people’s subjective views about the timing of their mental illness in relation to becoming homeless. Considering the heterogeneity of the homeless population, some individuals are diagnosed with a mental illness prior to becoming homeless, while others are diagnosed as part of the rehousing process. Most contemporary researchers though acknowledge that mental health and well-being cannot be studied independently from physical health, and vice versa (Prince et al., 2007).

**Older People and Homelessness**

Recent research has found growing rates of homelessness among older adults and the elderly (Cohen et al., 1997; Cranes and Warnes, 2007; 2010). The majority of this research has
been conducted in the U.S and the U.K., but very little in the Canadian context (see Stergiopoulos and Herrman, 2003; McDonald et al., 2006; 2009 for exceptions). It is important to note that most researchers consider “older age” in the homeless population to begin around 50 years due to accelerated aging (Hwang, 2000; Cranes et al., 2005; McDonald et al., 2006). For the most part, previous studies have focused on identifying risk factors for becoming homeless in late stages of life. Like younger age groups, homelessness in older age is also the outcome of the intersection between personal problems and broader systemic barriers. Common factors that contribute to homelessness in older age include mental and physical illness, a lack of family and social support networks, limited affordable housing options, a low income, substance abuse, and discrimination and ageism in the housing and job market (Crane et al., 2005; Cranes and Warnes, 2007, 2010). These factors are similar to those identified in research on the general homeless population, but some aspects are uniquely attributed to older age. As discussed in an earlier section, older adults in their later working years can experience financial problems as a result of mandatory retirement, unemployment, and income decline (Crane et al., 2005). People with unsteady work histories or chronic unemployment are also likely to have limited entitlement to pension and old age security benefits (Crane and Warnes, 2010). These factors in combination with changes in the economy and competition in the housing market are found to increase the risk of homelessness. Widowhood, marital and family breakdown, and the onset or worsening of physical and mental health problems are also risk factors for homelessness in older age (Crane et al., 2005; Crane and Warnes, 2010). To complicate matters further, some older people also lack the skills and resources to cope when unwelcomed events occur in later life (Crane et al., 2005; Cranes and Warnes, 2010). Research suggests that people with low incomes, mental illness,
histories of incarceration, and addictions are most at-risk of becoming homeless in their senior years (Cohen et al., 1997).

A small body of studies have examined the daily lives and habits of older homeless people. There is evidence that older people are less likely to use shelters, drop-in centres, and free meal programs than are younger homeless people (Bruckner, 2001). While some older people find temporary accommodations in shelters, many avoid social service agencies and charitable organizations for fear of crime and violence (Crane and Warnes, 2010). Crane and Warnes (2007) found that older homeless people are often overlooked by social service staff because they are preoccupied with the needs of younger clients. Older homeless people can also be distrustful and resistant to accepting help from staff and outreach workers on the street (Crane and Warnes, 2010).

To date, little research has been conducted on subgroups within the older homeless population. There has been some gendered comparisons conducted between older men and women who are homeless (Cohen et al., 1997; Crane and Warnes, 2007). Studies have found women to comprise a smaller percentage of the older homeless population than do men (Cohen et al., 1997; Buckner, 2001). Homelessness among older men has traditionally been viewed as the outcome of unemployment and alcoholism, but there is a need for updated research on this topic in the 21st century context. Homelessness among older women is more commonly viewed as the outcome of life events like widowhood, divorce, financial problems, and mental illness (Crane and Warnes, 2007). Some research suggests that older homeless women have the greatest potential for becoming and remaining permanently housed (Cohen et al., 1997). Some research suggests this is because women have greater access to social service agencies and opportunities to become housed than their male counterparts (Buckner, 2001). Women are more likely than
men to maintain relationships and social ties with family members and friends while they are homeless (Cohen et al., 1997; Crane and Warnes, 2007). Homeless women are also found to have lower levels of substance abuse and criminal offences, but higher rates of mental illness than those of men (Cohen et al., 1997; Crane and Warnes, 2007).

From these previous studies, some findings can be teased out about the health status of the older homeless population (Cohen et al., 1997; Buckner, 2001; Cranes and Warnes, 2010). The types of health conditions that are most commonly found among older homeless people include arthritis, hypertension, diabetes, chronic respiratory illnesses, gastrointestinal illnesses, circulatory disorders, tuberculosis, vision and hearing loss, skin infections, functional disabilities, and dental problems (Cohen et al., 1997; Buckner, 2001). These illnesses are similar to those identified among the general homeless population, but older people are found to have higher rates than both younger homeless people and seniors who are housed (Buckner, 2001). Homeless people with histories of chronic alcoholism and drug abuse, as well as those who regularly sleep outdoors instead of shelters typically have the poorest health statuses (Crane et al., 2010; Buckner, 2001).

For the most part, the existing literature has focused on people who have become homeless for the first time in their older years. Crane and Warnes (2010) recognize that some older people have been chronically or intermittently homeless throughout their lives; however, little is known about older people who have experienced homelessness in earlier life but are now stably housed in their older years (see McDonald et al., 2006; 2009; Shibusawa and Padgett, 2009 exceptions). The next section explains the common approaches that are taken by social service agencies to re-house homeless people. The section afterwards reviews the small body of research that has been conducted on the formerly homeless older population in Canada.
Re-Housing Homeless People

A review of the academic and grey, community-based literature reveals an endless number of studies that evaluate the most effective methods of re-housing people who are homeless. It is beyond the scope of this dissertation to review these specific methods in great detail, but some recent housing initiatives in Toronto are reviewed in Chapter Three. For the purpose of this study, being “re-housed” broadly refers to the process of transitioning from the street, often first to temporary accommodations, and then to permanent housing like an apartment or supportive housing facility. In Canada, formerly homeless people typically receive help from a social worker to find housing and if they become recipients of government social assistance, they are usually entitled to subsidized housing. Those who do not qualify for, or receive, social assistance benefits are usually forced to pay market-priced rent for their housing.

Within the broader literature, there has been significant debate over the most appropriate and effective approach to re-housing homeless people. Although approaches vary between social service organizations, most housing initiatives are predicated on one of two models: the “continuum of care” model and the “housing first” model. Recently, researchers have questioned whether homeless people should be given housing first, or if barriers like mental illness, addictions, and unemployment must be initially addressed (The City of Toronto, 2007; 2009; Atherton and Nicholls, 2008; Goering et al., 2011; The Mental Health Commission of Canada, 2011; Frankish et al., 2012). Until the mid-2000s, a continuum of care model was the most popular approach for re-housing homeless people. This approach requires homeless people to address their mental health and addiction issues first, usually in a transitional housing

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2 In Toronto, several supportive housing facilities offer residency to formerly homeless people for an indefinite period of time, especially those with histories of chronic homelessness, addiction, or mental health issues.
3 In Toronto, housing subsidies can be in the form of a rent-geared-to-income (RGI) apartment or indirectly through rent supplements to private landlords.
environment, before being provided with permanent housing. The continuum model takes a “treatment first approach”, meaning a client moves up and down a staircase depending on their ability to meet the formal steps of the housing program (Atherton and Nicholls, 2008; The Mental Health Commission of Canada, 2011). The purpose is for clients to demonstrate they can cope with everyday activities prior to being housed independently (Atherton and Nicholls, 2008).

In more recent years, research has demonstrated that a “housing first” approach is the most effective method for helping homeless people to remain permanently housed. From a housing first approach, homeless people are provided with stable housing immediately and efforts are made at the same time to address mental illness, addictions, and other barriers to remaining housed (Atherton and Nicholls, 2008; Frankish et al., 2012). In Toronto, most supportive housing facilities and other initiatives to end homelessness have adopted a housing first model, which encourages homeless people to adjust to living independently while simultaneously addressing other personal problems and structural barriers to being housed (Frankish et al., 2012).

**Reviewing Existing Research on the Formerly Homeless Older Population in Canada**

Although poverty and homelessness have received considerable attention within academic and public policy research in recent years, little is known about the formerly homeless older population in Canada and other places in the world. While conducting a literature review for this dissertation, an extensive search was conducted to find information on formerly homeless older people. The search yielded studies that focused on other groups within the formerly homeless population, such as children who were once homeless, and their health, development and educational outcomes (Menke and Wagner, 1997; Menke, 2000; Rafferty et al., 2002; Gewirtz, 2007). In the adult population, some focus has been given to assessing the housing,
supports, and health care needs of formerly homeless people with addictions and mental illness (Bebout et al., 1997; Dickey et al., 1996; Goldfinger et al., 1999; Caplan et al., 2006; Padgett et al., 2006; Hawkins and Abrams, 2007; Yanos et al., 2007; Kyle et al., 2008; Rotheram-Borus, 2009). In a systematic review of studies on housing and health among people with severe and persistent mental illness, Kyle et al. (2008) found those who were homeless benefited the most from housing interventions. Based on their conclusions, Kyle et al. (2008) suggest that more research is needed to understand the range of individual factors that affect housing needs and the effectiveness of housing at improving health and quality of life. The research presented in this dissertation addresses such recommendations and takes a further step to situate it within the context of healthy aging.

Scholars Shibusawa and Padgett (2009) applied theories of the life course to study the lived experiences of homelessness also among persons with addictions and mental illness. Shibusawa and Padgett (2009) found formerly homeless older adults felt “out of sync” with other people their age. Following a non-normative life course had resulted in feelings of social exclusion and internalized stigma, and the aging process had intensified such feelings. The participants in their study viewed becoming re-housed and treating their addictions and mental illness as a step towards “normalcy” or being an “average person” (p. 192). Although housing was found to offer formerly homeless older people greater control and agency over their own life, many participants in the Shibusawa and Padgett (2009) study continued to worry about their future health and well-being. The findings from their research provide some of the only information that exists about formerly homeless people’s experiences of aging. While Shibusawa and Padgett’s (2009) study included people aged 40 to 62 years, the research presented in this dissertation includes participants aged 45 to 80 years (see Table 5.1). The
approach taken in this dissertation offers greater insight into the experiences of formerly homeless older people in later stages of the aging process.

In the Canadian context, the *In From the Streets* project is the only recent study to examine health and well-being among the formerly homeless older population. This project was conducted by a research team at the University of Toronto’s Centre for Life Course Studies and was funded by the *National Research Program of the National Homelessness Initiative*. The findings from this study were published in the form of a final report (2006) and book chapter (2009), but not in peer-reviewed academic sources. The overall purpose of the McDonald et al. (2006) study was to understand the characteristics and socioeconomic status of older people who were previously homeless and the extent to which they were recovering in supportive housing facilities. Although McDonald et al. (2006) examined a similar population in Toronto, there are key conceptual differences between their study and the research presented in this dissertation. First, the research conducted by McDonald et al. (2006) was approached from a service delivery perspective with the intention of improving programming and practice at local housing organizations. Second, their research primarily focused on formerly homeless older people who were living in supportive housing facilities and supported housing⁴; whereas this study included participants both living independently in their own apartments as well as those in supportive housing environments. Third, McDonald et al. (2006) mainly approached their examination of health and well-being from a psychosocial perspective, while this study more explicitly considers the role that stable housing plays in improving physical health, along with mental health and well-being. Fourth, the study by McDonald et al. (2006) did not examine formerly homeless older people’s health based on the length of time they were re-housed. In this dissertation, the

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⁴ “Supportive housing” typically refers to housing with onsite supports and staffing whereas “supported housing” refers to community-based supports provided either on or off site (McDonald et al., 2006; p. 14-15).
participants’ experiences of health and health change are compared among subgroups depending on their time in stable housing. This approach considers how formerly homeless older people’s experiences of health might change over time, which was not addressed by the *In From the Streets* project.

Despite the differences in approach, the findings from the McDonald et al. (2006) study offer a valuable starting point for further research on formerly homeless older people. McDonald et al. (2006) considered “older age” among the formerly homeless to begin around 50 years and the average age of participants was 57 (p. 64). In terms of methodology, McDonald et al. (2006) collected data using a structured survey, interviews, and focus groups. The main purpose of their survey was to evaluate formerly homeless older people’s satisfaction in the supportive housing facility in which they resided. The survey included questions about daily activities, use of health care services, community and social supports, family support networks, and income sources. The interviews conducted by McDonald et al. (2006) generally expanded on these issues and examined participants’ feelings about living in a supportive housing facility (availability of supports, comfort level, rules, relationships with staff). Based on the findings, the formerly homeless older adults reported poorer health status, accelerated aging, and higher rates of chronic conditions than the general older population. The participants reported better access and more frequent usage of health care services compared to when they were homeless, but accelerated aging and residual feelings of trauma continued to limit recovery. McDonald et al. (2006) found recovering from health problems and the negative psychosocial effects of homelessness to be an ongoing process among formerly homeless older people.

One of the main findings from the *In From the Streets* project is the greater need for age-appropriate, affordable housing and supports for older people recovering from homelessness. In
terms of future policy and program development, McDonald et al. (2006) suggest the effects of homelessness and accelerated aging be taken into consideration. Housing and other programs must be designed to enhance community integration, social belonging, participation, as well as to address discrimination and other barriers to quality of life (McDonald et al., 2006). Future programming must also address the barriers to income and employment that older people with histories of homeless contend with after they are re-housed. The findings from the McDonald et al. (2006) study emphasize that formerly homeless people in their elderly years have unique needs from younger age groups. Furthermore, people in their 50s and 60s will also have unique needs compared to the general older population as a result of accelerated aging.

Although the study by McDonald et al. (2006) was conducted with a different purpose than the research in this dissertation, both studies are concerned with improving the health and lives of older people with histories of homelessness. This dissertation draws on the findings from the In From the Streets project as contextual and background information regarding the formerly homeless older population in Canada. In Chapter Five, the characteristics of the participants in the In From the Streets project are compared to the sample of formerly homeless older people who participated in this study.

**Reviewing Human Geography Literature on Healthy Aging**

Since the 1990s, human geographers have studied various aspects of aging, including the geographical distribution of the older population (Moore et al., 1997; Plane and Heins, 2003; Newbold and Filice, 2006; Warnes and Williams, 2006), access to services (Joseph and Hallman, 1998; Everitt et al., 2005; Cloutier and Skinner, 2006; Hanlon et al., 2007), and implications for public policy (Rosenberg and Moore, 1997; Skinner and Rosenberg, 2005). With regards to research on housing and healthy aging, a significant share of attention has been given to the
specific types of housing environments and amenities that promote positive experiences of aging (Kendig, H., 2003; Andrews and Phillips, 2004; Oswald and Hans-Werner, 2004; Iwarsson et al., 2007; Cheng et al., 2011). Much of what is known about housing and healthy aging emerges from the broader literature that seeks to conceptualize and design age-friendly communities (Laws 1993; Lui et al., 2009; Menec 2011; Buffel et al. 2012; Greenfield 2012). This research has primarily been conducted with the intention of improving the range of housing options that are offered in communities for the older population, along with other amenities and services like transportation, health care, and accessible infrastructure (Hodge 2008; Menec et al. 2011; Phillipson, 2011; Buffel et al. 2012; Kerr et al. 2012).

By and large, a focus on aging-in-place has dominated the theoretical literature on aging, housing, and health in human geography (Harper and Laws, 1995; Andrews and Phillips, 200b; 2004; Andrews et al., 2007). The concept of aging-in-place has been applied at various scales, ranging from older people’s subjective experiences to broader public policy debates about the impact of population aging on government expenditures for health care and long-term care (Harper and Laws, 1995; Rosenberg and Everitt 2001; Andrews and Phillips 2004; Andrews et al., 2007). For human geographers, the concept of aging-in-place denotes the complex decisions that older adults face in later life with regards to housing and care (Harper and Laws, 1995; Rowles, 2000; Andrews and Phillips, 2004; Andrews et al., 2007). Harper and Laws (1995) argue that older people’s decisions about their residential situations can only be understood as part of a complex, life-long housing career. According to Harper and Laws (1995), a person’s housing career “not only involves frequent environmental adjustments but are also continually tempered by structural constraints” (Harper and Laws, 1995; p. 204). They go on to argue, “the
variety of housing options open to older people is thus dependent upon their temporal, spatial, and social position in society” (Harper and Laws, 1995; p. 204).

In Canada, the housing options that are generally available to the older population fall into three categories (Northcott and Petruik, 2011). First, as the population ages, territorial and provincial governments are encouraging older people to age in their own homes through the use of publicly- and privately-funded home care services and informal support networks (Northcott and Petruik, 2011). Second, some older people migrate outside of their home and/or community to live with family members. Third, many older people reside in retirement facilities or long-term care facilities that are either publicly- or privately-funded depending on individual financial resources (Northcott and Petruik, 2011). When making decisions about where to live in older age, people must consider individual factors like health status, financial resources, access to family and informal caregivers, and the housing options and supports that are available in their communities. Within human geography, there has been some basic recognition that older people with limited financial resources will have fewer options when deciding about housing, locality, and care (Joseph and Chalmers, 1995; Harper and Laws, 1995; Andrews et al., 2007). This study is not about aging-in-place, but this view of the literature reveals poverty and homelessness are rarely factored into academic theories on housing and aging.

In response to population aging, a key focus of policy development and academic research has been to conceptualize models of “healthy aging” (Rowe and Kahn, 1997; Bartlett and Peel, 2005; Bowling and Dieppe, 2005). The term “healthy aging” is often used interchangeably with “successful” or “positive” aging and is concerned with both the quality and length of people’s lives (Bartlett and Peel, 2005). To date, most researchers have sought to identify the physical, psychosocial, and environmental determinants that promote positive
experiences in older age. A review of the broader literature on healthy aging shows two dominant models have emerged. The first is a biomedical model that views healthy aging in terms of optimizing the opportunity for life expectancy while reducing physical and mental deterioration and disability (Bowling and Dieppe, 2005). The focus of a biomedical model is primarily on the absence of chronic disease, the absence of risk factors for poor health, and independent physical functioning (Bowling and Dieppe, 2005). The purpose of a biomedical model is to identify the physiological and psychological risk factors that predict poor health with the ultimate goal of developing environmental and lifestyle interventions (Bartlett and Peel, 2005). The second model that dominates the literature is a psychosocial view of healthy aging, which extends beyond physical health and health care provision to also include quality of life, satisfaction with life, mental and social well-being, independence, self-care, finances, coping behaviours, access to support networks, and social participation (Rowe and Kahn, 1997; Bartlett and Peel, 2005; Bowling and Dieppe, 2005).

In contemporary studies though, most researchers adopt a model of healthy aging that combines both a biomedical and psychosocial perspective. Rowe and Kahn (1997) first conceptualized a model that encompasses three important components of healthy aging: (1) the absence of disease and risk factors for disease; (2) the maintenance of physical and cognitive functioning and; (3) engagement with social life. More recently, Bartlett and Peel (2005) have advanced Rowe and Kahn’s (1997) model of healthy aging by situating it within theories on the life course. They define “healthy aging” as the “adaptation to physical and psychosocial changes across the life course to attain physical, mental, and social well-being in older age” (p. 100). The research presented in this dissertation is informed by the views of Rowe and Kahn (1997) and
Bartlett and Peel (2005), recognizing that physical, mental, and social well-being throughout the life course are important for healthy, positive experiences of aging.

A review of the literature also reveals that similar theories on healthy aging have been applied to the study of housing (Oswald and Hans-Werner, 2004; Oswald et al., 2007). Oswald and Hans-Werner (2004) argue that most researchers have been preoccupied with identifying the objective risk factors that pose a threat to health in the home environment. As discussed throughout this chapter, the health implications of housing, however, are not restricted to the physical dwelling and immediate environment alone, but various micro and macro-level factors must also be considered. Oswald and Hans-Werner (2004) argue that the subjective meaning that older people attach to their home environment requires greater theorization within research on housing, health, and aging. How subjective aspects of housing like safety, privacy, and feelings of belonging can promote, or impede opportunities for healthy aging remains generally underexplored to date. To address this gap, a key component of this dissertation is to examine how such psychosocial aspects of stable housing might be particularly important among formerly homeless older people given their histories of housing insecurity.

Bartlett and Peel (2005) are among the few scholars who have acknowledged that the heterogeneity of the older population matters in the conceptualization of healthy aging. They argue that a person’s interpretation of their own health and chances for healthy aging is largely dependent upon factors like culture, gender, and age. In this dissertation, this critique is extended to argue that a person’s financial situation and housing history will also influence how they interpret their health and chances for healthy aging. Bartlett and Peel (2005) suggest that the opportunity for successful, positive experiences in later life is usually evaluated based on economic achievement, such as the accumulation of savings for retirement. Therefore, most
models of healthy aging are defined by normative values and mainly reflect the ideals of the middle to upper class (Bartlett and Peel, 2005). To move beyond such normative models, Bartlett and Peel (2005) suggest that healthy aging be evaluated on a continuum of achievement of success and failure, and not by standardized ideals. This dissertation is designed to challenge normative ideals and expectations about healthy aging by considering the perspectives of formerly homeless older people.

Chapter Discussion: Outlining the Guiding Conceptual Framework

The literature reviewed throughout this chapter forms the conceptual basis for this study on health, homelessness, and aging. The chapter opened by reviewing literature from human geography and the social sciences on homelessness and housing from a life course perspective. This discussion established that various social, economic, political, and spatial trends have transformed the normative life course in recent decades (Dear and Wolch, 1987; Takahashi 1996; Wolch and Dear 1993; Wolch et al., 1988; Bunting et al., 2006). According to social scientists, the outcome of such trends has been growing rates of homelessness and poverty in Canada, alongside other westernized countries. The outcome has also been that social researchers now conceptualize the life course as a more fluid, complex, and highly individualized process than it was conceived of in the decades after World War II (Dewilde, 2003; McDonough, 2005; Bailey, 2009). A consequence is that recent generations of older people are likely to have experienced more delays and divergences away from what was once considered a normal life course marked by standardized ideals and transitions.

At the same time, North America is undergoing significant demographic changes as the baby-boom generation enters their retirement and older years. By 2031, approximately 25 percent of Canada’s population will be 65 years of age or older (Moore and Rosenberg, 2001;
Hodge, 2008). The literature reviewed in this chapter showed the impact of population aging on Canadian society has received considerable attention in academic fields like human geography and social gerontology. Canadian public policy has also evaluated the impact of population aging, mainly in the context of debating the outcome of government expenditures for health and long-term care (Gee, 2000; Hodge, 2011). In response, major focuses of debate in the academic literature have been over the most appropriate environment for older people to age, the financial situations of seniors, and the provision of services and care that are required for healthy, successful aging. Public policies and academic theorists have yet to fully consider the barriers that older people with histories of homelessness face to healthy aging. Considering that homelessness is one of the greatest divergences away from a normative life course, this dissertation contributes further knowledge by exploring the relationship between past homelessness, becoming stably housed, and opportunities for healthy aging.

The literature reviewed in this chapter also examines homelessness through a contemporary social lens. While personal problems like addictions, unemployment, and mental illness can contribute to unstable housing situations, most contemporary researchers view homelessness as society’s failure to “ensure that adequate systems of funding and support are in place so that all people, even in crisis situations, have access to housing” (Canadian Homelessness Research Network, 2013; p.1). The literature review informs the perspective adopted in this dissertation that homelessness is not a static or permanent state and many people experience more than one episode in their lifetime (Watkins and Hosier, 2005). The “continuum of housed-homeless” offers a useful framework for conceptualizing how individuals can transition back and forth between being housed to homeless in relation to unexpected and negative events in the life course (Watkins and Hosier, 2005; Scott, 2007). However, researchers
to date have failed to connect homelessness from a life course perspective to experiences of health and aging. To contribute to this underexplored area of research, this dissertation also pulls in theories from the health sciences. The argument that life circumstances, environmental factors, and human behaviours can have a cumulative effect on health informs this study (Kawachi et al., 2002). As proposed by researchers like Blane et al. (2007), this dissertation views the body as a mechanism that stores both the benefits and dis-benefits of earlier life.

Existing research in the health sciences also establishes that homelessness and its related lifestyles pose serious risks to physical health and mental wellbeing (Hwang et al., 1997; Hwang, 2000; 2001; Hwang et al., 2001; Kondro, 2007; Turnbull et al., 2007; Wen et al., 2007; Grinman et al., 2007; Frankish et al., 2009). Based on such theories, this dissertation views homelessness as a health damaging process that ultimately results in poorer health than the general population. The health differences found among the homeless are viewed as the outcome of an unfair distribution of key social determinants of health (Braveman and Gruskin, 2003; 2003a; 2003b). Housing, which offers both physical shelter and non-material resources, is one of the greatest determinants of physical and mental wellbeing (Dunn, 2000; Dunn and Hayes, 2000). Generally speaking, most of what is known about health and homelessness has emerged from studies using objective or clinical measures. In this study, a different approach is taken and self-reported measures are used to explore how an absence of housing in earlier life might affect experiences of health and aging later on (The advantages and limitations of using self-reported measures of health are explored in Chapter Four).

The concept of “healthy aging” is useful for melding together theories from both health and social science disciplines. As reviewed earlier, the concept of “healthy aging” encompasses both physical health and social factors like quality of life, satisfaction with life, mental and social
well-being, independence, self-care, finances, coping behaviours, access to support networks, and social participation (Rowe and Kahn, 1997; Bartlett and Peel, 2005; Bowling and Dieppe, 2005). The research presented in this dissertation contributes to the healthy aging literature in four major ways. First, it explores the role that stable housing can play in helping older people with histories of homelessness to move forward on a continuum of healthy aging. Second, this study identifies the material and non-material factors related to stable housing that formerly homeless older people identify as having contributed to better health. Third, this study identifies the ongoing barriers that can continue to limit formerly homeless older people’s opportunities for healthy aging. And finally, this study explores how older people subjectively view the relationship between their past homelessness, current health, and their future expectations for aging. Most research to date has examined people who are presently in a state of homelessness, or who were housed very recently. One of the greatest contributions of this study is that it includes formerly homeless people who have been housed several years and even decades. Indeed some participants became homeless for the first time in older adulthood, but a large share had been housed for a significant period of time. This research offers a conceptual forecast for the types of challenges that seniors with low incomes and unstable housing histories will face to aging healthily and successfully.

Overall, this dissertation contributes to a better understanding of the long-term effects of homelessness on experiences of health and aging. This research not only addresses the physical health outcomes, but also explores how being homeless in earlier life can alter the social and economic context in which people age. This study conceptualizes how formerly homeless older people’s opportunities for healthy, positive aging can be improved with stable housing. And finally, this study advances the literature on healthy aging by exploring how experiences with
homelessness can affect people’s expectations for health and aging in later life. The next chapter reviews contemporary housing affordability problems and rates of homelessness in the case study site of Toronto, Canada before outlining the methodological approaches in Chapter Four.
CHAPTER THREE
Reviewing Contemporary Housing Affordability Problems and Homelessness in Toronto, Canada

Introduction

This chapter reviews contemporary housing affordability problems and homelessness among the older population in the study site of Toronto, Ontario. The research presented in this chapter was collected from a review of publications and reports by the City of Toronto, the Canada Mortgage and Housing Corporation (CMHC), and various non-profit and community-based organizations. The first part of the chapter establishes the prevalence of households with low incomes, housing affordability problems, and current rates of homelessness in Toronto, particularly among the older population. The second part of the chapter offers a brief history of important policies and key events that have concerned Toronto’s homeless population in recent years. The overall purpose of this chapter is to offer contextual information about the increasing rates of financial problems and housing insecurity in Toronto’s older population.

The Demand for Affordable Housing Options in Toronto

The City of Toronto is the largest urban area in Canada and is home to 2,503,291 people, comprising eight percent of the country’s total population (The City of Toronto, 2012). Toronto is among the fastest growing cities in Canada and increased in population by nearly 112,000 new residents (4.5%) between 2006 and 2011 (The City of Toronto, 2012). The city is a major destination for international immigrants as well as a desirable site of relocation for thousands of domestic migrants each year. It is anticipated that Toronto’s growing population will result in 100,000 new renter households over the next decade, further increasing the competition for
quality, affordable housing (The City of Toronto, 2006). At the same time, the population of Toronto is aging alongside the rest of Canada and the developed world. Population aging is expected to create an additional demand for housing that is affordable, as well as appropriate for the older population. There are currently 338,000 seniors living in Toronto comprising 14 percent of the city’s total population (The City of Toronto, 2012b). The two fastest growing age groups are the 55 to 59 years olds and the 80 to 84 years olds (The City of Toronto, 2012b). By 2031, it is expected that 20 percent of Toronto’s population will be 65 years of age or older (The City of Toronto, 2010; 2012b).

Research suggests that most seniors in Toronto reside in family households, but one in four persons over the age of 65 years lives alone (The City of Toronto, 2012b). At the present time, the life expectancy for Toronto residents is 79 years (The City of Toronto, 2012b). Further information about the health of the older population in Toronto and Canada are presented in Chapter Five. While seniors as a whole have experienced a growth in income since the post-war era, a significant proportion contends with financial and housing affordability problems (The City of Toronto, 2012b). For example, in 2011 there were 604,408 residents in Toronto earning a low income\(^5\) and 12 percent were in senior age groups (The City of Toronto, 2011). Housing affordability is one of the greatest challenges facing senior-led households, especially those who rent their housing. A report by the City of Toronto (2012b) suggests that 32 percent of seniors are in core housing need, meaning their housing is below standards in terms of affordability, quality, or suitability\(^6\).

\(^5\) Low income cutoff point (LICO) is a common measure used by Statistics Canada to determine the incidence of poverty. LICOs vary depending on household size and are adjusted annually in relation to the consumer price index. A household spending 70 percent or more of their income on shelter, food, and clothing are considered low income (Statistics Canada, 2005).

\(^6\) A household is considered to be in “core housing need” if its housing falls below at least one of the adequacy, affordability, or suitability standards and it would have to spend 30 percent or more of its total before-tax income to
As reviewed in the previous chapter, the majority of seniors in Canada reside in one of three common housing scenarios: alone in their own homes, in family members’ homes, or in a residential care or retirement facility. For seniors who are no longer healthy enough to live independently, the cost of a residential facility is far too expensive to afford with a low income. The Canadian Mortgage and Housing Corporation (CMHC) (2012a) reports the average monthly cost of a standard space\(^7\) in a seniors’ private retirement home is over $3,000. The common alternative is for seniors to remain living in their own housing or to downsize to a smaller space, such as a rented apartment. However, the average cost of a one-bedroom apartment in Toronto is also too expensive for many seniors to afford without the help of a housing subsidy. In 2012, the average cost of a market-priced, one-bedroom apartment was approximately $1,000, an increase from $977 in 2011 (CMHC, 2012b). It is currently estimated that an annual household income of $38,000 is needed to afford a one-bedroom apartment in Toronto without living in housing affordability stress (The City of Toronto, 2011a). For people who receive government social assistance or disability support benefits as their main source of income, current rates are insufficient to afford the cost of housing along with other basic needs. In 2011, the maximum financial benefit from Ontario Works\(^8\) for a single person was $592 a month, or $1,053 from the pay the median rent of alternative local housing that is acceptable. Adequate housing does not require any major repairs, according to tenants. Affordable dwellings cost less than 30 percent of total before-tax household income. Suitable housing has enough bedrooms for the size and composition of the household (Canadian Mortgage and Housing Corporation, 2012).

\(^7\) A “space” in a retirement facility refers to a residential area that is rented out. Examples of spaces include: one half of a semi-private unit, a private or bachelor unit, a one-bedroom unit and a two-bedroom unit. A “standard space” is a space where the resident does not receive high-level care (i.e., the resident receives less than 1.5 hours of care per day.) or is not required to pay an extra amount to receive high-level care (CMHC, 2012; p.30).

\(^8\) Ontario Works is a government-funded social assistance program in Ontario, which provides financial assistance and job seeking assistance. In 2012, Ontario Works payments include an amount for basic needs, maximum shelter allowance, and if a recipient has dependent children maximum Ontario Child Benefit (OCB) (Ontario Ministry of Community and Social Services, 2012).
Ontario Disability Support Program\(^9\) and this included subsidies for housing (Income Security Advocacy Centre, 2011).

Given these findings, it is not surprising the waiting list for social housing\(^10\) in Toronto has grown rapidly since the early 2000s (ONPHA, 2011). According to the City of Toronto (2011a), there are 93,198 social housing units and 70,379 rent-geared-income-units (RGIs) in the city. However, in 2011 there were 66,460 households actively on the waiting list for social housing and seniors accounted for nearly 30 percent of applicants (ONPHA, 2011). The average estimated wait-time for seniors to receive a social housing unit in Toronto is 61 months (ONPHA, 2011). As a consequence, many seniors are put at-risk of homelessness while they await the availability of affordable housing, and those in the process of exiting homelessness face a lengthy wait. To afford the cost of housing, many older people have no choice but to reduce their spending on other important determinants of health like food, heat and hydro, and medications. The increasing use of food banks by older people provides further evidence of affordability problems among the older population. In 1995, five percent of food bank users in Toronto were found to be 60 years of age or older (Daily Bread Food Bank, 2012). In 2010, 12 percent of food bank users were reportedly over the age of 65 years (The City of Toronto 2012b).

\(^9\) The Ontario Disability Support Program (ODSP) is a government-funded social assistance program in Ontario that helps people with disabilities who are in financial need pay for living expenses like food and housing. (The Ontario Ministry of Community and Social Services, 2012a).

\(^10\) Social housing can also be provided by a rental supplement program, commonly referred to as rent-geared-to-income (RGIs). A rental supplement is typically given to households living in buildings that are owned and operated by private landlords (The City of Toronto, 2012d). A housing allowance program also offers subsidies to households who are in need of financial assistance for a short period of time (The City of Toronto, 2012d). To receive social housing or a subsidy, households must have an active application on Housing Connection’s centralized waiting list (The City of Toronto, 2012d).
Current Rates of Homelessness in Toronto

The homeless population in Toronto has grown continuously over the past 30 years. In 1990, research found that approximately 1,900 people were using emergency shelters on any given night (Hwang, 2000a). By 1998, the number of users had increased to nearly 3,800 (Hwang, 200a). In 2009, counts conducted by the City of Toronto (2011) found that as many as 5,086 people were sleeping in emergency shelters each night. Other reports by the City of Toronto (2011a) suggest that 25,000 different people access shelters each year. At the present time, there are 57 emergency shelter facilities in Toronto with an average number of 3,800 beds used each night and an additional 168 beds on nights when an extreme cold warning alert is in effect (The City of Toronto, 2011). It is estimated that approximately 400 homeless people regularly sleep outdoors, but there are significant challenges to counting people who do not use shelters and this estimate is thought to be quite low (McDonald et al., 2006; The City of Toronto, 2011). Overall, little information exists about the prevalence of homelessness among the older population in Toronto, but it is estimated that about 13 percent of shelter users are seniors (Hwang, 2000a; Regional Geriatric Program of Toronto, 2013). It currently remains unknown how many older homeless people sleep outdoors, in makeshift accommodations, or stay with family members and friends.

A Brief History of Policies and Key Events Related to Homelessness in Toronto

The Anne Golden Report 1999

In 1999, the mayor of Toronto, Mel Lastman, formed a task force in response to unprecedented levels of homelessness in the city. The Mayor’s Homelessness Action Task Force published a 294-page reported titled *Taking Responsibility for Homelessness: An Action Plan for*
Toronto. The report became informally known as the Anne Golden Report (1999), named after the task force’s chair Dr. Anne Golden. The report was released in the aftermath of welfare state reforms in Ontario carried out by the Conservative Party’s Common Sense Revolution. As discussed in Chapter Two, Ontario underwent a process of social welfare reform throughout the 1990s, mainly in the way of program elimination, cutbacks, and restricted eligibility, that left many individuals and social groups at-risk of homelessness.

The Anne Golden Report (1999) was instrumental in identifying six major barriers that prevented homelessness from being reduced in the context of the late 1990s and early 2000s. First, the task force argued that Canada’s federal, provincial, and municipal governments were in a perpetual state of disagreement about which tier should be responsible for addressing homelessness. Second, the Anne Golden Report (1999) linked the increasing incidence of individual and family poverty to rising levels of homelessness. Third, the task force associated higher levels of homelessness with the disappearance of funding and support for social housing from upper-tiers of government since the late 1980s, as discussed in Chapter Two. Fourth, the structure of the social services system in the 1990s was more focused on emergency responses than long-term strategies for change. Fifth, the task force blamed the growing rates of homelessness on the inadequate amount of funding and support in the community for people with mental illness and addictions, much like the deinstitutionalization movements that were discussed in the previous chapter. And sixth, the Anne Golden Report (1999) argued social service agencies were limited in their capacity to coordinate and fund services to meet the needs of an increasingly socially and ethnically diverse homeless population.

Upon its release, the Anne Golden Report (1999) was criticized by its opponents for proposing strategies that were expensive and difficult to implement. The Report was commended
by its supporters, however, for documenting Toronto’s growing homeless problem and encouraging all three tiers of the Canadian government to take responsibility. The Anne Golden Report (1999) has provided an important foundation for contemporary research on homelessness in Toronto, and Canada more broadly. The report was among the first to acknowledge the broadening composition Canada’s homeless population, and how this reflected growing levels of poverty and social inequality at a structural level. Perhaps most importantly, the Anne Golden Report (1999) informs the contemporary view that homelessness is not simply the outcome of personal problems, but systemic barriers like poverty, discrimination, domestic abuse, and a lack of affordable housing options are also major contributing factors.

**Toronto’s Tent City 1998-2002**

In 1998, a group of homeless people built a settlement of makeshift shacks and temporary housing on a vacant property along Toronto’s waterfront (Gallant et al., 2004). At its beginning, the population of Tent City was approximately 17 people, but by 2002 it had grown to 125 (McTeague, 2002). In response to the growth of the settlement, the Toronto Disaster Relief Committee supplied residents with small numbers of portable homes, toilets, heaters, water, wood stoves, and several other social services agencies provided food and health care on occasion (Gallant et al., 2004). To complicate matters, the former industrial site upon which Tent City was built was owned by the Home Depot Corporation and known to be a contaminated brownfield (McTeague, 2002). Tent City became a heavily contested issue among land owners, local officials, law enforcement, advocacy groups, concerned citizens, health officials, researchers, and the media. Some groups accused the City of Toronto of ignoring the settlement because it solved the problem of visible homelessness by removing “undesirables” from the central business district and neighbourhoods that were undergoing renewal. The Toronto
Community Housing Corporation (TCHC) and many other local organizations argued for the demolition of Tent City in the interest of those living in the appalling, contaminated conditions. Other concerned citizens and health officials believed Tent City should be dismantled because it posed a public health concern, especially as it became a refuge for drug users when cocaine surged in popularity in the early 2000s. Groups with more radical views argued the residents of Tent City were not “homeless” and instead they had created a community that offered shelter and acceptance not found in other neighbourhoods (Gallant et al., 2002; McTeague, 2002).

In 2002, Tent City residents were officially evicted and removed from the property by Home Depot representatives (Gallant et al., 2004). The site was bulldozed and several community-based agencies provided the displaced residents with emergency shelter (Gallant et al., 2004). The Emergency Homelessness Pilot Project (EHPP) offered former residents housing, income, and personal supports to end their homeless situations (Gallant et al., 2004). While many former residents of Tent City accepted housing from the EHPP and TCHC, others continued to remain living outdoors or in emergency shelters (Gallant et al., 2003). Tent City has been used in academic research to exemplify how the poorest and most disenfranchised members of a community can be outcast from their own city. The process of building and dismantling Tent City forms an important part of Toronto’s’ “homeless history” and the formerly homeless population is comprised of some individuals who were re-housed by the EHPP and TCHC.

The Three Cities Within Toronto Report 2007

A report published by housing researcher David J. Hulchanski and colleagues, The Three Cities Within Toronto: Income Polarization Among Toronto’s Neighbourhoods (2010), has relevance to this dissertation. Although every city has an uneven distribution of wealth and poverty, the Hulchanski et al. (2010) report argued that spatial changes have occurred at a
relatively rapid rate in Toronto since the 1970s, leading to a “city of disparities”. Based on mapping the spatial distribution of income, Hulchanski et al. (2010) found some neighbourhoods have gone through minimal transformation in physical, social, and economic structure while others have changed dramatically between 1970 and 2007. For geographers and housing researchers, this report has been influential in understanding where Toronto’s lowest income households reside (see map in Appendix B). Hulchanski et al. (2010) found the neighbourhoods with the highest incomes are located in the central city along the Yonge-University and Bloor subway lines and in the gentrified areas south of Bloor Street and Danforth Avenue, as well as parts of the waterfront (p.6; see map in Appendix B). Based Hulchanski et al.’s (2010) report, the average before-tax income of individuals in these areas was $88,400 and $172,900 for households, which is much higher than Toronto’s average individual and household income of $40,400 and $80,300, respectively (p.22). These high-income areas of the city comprise 19 percent of all Toronto neighbourhoods and contain 17 percent of the total population (Hulchanski et al., 2010; p.8). Middle-income areas were found to account for 39 percent of all neighbourhoods and contain 38 percent of Toronto’s population (p.10). Spatially, these neighbourhoods tend to surround the high income areas but are located farther away from the subway lines and central city. The average before-tax income of individuals in these neighbourhoods was reportedly $35,700 for individuals and $71,500 for households (Hulchanski et al., 2010; p.22).

In contrast, the areas with Toronto’s lowest income neighbourhoods are concentrated in the northeast and northwest parts of the city (Hulchanski et al., 2010; p. 10). The average before-tax income of individuals in these neighbourhoods was $26,900 and $59,200 for households (p. 22). These areas account for 40 percent of all neighbourhoods in the city and contain 43 percent
of Toronto’s total population (p. 10). The research by Hulchanski et al. (2010) also found the proportion of immigrant households has also increased in these areas since the 1970s and the lowest income neighbourhoods presently contain a disproportionate share of immigrants and racialized minorities.

Overall, the report by Hulchanski et al. (2010) illustrates that Toronto’s lowest income neighbourhoods are no longer found in the central city as they were in the post-war era. The greatest concentration of low income households are now located in the inner suburbs and outlying areas. These neighbourhoods typically have poorer access to public transportation and other services that are located in the central city. The Three Cities Within Toronto: Income Polarization Among Toronto’s Neighbourhoods report is relevant to the research in this dissertation for several reasons. First, the survey results to be presented in Chapter Five show the majority of formerly homeless older adults who participated in the dissertation reported an annual income of $20,000 or less (see Table 5.1). Therefore, considering their income status, it is likely that older people with histories of homelessness will reside in the lowest income areas of the city identified by Hulchanski et al. (2010). Second, most of the participants in the dissertation have experienced homelessness at least once in the era of 1970 to 2005. The findings in the report by Hulchanski et al. (2010) offer valuable, contextual information about the spatial changes that occurred in Toronto with regards to income distribution and housing locality during this same time period. In later chapters, findings from the interviews show some of the formerly homeless participants made reference to how their access to affordable housing and other services are complicated by these changing spatial trends.
The Streets to Homes Project, 2005-Present

*Streets to Homes* project is a Toronto-based initiative that is intended to help homeless people find and remain stably housed. In response to the rising levels of homelessness in the early-2000s, *Streets to Homes* was developed to offer intensive case management for homeless people to transition from living on the street to stable housing (The City of Toronto, 2010). Using a housing first approach, *Streets to Homes* has assisted homeless people from a wide range of backgrounds to become re-housed, such as those with mental illness, addictions, physical disabilities, Aboriginal people, immigrants and refugees, victims of abuse and violence, low income families with children, youth in child welfare care, and seniors (The City of Toronto, 2010). Between 2005 and 2011, *Streets to Homes* has been responsible for successfully re-housing 3,000 homeless people and 90 percent have remained stably housed (The City of Toronto, 2010; 2011b).

The Chez Soi/At Home Project, 2009-Present

In 2009, the Mental Health Commission of Canada (MHCC) began the *Chez Soi/At Home* project. The underlying purpose was to compare a ‘housing first approach’ with the traditional continuum of care model, as reviewed in Chapter Two. The goal of *Chez Soi/At Home* is to determine the best approaches for combining housing and social supports to help homeless people cope with mental illness (MHCC, 2012a). Approximately 2,000 homeless people have participated in this project across Canada (MHCC, 2012a). To compare the two housing approaches, a sample of 1,030 homeless people with mental illness were housed in group homes and apartments and offered social services onsite. Another 980 homeless people were given housing and asked to access social services “as usual” in the community (MHCC, 2012a).
The project is presently underway in Toronto, Montreal, Moncton, Winnipeg, and Vancouver, with a unique homeless subpopulation targeted in each city (MHCC, 2012a). For example, urban Aboriginal people are the focus in Winnipeg and people with substance abuse issues are the focus in Vancouver. In Toronto, people from various ethno cultural backgrounds are the primary focus as 30 to 40 percent of the homeless population are from racialized minority groups (MHCC, 2012a). The intention of the Chez Soi/At Home project is to evaluate an anti-oppression service model by integrating mental, physical, social, economic, cultural, spiritual, and linguistic supports for recent immigrants and others who experience barriers to housing (MHCC, 2012a). A total of 240 homeless people in Toronto received housing with onsite social supports (MHCC, 2012a). Another 270 homeless people were provided housing and must access social services in the community (MHCC, 2012a). While the majority of participants are aged 25 to 55 years, one in 10 is over the age of 55 years in the Toronto study site (MHCC, 2012a).

Although the Chez Soi/At Home project will not reach completion until 2013, preliminary findings suggest that the housing first approach is most effective (Atherton and Nicholls, 2008; MHCC, 2012a). In the Toronto sample, 90 percent of participants in the housing first group were still living in housing one year later (Atherton and Nicholls, 2008). This group was also found to have fewer psychiatric and emergency admissions to hospitals, fewer criminal arrests, and reduced drug use (Atherton and Nicholls, 2008). However, housing first is a more expensive model to implement than the traditional continuum of care approach (Atherton and Nicholls, 2008).
The Redevelopment of Regent Park 2005-2020

Regent Park in inner-city Toronto was one of Canada’s first large-scale, publicly funded housing projects\(^{11}\) (CMHC, 2011). The first phase, Regent Park North was built in 1947 and Regent Park South was later constructed in 1954 (CMHC, 2011). Approximately 7,500 people with low incomes were housed in more than 2,000 units of walk-up apartments and row houses (CMHC, 2011). Over the five decades that followed, Regent Park became one of the most marginalized and immigrant-concentrated neighbourhoods in the city (CMHC, 2011). The average household income of Regent Park residents was nearly 50 percent less than the rest of Toronto with 68 percent of households earning below Canada’s low income cut off point (CMHC, 2011).

Beginning in 2005, the TCHC began a six-phase redevelopment plan for Regent Park that will take 15 years to complete. The housing project will expand by 5,000 units of mixed income housing, including RGIs, market rentals, and privately owned condominiums (CMHC, 2011). The redevelopment plan has generally been viewed by researchers, policy makers, and advocates as a positive improvement for Toronto’s inner-city, but concerns have been raised about the displacement of original residents during the 15-year revitalization process. Regent Park has been a major focus of discussions around social housing and poverty in Toronto and has garnered national attention. Regent Park continues to be an important site and topic of academic research on public housing and overcoming the stigma associated with living in a social housing complex (Dunn, 2012).

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\(^{11}\) Regent Park is owned and managed by the Toronto Community Housing Corporation (TCHC).
The Housing Opportunities Toronto Action Plan 2010-2020

In 2009, the City of Toronto Council adopted the Housing Opportunities Toronto Action Plan 2010-2020 (HOT). HOT was based on the outcome of public consultations with nearly 2,000 key informants and community agencies in Toronto (The City of Toronto, 2012c). The Action Plan is intended to direct investment and decision-making about housing in Toronto over the next decade. Jointly formed between the public and private housing sectors and the provincial and federal governments of Canada, HOT proposes several recommendations to improve housing in Toronto (The City of Toronto, 2012c). In summary these recommendations include: (1) creating housing opportunities in all neighbourhoods; (2) helping homeless and vulnerable people to find housing and remain housed; (3) assisting individuals and families to afford the increasing cost of rent; (4) preserving and repairing existing rental properties; (5) revitalizing selected neighbourhoods; (6) creating new affordable rental homes and; (7) assisting people in affording to become homeowners (The City of Toronto, 2012c).

Among its various recommendations, seniors are identified as one of the fastest growing groups in Toronto with specific housing needs (The City of Toronto, 2010). HOT recommends that seniors’ housing needs be addressed through the development of innovative housing models that allow for, and promote aging-in-place. Particularly related to this dissertation, HOT includes a component to address the unique, complex needs of older people with histories of homelessness and other vulnerable groups of seniors. HOT recognizes that formerly homeless seniors have unique needs that require specialized supports as they age, especially for those with chronic alcohol or drug dependencies (The City of Toronto, 2010). The action plan suggests that interim housing be provided to homeless people, especially seniors, as they await the availability of permanent subsidized housing (The City of Toronto, 2010). To date, the City of Toronto
appears to have made modest progress in implementing \textit{HOT}. For example, the City of Toronto (2011d) reported that so far investments have been made to repair and revitalize some of its existing social housing stock. The number of outreach workers has also been increased in the downtown core to reduce outdoor homelessness (The City of Toronto, 2011d). The effectiveness of the Action Plan at improving housing opportunities for Toronto’s most vulnerable groups of seniors remains presently unknown.

\textbf{Chapter Discussion}

The research presented in this chapter has provided contextual information about current rates of housing affordability problems and homelessness in Toronto, with a particular focus on the older population. This chapter also provided a brief history of policies and key events that have shaped Toronto’s “homeless landscape” in recent years. Although Toronto is a destination for thousands of young newcomers each year, the city’s population continues to age alongside the rest of Canada. Based on a review of local literature and reports, the City of Toronto and other stakeholders appear committed to addressing the housing needs and concerns of seniors as the population ages. Older people with low incomes and histories of homelessness though have traditionally been overlooked in public policy on aging and housing in Canada, but the \textit{Housing Opportunities Toronto Action Plan 2010-2020} is a positive step forward.

Although the participants in this study are stably housed, formerly homeless older people remain among the lowest income earners in Toronto. Results in Chapter Five show the majority of participants in this study earned $20,000 or less annually and most received government social assistance or disability support benefits as their main source of income (see Table 5.1). Although marginal increases have been made to social assistance benefits in Ontario since the mid-2000s, current rates are still inadequate for most recipients to compete fairly in Toronto’s private rental
market. The outcome of the growing demand for affordable housing has been a lengthy waiting list for subsidized and social housing units. While they await affordable housing, many seniors and other low income households are increasingly at-risk of homelessness as they struggle to afford market-priced rent in one of Canada’s most expensive housing markets. As a result of their unstable housing histories and limited savings for retirement, formerly homeless older people are particularly affected by the trends outlined above. Overall, this chapter illustrates how trends in urban housing markets and gaps in social welfare policies can complicate formerly homeless older people’s access to affordable housing, and ultimately limit the opportunity for healthy, positive experiences of aging.
CHAPTER FOUR
Research Design and Methodology

Introduction

In Chapter Two, the key theories and concepts that inform this research were introduced and Chapter Three set the context for conducting this study in Toronto, Canada. This chapter outlines the methodological approaches that were used to achieve the objectives of this study. A combination of quantitative and qualitative methods was employed to achieve the following goals of the research: (1) To advance our existing knowledge of the long-term effects of homelessness on experiences of health and aging; (2) To develop a better understanding of the role that stable housing can play in improving formerly homeless older people’s opportunities for healthy, positive aging and; (3) To explore how being homeless in earlier life might affect experiences of health and aging in later life.

This chapter opens with a discussion of the benefits and limitations of using a mixed-methods approach to health research, followed by an outline of operational definitions used in this study. The next section describes the methodological challenges to recruiting formerly homeless older people for participation in research. The three approaches that were employed to recruit the study sample are then explained. The specific methods of data collection are then provided, as well as the frameworks used to analyze the quantitative and qualitative data. The chapter closes with a review of the ethical considerations and limitations that emerged throughout this study.
A Mixed Methods Approach

A combination of quantitative and qualitative methods were employed in this study. A quantitative approach is grounded in positivism and the assumption that “all phenomena can be reduced to empirical indicators that represent truth” (Sale et al., 2002). In contrast, a qualitative paradigm is grounded in interpretivism and constructivism, meaning there are multiple truths that are based on a socially constructed reality (Sale et al., 2002; Onwuegbuzie et al., 2005). One of the fundamental differences is that quantitative researchers typically seek to identify causal relationships within a value-free framework; whereas interpretivists contend that multiple realities are constructed to produce different meanings for different people (Onwuegbuzie et al., 2005; 2006). Another difference is that positivists view the researcher as separate from the object being studied, while interpretivists believe both the researcher and researched will influence the research process (Onwuegbuzie et al., 2005). Due to its subjective nature, the findings in qualitative research are influenced by not only the participants, but also by the lens and values of the researcher (Sale et al., 2002; Onwuegbuzie et al., 2005).

Different methodologies are required to achieve the goals of research within these two paradigms. In quantitative research, sample sizes are intended to be large as to achieve statistically significant findings (Sale et al., 2002). In contrast, sample sizes in qualitative research are not required to be statistically representative, but instead are small and purposive with the intention of exploring a rich, in-depth experience or process (Onwuegbuzie et al., 2005). Quantitative and qualitative methods represent different philosophic approaches to analysis, but mixed methods can be used to complement each other. Quantitative and qualitative approaches, however, are paradigmatically separate in terms of how a researcher interprets the social reality that they enlighten.
The quantitative component of this research involved a structured survey to collect data on the formerly homeless older participants’ histories of homelessness, current housing situations, socioeconomic and demographic characteristics, and health status. The results from the health survey address the first research question: (1) Are older people with histories of homelessness aging in a different socioeconomic and health context than the general population? The qualitative component of this study involved semi-structured interviews with a subsample of survey respondents. The qualitative results from the interview stage of research address the remaining research questions: 2) How do formerly homeless older people perceive their health to have changed since becoming stably re-housed? (3) What aspects of stable housing do they identify as having contributed to better health? (4) What types of barriers continue to limit formerly homeless older people’s opportunities for healthy aging even after they are housed? (5) How do formerly homeless older people perceive their past homelessness to be affecting their current health? (6) How do they envision their past homelessness affecting their health as they continue to age? A conceptual framework in Figure 4.1 displays the mixed-methods approach to research.
**Figure 4.1:** A conceptual framework for using a mixed-methods approach

1. **Formulate a research problem and broad objectives:**
   To contribute a better conceptualization of:
   1. The long-term effects of homelessness on experiences of health and aging;
   2. How stable housing can improve formerly homeless older people’s (FHOP) opportunities for healthy aging;
   3. How being homeless in earlier life might affect experiences of health and aging in later stages of the life course

2. **Develop specific research questions**
   1. Are FHOP aging in a different socioeconomic and health context than the general older population?
   2. What health changes do FHOP experience once they are stably housed?
   3. What aspects of stable housing contribute to better health?
   4. What barriers continue to limit FHOPs’ opportunities for healthy aging even after they are housed?
   5. How do FHOP perceive their past homelessness to be affecting their current health?
   6. How do they envision their past homelessness will affect their health as they continue to age?

3. **Select a research method and data collection**
   - **Positivist quantitative approach**
     Health survey with structured protocols, orally administered questionnaire with a range of predetermined responses
     **Results:** Health data that reflects the current health statuses, prevalence of chronic conditions, and socioeconomic and housing situations of participants
   - **Interpretivist qualitative approach**
     Qualitative interviews with open ended and semi-structured questions
     **Results:** Explores participants’ experiences of health and how they perceive their past homelessness is affecting their current health and expectations for the future.
Operational Definitions

The participants in this study involved formerly homeless people aged 45 years and older. As reviewed in Chapter Two, homeless people have been found to develop health problems at younger ages and to have shorter life spans than the general population (Hwang et al., 2000; McDonald et al., 2006). Similar to other studies on former homelessness, the starting point for “older age” in this study was 45 years to account for accelerated aging. The research criteria required participants to have experienced at least one episode of homelessness, but to be stably housed for six months or longer at the time of the study. The results presented in later chapters show most participants had long, complex histories of transitioning in and out of homelessness and more than 60 percent reported their longest episode of homelessness had lasted for six months or longer (see Table 5.2). A participant was considered “stably housed” if they were living in a supportive housing facility or independently in an apartment, house, or shared accommodations. Many supportive housing facilities in Toronto provide accommodations to formerly homeless people for indefinite periods of time, particularly for those with histories of mental illness, addictions, and chronic homelessness. Participants were also required to have been housed for six months or longer because a “chronic” condition is typically defined as a long-term health problem that is expected to persist for six months or longer. It was important for participants to have been housed for at least six months for the survey to reflect conditions that are chronic, and not short-term health problems resulting from a recent episode of homelessness.
Methodological Challenges to Sampling Formerly Homeless Older People

The invisibility of formerly homeless older people among the general population presents challenges to recruiting participants for research on this topic. Gathering a representative sample is one of the greatest methodological challenges to conducting research on the homeless population. It is probably impossible to determine the size of the formerly homeless older population given there is no agreed upon definition of what constitutes homelessness. The size of the homeless population is also changing all of the time but not in a systematic fashion. It is likely that the formerly homeless comprise a relatively small percentage of Toronto’s total population and the potential size of the sample becomes even smaller when recruiting only individuals aged 45 years and older. Like other vulnerable social groups, the formerly homeless are particularly challenging because they cannot be easily identified or located among the general population. People’s housing histories are not reflected in Canadian census data, so existing census counts are not helpful for locating members of this hard-to-reach population.

Much of the existing literature on methodologies and hard-to-reach populations focuses on how to recruit a randomized, representative sample (Heckathorn, 1997; Heckathorn et al., 2002). The purpose of qualitative research, however, is to recruit a group of participants from the target population who can provide an in-depth account of an experience. That being said, findings from quantitative studies can be useful for qualitative researchers when trying to gain a general sense of the size of the target population. As reviewed in Chapter Three, Toronto’s Streets to Home program reportedly re-housed 3,000 homeless people between 2005 and 2011 (The City of Toronto, 2011b). These counts, though, do not include the number of homeless people who found housing without the help of the Streets to Home program. The counts do not
reflect homeless people who were re-housed prior to 2005, or those who were homeless in another city before moving to Toronto. Even when collecting a non-representative sample for qualitative studies, researchers face challenges recruiting members of a population for which so little information exists.

Issues of privacy and trust also present challenges in recruiting formerly homeless older people for participation in research. Feelings of distrust might cause a homeless person to feel uneasy about disclosing personal details about their life. Formerly homeless people might also decline to participate in a study because they do not want to be reminded of past trauma and negative experiences. Many also have a long history of interacting with people in positions of power, such as social workers, children’s aid workers, police officers, and other law officials, which might contribute to feelings of distrust. Previous studies have also found that some homeless people are involved in illegal activities like the sex or drug trades and such activities might continue even after they are re-housed (Lee et al., 2010). A fear of incrimination might prevent such individuals from consenting to participate in a study (Penrod et al., 2003). An individual’s decision to participate is also influenced by their personal views about the values and merits of research (Penrod et al., 2003). Poor health in combination with social isolation might also prevent the oldest and frailest segment of the formerly homeless population from being involved in activities outside of the home, where they could potentially be recruited for participation in research (Cornwall and Waite, 2009).
Participant Recruitment Techniques

The various challenges to recruitment made it necessary to employ several methods of convenience sampling. A review of the existing literature was conducted to select appropriate qualitative sampling techniques for recruiting members of a hard-to-reach population. When recruiting from a hard-to-reach population, it is common for researchers to rely on convenient methods of sampling (Semaan et al., 2002). Convenience sampling is a form of non-probability sampling that draws on members of the target population who are easily accessible and willing to participate (McFarland and Caceres, 2001). When convenience sampling is employed, a set number of participants are usually recruited to represent a specific demographic or behavioural subgroup (Semaan et al., 2002). A common criticism of convenience sampling is that it excludes the members of a population that are most difficult to reach, and this can lead to the misrepresentation of a phenomenon or experience (McFarland and Caceres, 2001). Researchers have also been skeptical of studies using convenience sampling because they are difficult to replicate and findings are not generalizable to the broader population (Penrod et al., 2003; Semaan et al., 2002). Despite such criticisms, Penrod et al. (2003) argue the invisibility of many vulnerable populations makes it necessary to use a convenient, accessible sampling framework. Useful findings can be produced by these techniques, but researchers must be careful when applying results beyond the study sample (Penrod et al., 2003). As outlined below, three types of convenience, purposive sampling techniques were employed to recruit formerly homeless older adults for this research.
Agency-Based Sampling

Agency-based sampling is one of the most common methods for recruiting members of a hard-to-reach population (Abrams, 2010; Clark, 2010). This method involves making initial contact with staff members from an agency or institution, who can then act as intermediaries or gatekeepers between the researcher and potential participants (Abrams 2010; Clark, 2010). Agency-based sampling offers convenient access to participants and safer meeting spaces for all parties involved (Runnels et al., 2009; Abrams, 2010). Gatekeepers also help to endorse a researcher’s credibility among potential participants (Clark, 2010). Considering the prevalence of mental illness among the homeless population, gatekeepers can also offer advice or insight regarding whether a participant is able to give informed consent (Runnels et al., 2009).

Previous researchers have found that formerly homeless people often continue to access community social services after they are housed (McDonald et al., 2006; Lee et al., 2010). For this reason, agency-based sampling offered a useful method of recruitment. In the initial stages of the recruitment process, a Microsoft Excel database was created of contact information for 130 different agencies in the City of Toronto. The database was constructed using the City of Toronto’s Guide to Services for People Who are Homeless (2010a), as well as websites, community brochures, and later referrals. A wide range of health and social care agencies were contacted and these fall into three main categories. First, agencies were contacted that offer programs specifically for people who are formerly homeless, including social workers, employees at supportive housing facilities, and workers for street-survival follow-up programs. Second, agencies were contacted if they offered programs that formerly homeless people might access, including food and clothing banks, free meal programs, advocacy resources for tenants, and drop-in and health care centres intended for socioeconomically marginalized persons. Third,
agencies were also contacted if they offered programs for seniors with low incomes, including affordable housing complexes, community recreational centres, and meals on wheels programs. The rationale was that seniors who were formerly homeless might be among the users of such programs.

Each of the 130 agencies were sent a letter of information (LOI) to explain the purpose of the study and to request help with recruiting participants. Agencies were also provided with LOIs to pass along to potential participants, which explained the purpose of the study and the role that participants were to play (see Appendix C). A total of 30 gatekeepers responded to the LOIs and actively facilitated interaction with potential participants. The gatekeepers’ professional roles typically included social workers, housing support workers, street health nurses, nurse practitioners, and managers of social service programs. In most cases, gatekeepers who declined to help did so because formerly homeless people were not among their client base. In a few cases, gatekeepers declined to help because they had insufficient levels of staff to assist with recruitment.

The limitations of agency-based sampling are well-noted within the existing literature. A common criticism is that agency-based sampling ignores the outside perspectives of people who are not affiliated with an agency or institution (Clark et al., 2010). Gatekeepers can be a helpful resource, yet they have the authority to deny a researcher access to their clients as participants (Rugkasa and Canvin, 2010). A gatekeeper’s willingness to assist with the recruitment process will vary depending on the time and resources available to offer a researcher (Clark, 2010). Other reasons why gatekeepers might decline include a disruption to service delivery, issues regarding clients’ privacy and confidentiality, and differing views about the research goals and methodology (Clark, 2010). A gatekeeper’s willingness to help also depends on their personal...
attitudes about the importance of research and knowledge translation (Rugkasa and Canvin, 2010). Another limitation is that using gatekeepers might introduce unknown biases into the study. For example, gatekeepers might refer the healthiest and most sociable of their clients, which can result in limited representation of the oldest, frailest and socially isolated segment. In spite of these limitations, agency-based sampling was the most effective method of recruiting formerly homeless older adults in this study. A total of 39 of 50 (78%) survey respondents were recruited using agency-based sampling and 20 of these individuals were also interviewed.

**Advertising with Posters**

Displaying posters at social service agencies and public spaces in Toronto’s lowest income neighbourhoods was also a highly effective method of recruitment. Posters advertised details about the study, participant criteria, and the researcher’s contact information (see Appendix D). Posters were distributed to over 100 social service agencies, either in digital form or hard copies were delivered. Gatekeepers at social service agencies were also asked to circulate information and posters throughout their professional networks. The majority of agencies agreed to display the posters and many also forwarded information about the study onto other interested parties. Posters were also displayed in public spaces such as information boards at libraries, in bus shelters, laundromats, coffee shops, and community message boards within low income areas of the city. This method encouraged formerly homeless people to self-identify as participants and broadened the sampling beyond those recruited from agencies.

A total of 9 of the 50 (18%) survey respondents were recruited by posters and seven of these individuals also took part in an interview. Some limitations to recruiting with posters emerged throughout the fieldwork. For example, it was impossible to monitor each poster that was displayed in a social service agency due to timing constraints. In public spaces, it was
impossible to prevent posters from being removed after a period of time. Also, many formerly homeless people do not have regular access to telephones or online computers, which emerged as a limitation throughout the research process.

**Street-Based Sampling**

Street-based sampling involves asking participants to facilitate interaction between the researcher and other potential participants (Penrod et al., 2003). Existing research has found that homeless people’s social networks are often comprised mainly of other homeless and street-involved people (Lee et al., 2010; Molina, 2000; Smith, 2008). Street-based sampling is built on the rationale that participants are in contact with other members of the target population and are perhaps best suited to assist with recruitment (Heckathorn et al., 2002; Penrod et al., 2003). A common criticism, though, is that members of a particular social circle are likely to share similar views and this can introduce unknown biases into the data set (Heckathorn et al., 2002; Penrod et al., 2003). However, a commonly cited benefit of street-based sampling is that it is designed to reach the most hidden members of a population.

In this study, street-based sampling was less effective at recruiting formerly homeless older people than were agency-based sampling and posters. Each of the 50 participants was asked to notify friends and peers who also fit the research criteria. Unfortunately, only two (4%) participants were recruited using street-based sampling, both of whom also took part in an interview. In order for street-based sampling to work effectively, each participant must be in contact with other members of the target population. Most participants were no longer in contact with friends or acquaintances from while they were homeless. Social networks from the streets had a tendency to dissolve once a person was housed, especially after several years or decades. Also, financial compensation was not offered so there was little incentive for participants to
actively assist with recruitment. The ethical debates around providing financial compensation are discussed in a later section of this chapter.

**Methods of Data Collection and Analysis**

**Creating a Health Profile of the General Older Population**

Prior to conducting the fieldwork, a secondary data analysis was conducted with the objective of creating a health profile of the general population of older Canadians. The purpose was to establish a benchmark for the health of the average older person in Canada and Toronto. Secondary data was retrieved from the Canadian Community Health Survey (CCHS) using the Ontario Data Documentation, Extraction Services, and Infrastructure (ODESI) web tool from Queen’s University. The CCHS provides health data at the national, provincial, and intra-provincial scales. Weighted data were downloaded for all 133 health regions and then only the cases for respondents aged 45 years and older were selected and examined. The age of 45 is typically considered middle-age within the general population, but this age was selected to maintain consistency with the sample of formerly homeless older adults in this study.

The secondary datasets were downloaded into IBM SPSS Statistics 19 for analysis. Variables were selected to analyze self-reported physical and mental health status, chronic conditions, sense of belonging in the local community, rates of cigarette smoking, and alcohol consumption. Once downloaded, frequency distribution tables were produced for each variable in SPSS. In a second step, the method was repeated to analyze the same variables for older adults living within the City of Toronto health region boundary. The purpose of the secondary data

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12 ODESI was obtained through the Maps, Data, and Government Information Centre at Queen’s University.
13 The CCHS targets persons aged 12 years and older who are living in private dwellings in the ten provinces and three territories. Persons living on Indian Reserves or Crown lands, those residing in institutions, full-time members of the Canadian Forces and residents of certain remote regions are excluded from this survey. The CCHS covers approximately 98% of the Canadian population aged 12 and older (Ontario Council of University Libraries, 2009).
analysis was to establish a benchmark that can be used to interpret the health differences found among the sample formerly homeless older people. The findings from the secondary data analysis are presented in Chapter Five alongside the survey results reflecting the health and socioeconomic situations of the formerly homeless older participants.

**The Structured Health Survey**

Prior to the data collection, approval was sought and granted by Queen’s University’s General Research and Ethics Board (see Appendix E). The first stage of primary data collection involved a structured health questionnaire, which was developed based on the CCHS and administered to the sample of 50 formerly homeless older adults (see Appendix F). The first part of the survey collected self-reported health data by asking respondents to rate their current physical and mental health status. They were also asked to rate their sense of belonging in the local community, amount of daily stress, and general satisfaction with life. The second part of the survey asked respondents about their histories of homelessness and current housing situations. The third part of the survey asked respondents to disclose any professionally diagnosed chronic physical conditions and mental illnesses. The last part of the survey collected basic demographic and socioeconomic data on the respondents.

The structured survey was conducted face-to-face with each of the 50 formerly homeless older adults. It was important to conduct each survey orally because literacy levels and knowledge of health-related terms among the participants were unknown. In most cases, the survey was conducted with participants at the social service agency through which they were recruited. If this was not possible, participants were usually met at another mutually agreed upon location, such as a coffee shop or public library. Prior to beginning the interview, the purpose of
the study and terms of informed consent were reviewed with each participant and a consent form was signed (see Appendix G).

Like any methodology, there are limitations to using self-reported health data. Self-rated health is a common measure of health and is used in large-scale surveys like the CCHS. Within the existing literature on methodologies, researchers have examined how accurately self-rated health reflects objectively measured health (Leinonen et al., 2001; Layes et al., 2012). Layes et al. (2012) suggest self-reported health can be conceptualized as consisting of two components: latent health status and reporting behaviour. Martin (2012) defines latent health as the interval between exposure to a disease and the initial appearance of symptoms. Reporting behaviour refers to the factors that influence how a person perceives of, and rates their own health status (Layes et al., 2012). Reporting behaviour is largely influenced by a person’s knowledge of their health, social norms and expectations, and adaptability and acceptability of illness (Layes et al., 2012). Demographic factors such as age, gender, income, education, (un)employment, as well as health behaviours, culture, and place are also found to influence self-reported health (Leinonen et al., 2001; Layes et al., 2012).

Some research finds that older people will evaluate their health using a different frame of reference than that of younger people (Leinonen et al., 2001; Bartlett and Peel, 2004). Benyamini et al. (2002) found older people often cited the following factors as having influenced their perception of health: understanding of global health issues, absence or presence of disease or medical conditions, functional ability, energy, psychological health, and health behaviours. While some older people evaluate their current health in relation to earlier life, others compare their health to peers within their age group (Layes et al., 2012). Research suggests that when objectively measured, older people’s health and functional status declines with age, their
physical strength and cognitive ability decrease and the incidence of chronic disease and
disability increases (Leinonen et al., 2001; Bartlett and Peel, 2004). However, older people’s
self-rated health usually remains relatively stable when measured subjectively, despite the
presence of chronic disease (Leinonen et al., 2001). Leinonen et al. (2001) explain this process as
older people adjusting to decremental changes in their health as they age. Older people’s criteria
and expectations for good health is likely to decrease over time, which results in little change in
the self-evaluation of their health (Leinonen et al., 2001).

It is important to point out, though, that most studies have examined the accuracy of self-
rated health among the general population. Pedersen et al. (2012) measured the associations
between deprived life circumstances, well-being, and self-rated health in a socioeconomically
marginalized population. The Pedersen et al. (2012) research found lower health status ratings
were associated with living situations, depressed moods, symptoms of alcoholism, unemployment, and low levels of education. Their research also found that the accumulation of
disadvantaged life circumstances will influence how a person perceives of their health. Pedersen
et al. (2012) argue that members of socioeconomically marginalized populations often
experience more than one disadvantaged life circumstance at a time. The greater number of
disadvantaged circumstances that a person is exposed to, the poorer they will rate their health—even when controlling for age and the presence illness (Pedersen et al., 2012).

According to the existing literature, another common limitation of using self-reported
measures of health is that a person might feel pressured to justify their responses to a researcher
(Benyamini et al., 2002). This might cause them to cite the most noticeable factors, or provide
explanations for their health that are reasonable but not necessarily accurate (Benyamini et al.,
2002). Despite these conceptual challenges, many researchers share the consensus that
subjective, self-rated health closely reflects objectively measured health status (Dean and Wilson, 2010).

**Analyzing the Survey Data**

To analyze the survey data, a database of responses was created using IBM SPSS Statistics 19. Frequency distribution tables were produced to analyze health status, prevalence of chronic conditions, socioeconomic status, and other characteristics of the survey sample. As mentioned earlier, the survey results were used to address the first research question: Are older people with histories of homelessness aging in a different socioeconomic and health context than Canada’s general older population? To answer this question, the health status ratings and prevalence of chronic conditions reported in the sample of formerly homeless older adults were compared to the general population of older Canadians as represented in the CCHS. The findings offer insight into how a formerly homeless older person’s health and socioeconomic situation might differ from the average older person.

In Chapter Five, the health status ratings are compared between the survey respondents who were aged 45 to 55 years and those aged 56 years and older. The purpose was to examine whether the younger cohort of the sample was more likely to report positive health status than the oldest cohort. The health status ratings of participants are also compared in Chapter Five based on the length of time they had been re-housed. The purpose was to explore whether respondents who had been re-housed for longer periods of time were more likely to report better health statuses than those recently housed. A limitation, though, is that this study does not use a longitudinal approach to examine changes in health among formerly homeless people as they age. Unfortunately, a longitudinal approach was not possible due to funding and time constraints, as well as methodological and ethical issues. The transient nature of the homeless population
creates insurmountable obstacles to achieving a longitudinal study. It is also unethical to assume that researchers have the right to track and monitor people simply because they are homeless. The alternative of a longitudinal approach was to ask participants to self-rate their health at the time of the study. Then, a cohort analysis was conducted to compare health status among participants housed for various lengths of time. The results from the survey and cohort analysis are presented in Chapter Five.

The Qualitative Interview

A total of 29 of 50 survey respondents took part in the qualitative interview stage of the research. The interviews were designed to last approximately 30 to 45 minutes and were digitally recorded with permission from the participant. Field notes and written observations were also recorded in a research journal during the fieldwork. As mentioned at the outset of this chapter, the qualitative data collected from the interviews were used to answer research questions two to six (see Table 2.1). Prior to beginning the interview, the purpose of the study was again reviewed with each participant and they were asked to sign a second consent form (see Appendix H). The qualitative interview was comprised of four main parts and the complete guide can be reviewed in Appendix I.

The first part of the interview collected details about the participants’ past experiences with homelessness, including the underlying causes, the geographical setting, and their method of becoming re-housed. The second part explored how the formerly homeless older adults experienced their health prior to becoming homeless and during episodes of homelessness. The purpose was not to make causal statements about the connection between an individual’s health prior to homelessness and their current health status. Rather, the purpose was to establish a general benchmark for how the participants experienced their health prior to becoming homeless.
Official health records could not be obtained due to ethical and methodological barriers, so the alternative was to ask participants to qualitatively describe their health history. A limitation of this approach is that some participants might have had latent or undiagnosed health conditions, but this remains a shortcoming of studies that use self-reported measures (Leinonen et al., 2001; Dean and Wilson, 2010; Layes et al., 2012) or retrospective views of health (Shibusawa and Padgett, 2008).

The interview then shifted to examine the health changes that the formerly homeless older adults have experienced since becoming stably re-housed. Each participant was explicitly asked if their health was better, the same, or worse today in relation to when they were homeless. They were then asked to self-identify the specific factors, or aspects of stable housing that had contributed to better health, as well as any ongoing barriers to health improvement. It is important to note that the purpose was not to make generalizations about health, housing, and homelessness, but rather to offer insight into formerly homeless older people’s experiences of health change and the factors that contributed. Participants were also asked questions about their health behaviours, such as cigarette smoking, alcohol consumption, and drug use, which are often associated with the homeless experience. The last part of the interview explored how participants perceived the relationship between their current health and past homelessness, and their future expectations regarding their opportunities for healthy aging.

A limitation of a retrospective approach is a person might evaluate their past health in the context of current beliefs and this can misrepresent the actual occurrence. In a study on former homelessness and mental illness, Shibusawa and Padgett (2008) found older adults engaged in self-reflection and re-evaluated their lives as they approached their elderly years. Shibusawa and Padgett (2008) also found participants gave consistent and credible accounts of both good and
bad experiences of life. In this study, there were some concerns about the participants’ ability to evaluate their health and other experiences in retrospect. Histories of mental illness, addiction, and trauma are common among the homeless population and these factors might affect a person’s ability to accurately recall past events.

To address this limitation, excluding people with a history of mental illness or addiction was considered, but this was not a practical or ethical solution for a number of reasons. First, it should not be assumed that everyone with a history of mental illness or addiction has memory problems or cognitive impairment. Second, excluding those with a mental illness or addiction would not represent the experiences of the broader homeless population accurately. Third, this research was not conducted by a mental health care practitioner; and therefore professional diagnoses about mental illness and cognitive function could not be made. Fourth, excluding people with a mental illness was viewed as condescending and unethical. Since the deinstitutionalization movements of the 1960s and 1970s, the mental health field has shifted towards viewing and promoting people with a mental illness as capable and autonomous. Excluding the perspectives of formerly homeless older people with a mental illness or addiction contradicts such contemporary rights-based movements. Also, as discussed in Chapter Two, many researchers claim that physical health cannot be studied independently from mental health and well-being (Prince et al., 2007).

The following protocols were designed to address the limitations outlined above. First, a participant was not invited into the interview stage of research if they could not clearly answer the survey questions about their current health. If a participant could not evaluate their current health, they would likely have trouble discussing their health in retrospect during the interview. Second, a participant was not interviewed if they exhibited any signs of emotional distress or
agitation while completing the survey. The interview was intended to explore details about the participants’ lives in greater detail, which might cause further distress. As a precaution, participants were notified of their right to terminate the interview at any time. A list of counseling and crisis intervention services was given to each participant (see Appendix J). Overall, only two survey respondents were not invited into the interview stage because they did not meet the criteria. In most cases, survey respondents who did not participate in an interview declined for their own reasons, or were unable to be reached to schedule an interview for a later date.

Analyzing the Qualitative Data

To analyze the qualitative data, the interviews were transcribed in a Microsoft Word document. Each transcription record was reviewed multiple times. Both content analysis and a grounded theory approach were used to analyze the qualitative data. Content analysis was used to identify reoccurring patterns and themes in the interview data. Content analysis focuses on the contextual meaning of verbal communication or text that is derived from interviews (Hsieh and Shannon, 2005). A grounded theory framework was also used to allow empirical findings, themes, and theoretical ideas to emerge from the data throughout the research process (Singleton and Straits, 2005; Strauss and Corbin, 2008). As displayed in Table 4.1, previous researchers Pope et al. (2000) outlined five stages of qualitative analysis that include: becoming familiar with the data, identifying a thematic framework, coding, charting, and interpreting. To code, the transcription records were carefully reviewed and a list of reoccurring themes and topics were made. The responses, themes, and supporting quotes was then organized into a Microsoft Excel spreadsheet. The Excel spreadsheet made it easy to compare and identify commonalities between
participant’s responses, as well as to identify unique and emerging themes. In the end, three overarching categories were created and several subcategories of themes were identified. Table 4.2 below clearly outlines how these themes address the specific research questions and meet the broader theoretical goals of this study. The results from the qualitative analysis are presented in Chapters Six and Seven. Whenever possible, the quotes are presented verbatim; however, minor edits were done to shorten some quotes and to remove colloquialisms or jargon (“uh, “like”, “eh”) for the purpose of clarity.

Table 4.1: Pope et al.’s (2000) five stages of qualitative data analysis

<table>
<thead>
<tr>
<th>Five stages of qualitative data analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Familiarization:</td>
</tr>
<tr>
<td>Immersion in the raw data by listening to tapes, reading transcripts, studying notes, etc. to produce a list of key ideas and recurrent themes.</td>
</tr>
<tr>
<td>Identifying a thematic framework:</td>
</tr>
<tr>
<td>Identifying all the key issues, concepts, and themes by which the data can be examined and referenced. Completed by drawing on a priori of issues and questions derived from the objectives of the study. Issues raised by the participants and views or experiences that recur in the data are also used. A detailed index of the data is the end product.</td>
</tr>
<tr>
<td>Indexing (commonly referred to as 'coding')</td>
</tr>
<tr>
<td>Applying the thematic framework or index systematically to all the data in textual form by annotating the transcripts with numerical codes from the index (these may be supported by short descriptions to elaborate the index headings).</td>
</tr>
<tr>
<td>Charting</td>
</tr>
<tr>
<td>Involves forming charts by rearranging the data according to the thematic framework to which they relate.</td>
</tr>
<tr>
<td>Mapping and interpretation</td>
</tr>
<tr>
<td>Charts are used to define concepts, map the range or nature of social phenomena, create typologies and identify associations between themes. Purpose is to provide explanations of the findings. This stage is influenced by the original objectives of research and by the themes that emerged from the data.</td>
</tr>
</tbody>
</table>
Table 4.2: Categories used to code the qualitative interview data.

<table>
<thead>
<tr>
<th>Overarching category</th>
<th>Subcategories of themes</th>
<th>The research question it addresses:</th>
<th>How it addresses the broader theoretical goals of the study:</th>
</tr>
</thead>
</table>
| Experiences of homelessness throughout the life course    | • Self-identified reasons for homelessness  
• Details about past homelessness  
• Geographical setting of homelessness  
• Steps taken to become re-housed | (1) Are older people with histories of homelessness aging in a different socioeconomic and health context than general older population in Canada? | Offers a better understanding of homelessness from a life course perspective.                                                   |
| Experiences of Health Change Since Becoming Re-housed     | • Experience, or perception of health prior to homelessness  
• Notable changes in health during episodes of homelessness  
• Experience of health change since becoming housed (better, the same, worse)  
• Factors, or determinants of health improvement  
• Reasons for no health improvement, or a further decline | (2) What health changes do FHOP experience once they are stably housed? Did experiences vary depending on the length of time re-housed?  
(3) What factors, or aspects of stable housing are identified as contributing to better health? What ongoing barriers do FHOP face to healthy, successful aging? | Purpose is to develop a better theoretical understanding of:  
(1) The long-term effects of homelessness on experiences of health and aging;  
(2) How stable housing improves formerly homeless older people’s (FHOP) opportunities for healthy aging and;  
(3) The ways in which being homeless in earlier life might affect experiences of health and aging in later life. |
| Perspectives on the Relationship Between Past Homelessness and Health and Aging in Later Life | • Perceived relationship between current health and past experiences with homelessness  
• Expectations for health in older age  
• Views on growing older  
• Responses that challenge normative ideals and expectations about aging and home. | (4) How do FHOP think their current health is affected by their past homelessness?  
(5) How will their past experiences with homelessness affect their health as they continue to age?  
(6) How do experience with homelessness in earlier life create barriers to healthy and successful aging? | |
**Limitations and Ethical Considerations**

The main limitations of this study were reviewed throughout this chapter, but a few additional ones must be noted. First, each participant had been homeless at some point within the last 30 to 40 years. It is recognized that specific policy trends will have shaped individual experiences differently at different points in time. However, it was impossible to situate and analyze each individual’s experience within the specific political, social, and economic trends that were occurring while they were homeless. Instead, participants were viewed as having experienced homelessness within the broader context and changing trends of the past four decades, as outlined in Chapters Two and Three.

Second, this study was not designed to examine the gender differences among formerly homeless older people. Participants were not explicitly asked questions related to gender, but some differences in the experiences of women, men, and transgendered persons are highlighted in the analytical chapters. In the future, further research is needed into the topic of homelessness, health, and aging from a gendered perspective.

Third, it is becoming increasingly common for qualitative health researchers to pay or reward participants for their involvement in a study (Rugkasa and Canvin, 2010). The ethical issues around offering compensation are noted within the existing literature. For example, offering financial compensation is often criticized as being coercive or commodifying a participant’s experiences (Rugkasa and Canvin, 2010). The other side of the argument is that participants should be compensated for their time and efforts (Rugkasa and Canvin, 2010). This argument has especially arisen in the context of studying members of a vulnerable population who have limited financial resources. In this study, participants were not provided financial compensation due to funding constraints of the researcher. The decision not to provide
compensation created barriers to recruiting participants as well as when recruiting gatekeepers. Several gatekeepers at social service agencies declined to assist with recruitment because participants were not offered payment. Some gatekeepers viewed this as an ethical issue, but most believed it would be too difficult to recruit formerly homeless older people without offering a financial incentive. The homeless population is a commonly researched population, especially in inner city Toronto. Many potential participants indicated they supplemented their incomes by participating in university and community-based studies throughout the year. Once they were informed that compensation was not being offered, many declined to participate and this remains a common limitation in research on socioeconomically marginalized populations.

Chapter Discussion

The purpose of this chapter has been to outline the methodological approaches that were employed to achieve the research goals. The chapter opened with a review of the advantages and limitations of using a combination of quantitative and qualitative techniques, and why a mixed methods approach was appropriate in this study. Important operational definitions were then outlined and the practical challenges that arise when studying vulnerable, hard-to-reach populations were discussed, followed by an outline of the sampling approaches. The remaining sections explained the methods of quantitative and qualitative data collection. The protocols for administering the structured survey and semi-structured interviews were then described, followed by the framework for analyzing the quantitative and qualitative data (see Table 4.2). demonstrated how the results addressed the broader goals of research. The ethical issues that emerged during this study were discussed throughout this chapter and some additional limitations were addressed in the final section. The remainder of this dissertation presents the empirical findings that emerged from this study.
CHAPTER FIVE
Introducing the Study Sample of Formerly Homeless Older People

Introduction

The literature reviewed in Chapter Two illustrated little research has been conducted on older people with histories of homelessness in the context of healthy aging. Within the small body of literature that does exist, the greatest share of attention has been given to people who are presently in a state of homelessness (Cohen et al., 1997; Crane and Warnes, 2007; 2010). For this reason, limited information exists on the demographic characteristics, socioeconomic situations, and health status of older Canadians who were once homeless but stably housed in later life (see McDonald et al., 2006; 2009 for an exception). The quantitative evidence presented in this chapter is derived from the survey results with the purpose of addressing the first research question: Are older people with histories of homelessness aging in a different socioeconomic and health context than the general older population in Canada?

The chapter begins with the demographic, socioeconomic, and housing history background of the sample of formerly homeless older adults, followed by a health profile. The survey respondents’ self-reported health statuses are then compared based on their age and the length of time re-housed. As reviewed in Chapter Two, a study by McDonald et al. (2006) is the only recent research to be conducted on formerly homeless older people’s health and well-being in Toronto, and Canada more broadly. The characteristics and health status of the participants in the McDonald et al. (2006) study are compared to the sample collected for this research. Overall, this chapter provides evidence that people with histories of homelessness are aging in the context of poorer health, low incomes, a reliance on government social assistance, minimal family support networks, and limited housing opportunities.
Demographic Characteristics and Housing Histories of the Survey Sample

One component of the structured survey collected basic demographic and socioeconomic data on the formerly homeless older adults who participated in this study. The sample (N=50) was comprised of 68 percent males, 30 percent females, and two percent transgendered persons (see Table 5.1). The majority of the formerly homeless older adults were between the ages of 45 and 60 years (88%) and no respondents were over the age of 80 years. In terms of ethnocultural background, 80 percent of respondents self-identified as white, 4 percent as Chinese, 4 percent as black, and 4 percent as Aboriginal. The greatest share of survey respondents reported their marital status as single (54%) or separated or divorced (36%). Four percent were widowed, four percent were married, and two percent were in a same-sex partnership (see Table 5.1).

Three quarters of the formerly homeless older adults had some form of post-secondary training (see Table 5.1). Thirty-two percent had earned a trade certificate, 27 percent a college diploma or certificate, and 17 percent had a bachelor’s degree or higher. A quarter of the respondents reported no post-secondary education or training. The survey results revealed the majority of the formerly homeless older adults were living on a very low income. Forty-five percent reported an annual household income of $10,000 or less and 31 percent earned $20,000 or less. No female respondents earned more than $30,000 annually but six percent of males earned $50,000 to $80,000. A cross-comparison of income to marital status showed all respondents with an annual household income of $60,000-$79,000 were married or in a partnership, which likely accounts for a larger household income. Sixty percent of the formerly homeless older adults were receiving their main source of income from government social assistance programs. Approximately half received benefits from the Ontario Disability Support Program (ODSP) and 12 percent received benefits from Ontario Works (OW). Sixteen percent
received their income from the Canada Pension Plan (CPP) and only eight percent were employed full-time and six percent were employed part-time (see Table 5.1).

A second component of the structured survey asked respondents about their history of homelessness and length of time re-housed. Overall, the sample of formerly homeless older adults has been stably housed for a time period ranging from the minimum six months to nearly 30 years (see Figure 5.1 and Table 5.2). The greatest share (63%) of respondents had been re-housed for a time period of less than five years. Twelve percent had been re-housed for five to less than eight years, 10 percent for eight to less than 12 years, five percent for 12 to 15 years, and eleven percent had been living in stable housing for 15 to less than 30 years. At the time of the study, 49 percent of the formerly homeless older adults were living in rented apartments, with 43 percent living alone and six percent with family members (see Table 5.2). Thirty-seven percent were living in a supportive housing facility and six percent were living in rented, shared accommodations with a roommate(s).

With regards to their histories of homelessness, 40 percent of the respondents had been homeless once and 14 percent had been twice (see Figure 5.2). Many respondents had been homeless several times throughout their life. Twenty-eight percent reported 3 to 5 episodes of homelessness, five percent reported 6 to 8 episodes, and two percent had been homeless 12 to 15 times. Nine percent of the survey respondents indicated they had been homeless intermittently during their life, but could not provide a total number of episodes. A gendered comparison of the number of homeless episodes is displayed in Figure 5.3.
Table 5.1: Demographic Characteristics of the Survey Sample % (n=50)

<table>
<thead>
<tr>
<th>Gender</th>
<th>Male</th>
<th>68 (34)</th>
<th>Aboriginal</th>
<th>4 (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>30 (15)</td>
<td>Not specified</td>
<td>8 (4)</td>
</tr>
<tr>
<td></td>
<td>Transgendered</td>
<td>2 (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>45-50</td>
<td>32 (16)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>51-55</td>
<td>26 (13)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>56-60</td>
<td>30 (15)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>61-65</td>
<td>4 (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>66-70</td>
<td>6 (3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>71-75</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>76-80</td>
<td>2 (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td>Single</td>
<td>54 (27)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Separated/divorced</td>
<td>36 (18)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Married/common-law partnership</td>
<td>4 (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Widow(er)</td>
<td>4 (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Same-sex partnership</td>
<td>2 (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth country</td>
<td>Canada</td>
<td>70 (35)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>France</td>
<td>2 (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Germany</td>
<td>2 (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hong Kong</td>
<td>2 (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Italy</td>
<td>2 (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>United Kingdom</td>
<td>4 (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Grenada</td>
<td>4 (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other, but did not specify</td>
<td>14 (7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural or racial background</td>
<td>White</td>
<td>80 (40)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Black</td>
<td>4 (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>South Asian</td>
<td>4 (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highest level of education completed</td>
<td>No post-secondary education</td>
<td>24 (10)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Trade certificate or diploma</td>
<td>32 (13)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-university certificate or diploma</td>
<td>27 (11)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Some university at the bachelor’s level</td>
<td>7 (3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>University degree above a bachelor’s level</td>
<td>10 (4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Source of annual household income</td>
<td>Ontario Disability Support Program (ODSP)</td>
<td>48 (24)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Canadian Pension Plan (CPP)</td>
<td>16 (8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ontario Works (OW)</td>
<td>12 (6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Paid part-time employment</td>
<td>8 (4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Paid full-time employment</td>
<td>6 (3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Employment insurance (EI)</td>
<td>2 (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Long-term disability benefits (other than ODSP)</td>
<td>2 (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other, but did not specify</td>
<td>2 (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Did not know</td>
<td>2 (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual household income level</td>
<td>&lt; $10,000</td>
<td>45 (22)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$10,000 &lt; $20,000</td>
<td>31 (15)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$20,000 &lt; $30,000</td>
<td>6 (3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$30,000 &lt; $40,000</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$40,000 &lt; $50,000</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$50,000 &lt; $60,000</td>
<td>2 (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$60,000 &lt; $80,000</td>
<td>2 (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Did not know</td>
<td>14 (7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Missing cases</td>
<td>(1)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The survey respondents were also asked to identify the age when they had experienced their first episode of homelessness (see Figure 5.4). Approximately a quarter of the sample had become homeless for the first time between the ages of 12 and 18 years. Fifteen percent reported their first episode of homelessness had occurred in young adulthood between the ages of 19 and 29 years. Thirty-two percent had experienced their first episode of homelessness during their working-age years, between the ages of 30 and 44. Another 32 percent became homeless for the first time after the age of 44 years.

A few limitations emerged when trying to capture the participants’ experiences with homelessness in the form of a structured survey. Several respondents were unable to calculate the total duration of their homelessness due to prolonged episodes, or a long complex history of unstable housing. For example, some respondents had experienced one episode of homelessness but it had lasted for several consecutive years. Others were homeless on multiple occasions but each episode had lasted for only a week or two. The majority of respondents, however, could recall their longest period of homelessness (see Figure 5.5). One quarter of the sample reported their longest episode of homelessness had lasted between two weeks to less than six months. Forty percent reported their longest episode had lasted between six months to less than two years. Twenty percent reported their longest episode of homelessness had lasted between five years to 10 years.
Figure 5.1: Length of time stably re-housed among the sample of formerly homeless older people, self-reported, (%)

Figure 5.2: Number of homeless episodes among the sample of formerly homeless older people, self-reported, (%)

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**Figure 5.3:** A gender comparison of the number of homeless episodes among the sample of formerly homeless older people, self-reported, (%)

**Figure 5.4:** Age of first episode of homelessness among the sample of formerly homeless older people, self-reported, (%)
**Figure 5.5:** Longest episode of homelessness among the sample of formerly homeless older people, self-reported, (%)
Table 5.2: Summary Table of Characteristics of Past Homelessness and Current Housing Situation % (n=50)

<table>
<thead>
<tr>
<th>Type of current housing</th>
<th>Longest episode of homelessness</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2 weeks &lt; 1 month</td>
</tr>
<tr>
<td></td>
<td>1 month &lt; 3 months</td>
</tr>
<tr>
<td></td>
<td>3 months &lt; 6 months</td>
</tr>
<tr>
<td></td>
<td>6 months &lt; 1 year</td>
</tr>
<tr>
<td></td>
<td>1 year &lt; 2 years</td>
</tr>
<tr>
<td></td>
<td>2 years &lt; 5 years</td>
</tr>
<tr>
<td></td>
<td>5 years &lt; 8 years</td>
</tr>
<tr>
<td></td>
<td>8 years &lt; 10 years</td>
</tr>
<tr>
<td></td>
<td>10 years &lt; 15 years</td>
</tr>
<tr>
<td></td>
<td>15 years &lt; 20 years</td>
</tr>
<tr>
<td></td>
<td>20 years &lt; 30 years</td>
</tr>
<tr>
<td>Apartment (living alone)</td>
<td>2 (1)</td>
</tr>
<tr>
<td>Supportive housing facility</td>
<td>15 (6)</td>
</tr>
<tr>
<td>Apartment (living with family members)</td>
<td>5 (2)</td>
</tr>
<tr>
<td>Shared accommodations with roommates</td>
<td>20 (8)</td>
</tr>
<tr>
<td>Owns a home</td>
<td>1 (1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Length of time re-housed</th>
<th>Age when first became homeless</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 months &lt; 1 year</td>
<td>Under 12 years</td>
</tr>
<tr>
<td>1 year &lt; 2 years</td>
<td>13-18</td>
</tr>
<tr>
<td>2 years &lt; 3 years</td>
<td>19-24</td>
</tr>
<tr>
<td>3 years &lt; 5 years</td>
<td>25-29</td>
</tr>
<tr>
<td>5 years &lt; 8 years</td>
<td>30-34</td>
</tr>
<tr>
<td>8 years &lt; 10 years</td>
<td>2 (1)</td>
</tr>
<tr>
<td>10 years &lt; 12 years</td>
<td>20 (8)</td>
</tr>
<tr>
<td>12 years &lt; 15 years</td>
<td>10 (4)</td>
</tr>
<tr>
<td>15 years &lt; 20 years</td>
<td>2 (1)</td>
</tr>
<tr>
<td>20 years &lt; 30 years</td>
<td>5 (2)</td>
</tr>
<tr>
<td></td>
<td>5 (2)</td>
</tr>
<tr>
<td>Total number of homeless episodes</td>
<td>10 (4)</td>
</tr>
<tr>
<td>1</td>
<td>40 (17)</td>
</tr>
<tr>
<td>2</td>
<td>14 (6)</td>
</tr>
<tr>
<td>3-5</td>
<td>21 (6)</td>
</tr>
<tr>
<td>6-8</td>
<td>5 (2)</td>
</tr>
<tr>
<td>9-11</td>
<td>0</td>
</tr>
<tr>
<td>12-15</td>
<td>2 (1)</td>
</tr>
<tr>
<td>Reported several episodes/could not recall total</td>
<td>19 (8)</td>
</tr>
</tbody>
</table>

*Missing cases*
Physical Health Status Ratings

The survey results reveal the sample of formerly homeless older adults reported poorer physical health than found among Canada’s general older population, as represented in the CCHS. Among the formerly homeless survey respondents, 16 percent rated their physical health as “poor” and 40 percent as “fair”. Thirty percent rated their health as “good” and only 14 percent reported their health as “very good” or “excellent” (see Figure 5.6). As explained in Chapter Four, an analysis of secondary health data from the CCHS was used to create a health profile of the general older population in Toronto and Canada more broadly. As displayed in Figure 5.7, a much greater percentage of Toronto’s population aged 45 years and older rated their physical health as “good”, “very good”, or “excellent” compared to the sample of formerly homeless older people.

A review of the existing literature in Chapter Two showed previous studies have found certain health conditions to be more prevalent among the homeless than the general, housed population (Hwang, 2001; Frankish et al., 2009). These conditions most commonly include diabetes, tuberculosis, respiratory infections, COPD, arthritis, musculoskeletal disorders, HIV/AIDS, hepatitis, chronic skin sores, and dental problems (Hwang, 2001; Frankish et al., 2009). Based on the survey results, the same types of health conditions were also prevalent among the formerly homeless older adults in this study. As displayed in Table 5.3, the most common chronic health conditions in this sample included: vision problems (67%), dental problems (57%), back problems (47%), arthritis (31%), asthma (31%), hearing problems (31%), chronic skin sores (29%), hepatitis (27%), migraines (29%), chronic foot sores (25%), and bowel disorders (22%) (see Figure 5.9 and Table 5.3). It is also important to note that hepatitis (29%), particularly hepatitis C, was common among the survey respondents, which is acknowledged in
the existing literature as a growing health concern among Canada’s homeless and street-involved populations (Patrick et al., 2000; Fischer et al., 2006). To contextualize the rates of chronic illness among the formerly homeless older adults, the health conditions that are most prevalent among the general older population in Toronto and Canada are displayed in Figure 5.10.

![Physical health status ratings among the sample of formerly homeless older adults, self-reported (%)](image)

**Figure 5.6:** Physical health status ratings among the sample of formerly homeless older adults, self-reported (%)
Figure 5.7: Physical health status ratings of the general older population in Toronto and Canada, (%)

Figure 5.8: A gender comparison of physical health status ratings among the sample of formerly homeless older adults, self-reported (%)
Figure 5.9: Chronic health conditions reported among the sample of formerly homeless older people, self-reported (%)

Figure 5.10: The prevalence of chronic health conditions among the general population, aged 45 year and older in Toronto and Canada (%). (Data source: CCHS, 2010)
Table 5.3: The prevalence of physical health conditions among the formerly homeless older adults, self-reported.

<table>
<thead>
<tr>
<th>Chronic condition</th>
<th>Percent of valid cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision problems</td>
<td>67 (31) Chronic bronchitis 20 (10)</td>
</tr>
<tr>
<td>Dental problems</td>
<td>57 (27) Chronic fatigue syndrome 17 (8)</td>
</tr>
<tr>
<td>Back problems</td>
<td>47 (23) Obesity 17 (8)</td>
</tr>
<tr>
<td>Arthritis</td>
<td>38 (19) Diabetes 16 (8)</td>
</tr>
<tr>
<td>Hearing</td>
<td>31 (14) Intestinal or stomach ulcers 14 (7)</td>
</tr>
<tr>
<td>Asthma</td>
<td>30 (15) Chronic obstructive pulmonary disease 13 (6)</td>
</tr>
<tr>
<td>Hepatitis</td>
<td>29 (14) Cataracts 12 (6)</td>
</tr>
<tr>
<td>HEPATITIS A</td>
<td>27 (4) Emphysema 12 (6)</td>
</tr>
<tr>
<td>HEPATITIS B</td>
<td>7 (1) Had a stroke 12 (6)</td>
</tr>
<tr>
<td>HEPATITIS C</td>
<td>60 (9) Cancer 10 (5)</td>
</tr>
<tr>
<td>Migraines</td>
<td>29 (14) Fibromyalgia 10 (5)</td>
</tr>
<tr>
<td>Chronic foot sores</td>
<td>25 (12) Glaucoma 8 (4)</td>
</tr>
<tr>
<td>Bowel disorder</td>
<td>22 (11) Thyroid condition 4 (2)</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>22 (11) HIV/AIDS 2 (1)</td>
</tr>
<tr>
<td>Heart disease</td>
<td>21 (10)</td>
</tr>
</tbody>
</table>

Mental Health Status Ratings

Similar to physical health, the sample of formerly homeless older adults reported poorer mental health than the general population of people aged 45 years and older in Toronto (see Figures 5.11 and 5.12). Among the formerly homeless older adults, six percent reported “poor” mental health, 31 percent reported “fair”, and another 31 percent rated their mental health as “good”. Eighteen percent rated their mental health as “very good” and 14 reported “excellent” mental health. At the time of the study, 66 percent of the participants were diagnosed with a mental health condition by a professional. The interview stage of research offered further insight into the timing of participants’ diagnoses in relation to becoming homeless. A wide range of mental health conditions was reported, and a concurrent set of disorders was common (see Table 5.4). There is a general assumption that schizophrenia is very common among the homeless
population, but only 12 percent of respondents with a mental illness reported schizophrenia (see Table 5.4). When possible, gatekeepers were consulted to understand the severity of symptoms in participants with schizophrenia and if the individual was able to give informed consent. Anyone with more than mild symptoms of schizophrenia was unlikely to participate, and therefore the results regarding those with the mental illness should be treated with caution.

Figure 5.11: Mental health status ratings among the sample of formerly homeless older people, self-reported (%)
Figure 5.12: Mental health status ratings among the general population, aged 45 years and older in Toronto and Canada, (%). (Data source: CCHS, 2010)

Figure 5.13: A gender comparison of mental health status ratings among the sample of formerly homeless older people, self-reported (%)

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Table 5.4: Mental health conditions reported among the sample of formerly homeless older people, self-reported (%).

<table>
<thead>
<tr>
<th>Mental health condition (n=33)</th>
<th>Percent of valid cases (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concurrent mood and general anxiety disorder</td>
<td>33 (11)</td>
</tr>
<tr>
<td>Mood disorder</td>
<td>24 (8)</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>12 (4)</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>12 (4)</td>
</tr>
<tr>
<td>Posttraumatic stress disorder</td>
<td>6 (2)</td>
</tr>
<tr>
<td>Borderline personality disorder</td>
<td>3 (1)</td>
</tr>
<tr>
<td>Obsessive compulsive disorder</td>
<td>3 (1)</td>
</tr>
<tr>
<td>Concurrent depression and anxiety disorder</td>
<td>3 (1)</td>
</tr>
<tr>
<td>Concurrent depression and mood disorder</td>
<td>3 (1)</td>
</tr>
<tr>
<td>Concurrent generalized anxiety disorder and mood disorder</td>
<td>3 (1)</td>
</tr>
<tr>
<td>Did not specify condition</td>
<td>9 (3)</td>
</tr>
</tbody>
</table>

Other Self-Rated Measures of Health

Other common measures of health and wellbeing include satisfaction with life, perceived daily stress, and sense of belonging in the local community. Although they were stably housed, eight percent of respondents were “very dissatisfied” with their life, 25 percent were “dissatisfied”, and another 25 percent were “neither satisfied nor dissatisfied”. Thirty percent were “satisfied” and only 12 percent were “very satisfied” (see Figure 5.14). Fourteen percent of the formerly homeless older adults reported their daily lives as “extremely stressful”, 25 percent “quite stressful”, and 43 percent a “bit stressful”. Only 14 percent said their lives were “not very stressful” and four percent said “not stressful at all” (see Figure 5.14). When asked to rate their sense of belonging in the local community, 33 percent of respondents felt it was “very strong”, 27 percent “strong”, 29 percent “somewhat weak”, and 11 percent “very weak” (see Figure 5.16).
**Figure 5.14:** Satisfaction with life among the sample of formerly homeless older adults, self-reported (%)

**Figure 5.15:** Perceived daily stress among the sample of formerly homeless older adults, self-reported (%)
A Comparison of Health Status Ratings by Age Cohort

Existing research has found accelerated aging to be common among homeless and formerly homeless populations (Hwang, 2000; McDonald et al., 2006). As outlined in Chapter Two, the age of 45 to 50 years is typically used as the starting point for older age in studies on the homeless population (Crane et al., 2005; McDonald et al., 2006). A common critique of this approach is that people in their 40s and 50s are likely to have better health than those in their 70s and 80s. To address this criticism, the health status ratings of two different age groups within the sample of formerly homeless older adults were compared. The first group included the respondents who were aged 45 to 55 years of age ($n=29$). The second age group included the respondents who were aged 56 and older ($n=21$).

The results from this comparison showed little difference in the way the two age groups rated their physical and mental health. Although a smaller percentage of the 45-55 age group
(7%) rated their physical health as “poor” compared to the 566 and older group (29%), the largest percentage in both groups reported “fair” health. As displayed in Figure 5.17, the smallest percentage in both groups rated their physical health as “very good” “or excellent”. Surprisingly, slightly better mental health status was reported among the 56 and older age group than the 45-55 years olds (see Figure 5.17). Overall, the majority of formerly homeless older adults in both age groups rated their physical health as “fair” and their mental health as “fair-good”.

**Figure 5.17**: Physical health status ratings among the sample of formerly homeless older people by age cohort (%)
A Comparison of Health Status Ratings by Length of Time Re-Housed

As previously displayed in Figure 5.1, the formerly homeless older adults had been living in stable housing for a time period ranging from six months to nearly 30 years. The following question emerged throughout the analysis: was better health status reported among the survey respondents who had been living in stable housing for several years or decades compared to those more recently housed? To answer this question, the health status ratings of three subgroups of survey respondents were compared. The first group included the formerly homeless older adults who had been living in stable housing for six months to less than three years \((n=19)\). The second group included those who had been housed for three to less than 10 years \((n=15)\). The third group included those who had been housed for 10 years or longer \((n=9)\).

The poorest physical health status was reported among the formerly homeless older adults who had been living in stable housing for six months to less than three years (see Figure 5.18).
Only slightly better health status was found among the respondents who had been re-housed for three years to less than 10 years. Not surprising, those who had been re-housed for 10 years or longer reported the most positive health status. Similar trends also appeared when examining mental health (see Figure 5.20). Unfortunately, the sampling approach does not allow for causal statements or definitive conclusions to be made. Although the health status of each subgroup was relatively poor, these findings suggest the formerly homeless older adults who had been living in housing for several years reported better health than those housed more recently. A limitation is that other factors were not considered in this analysis, only the length of time that had passed since becoming re-housed. In Chapter Six, qualitative evidence offers further insight into the participants’ experiences of health since moving into stable housing.

**Figure 5.19:** Physical health status ratings among the sample of formerly homeless older people by length of time re-housed, self-reported (%)
Comparing the Sample Characteristics to a Previous Study

As reviewed in Chapter Two, the *In From the Streets Project*, conducted by McDonald et al. (2006) has been the only other study to examine the health and wellbeing of formerly homeless older people in Toronto, and Canada more broadly. Given the limited research on this topic, it is useful to compare the characteristics of the participants in the McDonald et al. (2006) study to the sample collected for this research. A comparison of the sample characteristics in Table 5.5 reveals both sets of formerly homeless older adults reported very similar demographic, socioeconomic, and health backgrounds. For example, the gender composition of both samples was quite similar, which McDonald et al. (2006) found to be representative of the broader homeless population. In both samples, the majority of participants were single or separated/divorced, earned $20,000 or less annually, and most received their income from

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**Figure 5.20**: Mental health status ratings among the sample of formerly homeless older people by length of time re-housed, self-reported, (%)
government social assistance and disability support programs. In terms of their housing histories, a large share of participants in both studies had experienced more than one episode of homelessness (see Table 5.5). As indicated in Chapter Two, the McDonald et al. (2006) study mainly focused on formerly homeless older people who were living in supportive housing environments. In contrast, the research conducted for this dissertation included participants from a wider range of housing situations, including those living independently in their own apartments or houses, as well as those living in supportive housing facilities. Despite the differences in living accommodation, the greatest percentage of the formerly homeless older adults in both studies rated their health as “poor-fair”. As displayed in Table 5.5, similar types and rates of chronic health conditions were also found in both samples. To summarize, the sample in this study and the one collected by McDonald et al. (2006) reported very similar characteristics and health status. This can be explained as both studies examined a similar population in Toronto within the last ten years. McDonald et al.’s (2006) previous work and the findings from this study offer evidence that formerly homeless people are aging in a different, more disadvantaged context than the general older population in Toronto and Canada.

Table 5.5: Comparing the Sample Characteristics to the McDonald et al. (2006) Study (%)

<table>
<thead>
<tr>
<th>Sample characteristics</th>
<th>McDonald et al. (2006) (% of n=201)</th>
<th>This study (2012) (% of n=50)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>62</td>
<td>68</td>
</tr>
<tr>
<td>Female</td>
<td>38</td>
<td>30</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>35</td>
<td>54</td>
</tr>
<tr>
<td>Separated/divorced</td>
<td>42</td>
<td>36</td>
</tr>
<tr>
<td>Married/common-law</td>
<td>20</td>
<td>4</td>
</tr>
<tr>
<td>Widowed</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Cultural or racial background</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aboriginal</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Black</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-----</td>
<td>----</td>
</tr>
<tr>
<td>South Asian</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>White</td>
<td>69</td>
<td>80</td>
</tr>
<tr>
<td>Born in Canada</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>76</td>
<td>70</td>
</tr>
<tr>
<td>No</td>
<td>24</td>
<td>30</td>
</tr>
<tr>
<td>Main source of income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paid employment (full or part-time)</td>
<td>18</td>
<td>14</td>
</tr>
<tr>
<td>ODSP</td>
<td>53</td>
<td>48</td>
</tr>
<tr>
<td>OW</td>
<td>31</td>
<td>12</td>
</tr>
<tr>
<td>Homeless once</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>Homeless more than once</td>
<td>60</td>
<td>60</td>
</tr>
<tr>
<td>Length of time housed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than one year</td>
<td>19</td>
<td>16</td>
</tr>
<tr>
<td>One to three years</td>
<td>30</td>
<td>28</td>
</tr>
<tr>
<td>Five or more years</td>
<td>50</td>
<td>56</td>
</tr>
<tr>
<td>Current housing situation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living independently (e.g., apartment, house)</td>
<td>0</td>
<td>63</td>
</tr>
<tr>
<td>Supportive housing environment/</td>
<td>71</td>
<td>37</td>
</tr>
<tr>
<td>Supported housing with community supports</td>
<td>29</td>
<td>0</td>
</tr>
<tr>
<td>Self-reported health status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fair-poor</td>
<td>50</td>
<td>56</td>
</tr>
<tr>
<td>Very good-excellent</td>
<td>18</td>
<td>14</td>
</tr>
<tr>
<td>Most common health conditions reported</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision problems</td>
<td>63</td>
<td>67</td>
</tr>
<tr>
<td>Dental problems</td>
<td>45</td>
<td>57</td>
</tr>
<tr>
<td>Back problems</td>
<td>44</td>
<td>47</td>
</tr>
</tbody>
</table>

**Chapter Discussion**

The purpose of this chapter has been to introduce the sample of formerly homeless older adults by providing a demographic, socioeconomic, housing, and health background. The largest percentage had been stably housed for six months to less than three years, followed by those who were housed for three years to less than 10 years. The smallest percentage had been living in stable housing for 10 years or longer. Based on the survey results, the participants reported a wide range of experiences with homelessness. While some had become homeless for the first time in their youth or young adulthood, others experienced their first episode in the working age years. Interestingly, a relatively large percentage of the sample became homeless for the first time in older adulthood. The results indicate many participants had moved back and forth along
the housed-homeless continuum for much of their lives. In many cases, a complex housing history presented methodological barriers to calculating the total duration of homelessness. Some participants were homeless once, but for several consecutive years. Others reported multiple episodes of homelessness, but for shorter periods of time.

Returning to the first research question, are older people with histories of homelessness aging in a different socioeconomic and health context than the general population? The survey results, along with the previous findings by McDonald et al. (2006), suggest formerly homeless older people are aging in a context of poorer health. Not only did the formerly homeless older adults rate their physical health worse than the average older Canadian, but they also reported poorer mental health and relatively high rates of mental illness. Even the survey respondents who were in the younger cohort of the sample (45-55) rated their health relatively poor, along with the older segment (55 and older). The participants who were re-housed for more than 10 years experienced more positive health than those housed for less time. The greatest share of respondents, though, still rated their health poorer than the average older person in Toronto and Canada, despite the fact that some had been re-housed for several years or decades.

As discussed in Chapter Four, a person’s self-rating of their health is influenced by age, gender, and culture. There is some existing evidence that health status ratings among older people remain relatively stable as they age, despite a gradual decline in their health (Leinonen et al., 2001). If this holds true among the homeless population, than the participants in this study might actually have poorer health than reflected in the survey results. A study by Pedersen et al. (2012) found people of lower socioeconomic status often rate their health poorer due to depressed moods, alcoholism, unemployment, and low levels of education. In the future,
additional research is needed to identify the specific factors that might influence how older people with histories of homelessness self-rate their health.

Finally, the results in this chapter demonstrate that older people with histories of homelessness are aging in a context of low incomes and a reliance on government social assistance. The majority of the survey respondents in this study, and in the McDonald et al. (2006) research, reported an annual household income $20,000 or less. The greatest share of formerly homeless older adults in both studies received their main source of income from Ontario Works or the Ontario Disability Support Program. As discussed in Chapter Three, an annual household income of $38,000 is needed to afford the cost of a one-bedroom apartment in Toronto (The City of Toronto, 2011a). These findings suggest older people with histories of homelessness face significant socioeconomic barriers to affording quality housing, even with the help of a government subsidy. Qualitative results in Chapter Six offer a further explanation of the types of barriers that limit formerly homeless older people’s opportunities for healthy aging. The findings presented in this chapter demonstrate that formerly homeless people are indeed aging in the context of poorer health, low incomes, minimal family networks, and limited housing options.
CHAPTER SIX
Exploring the Relationship among Homelessness, Stable Housing, and Opportunities for Healthy Aging

Introduction

The research presented throughout this dissertation suggests that formerly homeless older people are at a disadvantage with regards to their opportunities for healthy, positive experiences of aging. Using qualitative evidence from the interviews, this chapter explores how a group of formerly homeless older persons perceive their health to have changed since moving into stable housing. The chapter opens with details about the participants’ past experiences of homelessness, including the common underlying causes, the geographical and socio-environmental setting, and their method of becoming re-housed. Qualitative findings then reveal the majority of participants perceive their health to have improved in relation to when they were homeless. The focus of this chapter discusses the various aspects of stable housing that participants self-identified as contributing to better health. The chapter concludes with a discussion of the ongoing barriers that can limit formerly homeless older people’s opportunities for healthy, successful aging.

Homelessness throughout the Life Course

The interviews revealed the participants’ experiences of homelessness were typical of other homeless people in Canadian urban centres, as reflected in the existing literature (e.g., Lee et al., 2010). In Chapter Five, the survey results offered some insight into the histories of homelessness among the sample, but the qualitative interviews offered an opportunity to explore this in greater detail. Each participant described a unique, individualized pathway into homelessness but there were commonalities in the underlying causes. Most responses indicated
that a combination of personal problems and broader systemic barriers had contributed to becoming homeless. Broadly speaking, the personal problems that were most commonly cited included unemployment, other loss of income, divorce or family breakdown, an addiction to alcohol or drugs, and mental or physical health problems. In the Ontario and Toronto context, the broader structural factors that had complicated access to housing generally included: a constrained economic environment; the high cost of housing; insufficient social assistance rates; waiting-lists for social housing; gaps in the mental health care system; and discrimination in the housing market. Discrimination typically occurred on the basis of being: unemployed, a recipient of social assistance, without positive references from a previous landlord, or having a criminal record. As reviewed extensively in Chapter Two, the existing literature recognizes these types of personal problems and systemic barriers intersect to produce a homeless situation.

The interviews also provide further insight into the nature of homelessness across the participants’ life course. Many individual’s histories of homelessness had begun in youth after leaving the parental home. A few participants had left home to avoid abuse or other family troubles, or were asked to leave due to behavioural misconduct or problems with drugs and alcohol. There is some evidence in the existing literature that one episode of homelessness increases the likelihood that a person will become homeless again in later life (Robertson, 1992; Herman et al., 1997; May, 2000; Martijn and Sharpe, 2006). The findings in this study suggest a similar pattern as every participant who was homeless in youth experienced homelessness again in adulthood. By most accounts, participants explained being homeless in early stages of life had limited their educational and employment opportunities, which led to poverty and repeated homelessness in later life. In some cases, participants became homeless in youth as a result of addictions and mental illness, and this also contributed to additional episodes in later life.
The survey results in Chapter Five showed a significant proportion of the participants experienced their first episode of homelessness in older adulthood (see Figure 5.2). As reviewed in Chapter Two, existing research has found homelessness in older age is usually caused by the same factors as among young people, but some are uniquely attributed to older age (Crane et al., 2005; Crane and Warnes, 2007, 2010). In this study, most individuals who became homeless in older adulthood identified similar reasons as found by previous studies. An underlying cause of homelessness for many participants included: financial problems, often as an outcome of unemployment, an unsteady work history, limited financial savings, and ageism in the job market. However, ageism in the job market emerged less frequently as a theme than in other research on older people and homelessness (McDonald et al., 2006). Most participants in this study indicated they were unable to work due to chronic health problems or disabilities. Some participants also became homeless in later life after divorcing from their spouse. The breakdown in family after decades of partnership contributed to financial problems, mental health problems, and even addiction. In one case, a participant explained that he had begun to overuse alcohol as a way of coping with divorce and this eventually led to job loss and financial troubles. In another, a participant with a mental illness became homeless for the first time in his 40s after his mother passed away and he could not live independently without a full-time caregiver.

Overall, the qualitative findings show evidence that many participants had moved back and forth along a continuum of housed-homeless throughout their earlier life course. The qualitative results also suggest that a combination of negative events and factors not only create homeless situations at one point in time, but also contribute to ongoing economic strain, repeated hardships, and discrimination for later stages of life. These findings are important for considering how homelessness in earlier life can prevent healthy, positive experiences in older age.
Geographical Setting of Past Homelessness

Each participant had experienced homelessness in the case study site of Toronto, Ontario. Six participants had also been homeless in other Canadian cities, including Ottawa, Kingston, Vancouver, Edmonton, and Calgary. The participants reported sleeping in a combination of indoor and outdoor settings throughout the time they were homeless. These settings typically included emergency shelters, hostels, bus shelters, subway stations, tents in city parks, and outdoors in public spaces. It was common for participants to have slept outside in the summertime and in shelters when the weather turned cold and wet. However, many reported sleeping outdoors even when temperatures fell below -10° Celsius in the wintertime, mainly because they viewed shelters as unsafe spaces where theft and violence were common occurrences.

P10: I slept outside. I never slept in shelters. I wouldn’t do it. They’re dirty. Well, it’s not that it’s just, you know, this whole, the bugs issue and too many men, the smells, and I couldn’t deal with it. So, sleeping bag and a park bench outside, even in the winter. (Male, age range 51-55, six episodes of homelessness, housed 4 years).

In Toronto, shelters are typically closed during the daytime and drop-in centers open for only a few hours each day. Homeless people are often evicted from public spaces, restaurants, and coffee shops by owners, law enforcement, and broader public attitudes. In several cases, participants recalled how they used to spend the day outside, panhandling on the street, or walking between social service agencies in search of food or warmth. These qualitative findings offer insight into where the participants dwelled and their daily activities in past episodes of homelessness.
**Method of Becoming Re-Housed**

The interview participants were asked to describe their pathways back into stable housing. Sixteen of the 29 formerly homeless older adults (55%) were re-housed with the help of a social worker. Most participants became a client of a social worker while staying in a shelter, or were approached by an outreach worker on the street. A few participants had been assigned a case worker while admitted to the emergency room for an illness or injury. As explained in Chapter Five, the majority of participants were living in a subsidized apartment or supportive housing facility at the time of the study (see Table 5.2). Throughout the re-housing process, many participants received help from a social worker to apply for government social assistance and disability support benefits. In several cases, social workers had facilitated participants’ interaction with health care professionals and were treated for illnesses and problems that had emerged while homeless. Ten of the 29 participants (35%) had found housing without the help of a social worker. Two participants (7%) were re-housed as part of the *Streets to Home* project (see Chapter Three). One participant (4%) was a former resident of Tent City and was housed by the Toronto Community Housing Corporation after the settlement was demolished in 2002.

**Experiences of Health during Episodes of Homelessness**

Before asking the participants to describe their health since becoming re-housed, it was important to establish a benchmark for their experiences of health before and during homelessness. In the absence of official health records, the alternative method was for each participant to qualitatively describe their health history. Based on their responses, only three of the 29 participants (10%) reported a history of physical health problems prior to experiencing homelessness (see Table 6.1). One participant had a history of cancer prior to becoming homeless in her mid-30s. The second reported poor health due to alcoholism before becoming
homeless in his late-30s. The third reported health problems related to an eating disorder prior to becoming homeless in her late teens. Six of the 29 participants (21%) had been professionally diagnosed with a mental illness at some point in their life course prior to becoming homeless. Two were diagnosed with schizophrenia in their youth. Three were diagnosed with a mental illness in adulthood, one with a mood disorder and two with mental health problems related to addiction.

The participants were then asked to recall if, and how their health had changed throughout the time they were homeless. Although few reported a history of health problems, the majority (22 of 29, 76%) recalled a decline in their health while homeless (see Table 6.1). Among the participants who were homeless more than once, most indicated their health was generally poorer during these times. Later in this chapter, qualitative results reveal the perceived factors that had contributed to a decline in health.

**Experiences of Health Change Since Being Stably Re-Housed**

The participants were then asked whether their health was better, the same, or worse since being re-housed. The greatest share of participants said their health had improved in relation to when they were homeless (see Table 6.1). Among the 29 participants, 21 (72%) reported better physical health and 17 (59%) reported improved mental health. A quote by one interviewee illustrates a commonly shared view: “My health was best before I was homeless, it got the worst while I was homeless, and it’s better now, but still not back to where it used to be”. A small group of participants (3 of 29, 10%) were experiencing the same physical health as when they were homeless. Only one participant (4%) responded this way about their mental health. Another small group said their physical health (3 of 29, 10%) and mental health (4 of 29, 14%)
had actually worsened since being re-housed (see Table 6.1). The factors that had contributed to changes in their health, both good and bad are discussed later in this chapter.

**Experiences of Health Change Based on Length of Time Re-Housed**

As discussed in Chapter Five, the most positive health status was reported among the formerly homeless older adults who were re-housed for 10 years or longer (see Figures 5.19 and 5.20). The interview was another opportunity to explore how experiences of health varied among the participants, depending on the length of time re-housed. Since a longitudinal approach was not possible, the alternative method was to conduct a cohort analysis by comparing the qualitative responses of three subgroups: (1) Those housed for six months to less than three years ($n=13, 45\%$); (2) Those housed for three years to less than 10 years ($n=9, 31\%$); and (3) Those housed for 10 years or longer ($n=7, 24\%$). The purpose was to understand if the participants who were re-housed for several years reported better health than those housed more recently.

Overall, the greatest share of participants in each subgroup were experiencing better health. Among those stably housed for six months to less than three years, 10 of the 13 (77\%) participants said their physical health had improved. Among those re-housed for three years to less than 10 years, six of the nine (67\%) participants reported better health. Among the participants re-housed for 10 years or longer, five of the seven (71\%) reported improved health. Similar trends emerged with regards to experiences of mental health change. Based on these findings, the majority of participants reported better health regardless of how long they had been stably re-housed. Even participants who were among the most recently housed were already experiencing better health. As explained in earlier chapters, the size of the subsamples do not allow for causal statements to be made. This analysis, though, offers some explanation of formerly homeless older people’s experiences of health change over time.
Table 6.1: Interview participants’ experiences of health change related to homelessness and common qualitative responses

<table>
<thead>
<tr>
<th>How would you describe your health prior to experiencing homelessness?</th>
<th>Generally experienced good health:</th>
<th>Reported a history of physical health problems:</th>
<th>Reported a history of mental illness:</th>
</tr>
</thead>
<tbody>
<tr>
<td>P10: Before I was homeless? I’d say my health was good to excellent. You know, I was always in good shape, able to get up and go to work. I never had any issues.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How would you describe your health during the time you were homeless?</th>
<th>Health declined during homelessness:</th>
<th>Both physical and mental health declined:</th>
</tr>
</thead>
<tbody>
<tr>
<td>P13: My health declined. Yeah, it declined a lot.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is your physical health better, the same, or worse since becoming stably housed?</th>
<th>Physical health is better:</th>
<th>Physical health is the same:</th>
<th>Physical health is worse:</th>
</tr>
</thead>
<tbody>
<tr>
<td>P9: My health has improved 100% since I’ve been housed, because as I say, when you’ve got a home, your health is good.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is your mental health better, the same, or worse since becoming stably housed?</th>
<th>Mental health is better:</th>
<th>Mental health is the same:</th>
<th>Mental health is worse:</th>
</tr>
</thead>
<tbody>
<tr>
<td>P19: Not even just my physical health, it’s my mental health too. It’s gotten much better.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

P13: My health was not great. I’ve had quite a few bowel surgeries, and then the cancer. I was 28 years old when I was diagnosed with cancer, so I’ve had bad health since that age.

P14: Yeah, I was sick. I went in and out of the hospital in the early days of my teenage years. In and out of the hospital with schizophrenia.
Identifying Determinants of Health Improvement Related to Stable Housing

As reviewed in Chapter Two, existing research has found that quality, stable housing improves the lives and well-being of people who are homeless (Crane et al., 2007; McDonald et al., 2006; 2009; Atherton and Nicholls, 2008; Kyle et al., 2008; Goering et al., 2011; Frankish et al., 2009; 2011; 2012). Most of this evidence though, has emerged from studies that seek to evaluate the effectiveness of particular models of supportive housing and community supports (McDonald et al., 2006; Atherton and Nicholls, 2008; Goering et al., 2011). To date, formerly homeless older people’s voices are generally absent from the theoretical literature on housing and healthy aging (see Shibusawa and Padgett, 2009; Padgett et al., 2010 for exceptions). Older people who have experienced homelessness and the re-housing process can offer valuable insight into the factors that affect positive changes in health. The qualitative results presented below explain why participants’ health had generally declined during homelessness, and the aspects of stable housing that now contribute to better health. These findings help to understand the role that stable housing can play in improving formerly homeless older people’s opportunities for positive experiences of aging.

Housing provides protection from the physical environment

The majority of participants had slept outdoors throughout the time they were homeless, at least on occasion. Even those who regularly slept in shelters at night were exposed to poor weather outside during the daytime. Most emergency shelters in Toronto open in the evening and close in the early morning. Many participants recalled spending the day outdoors without proper clothing or protection from the physical elements. Several participants blamed their exposure to cold, damp weather as reasons they developed illnesses such as bronchitis, lung infections, and
other respiratory problems while homeless. Injuries related to frostbite and hypothermia were commonly cited as health outcomes of exposure to cold weather. The close proximity to people with illnesses in crowded shelters was also viewed as a pathway for contracting colds and flus. Some participants also recalled contracting serious illnesses while they were homeless such as tuberculosis and pneumonia.

P27: In the morning, you’re kicked out in the middle of a snowstorm and they say ‘here take your clothing and leave! And they’ll open again at 8 o’clock that night. So you grab your sleeping bag and curl up in a bus shelter and try to stay warm. (Male, age range 51-55, one episode of homelessness, housed 2.5 years)

P6: My health was very poor. Um nutrition was basically absent. I was underweight, I was smoking heavily. I probably had COPD for years and it was just never diagnosed. I was very prone to pneumonia. And as a matter of fact, that is why I was taken out of the shelter in the ambulance and it was later determined that I had actually contracted tuberculosis. (Male, age range 45-50, two episodes of homelessness beginning at the age of 35 years, housed 2.5 years).

P21: My physical health? When I was homeless, I got cellulitis twice. You know, ill-fitting shoes, walking all the time, it rains and then you have blisters and all of a sudden your whole leg swelled right up to the hip. I had intravenous antibiotics. (Female, age range 45-50, two episode of homelessness, housed 13 years).

Since moving into stable housing, the majority of participants indicated their health had improved because they were protected from the physical environment. Many said their chronic skin infections had healed, or were in the process of healing. Several participants also said they now experienced fewer colds and flus compared to when they were homeless. This was attributed to being “healthier overall” and not having to sleep and eat in crowded shelters and public spaces, where contagious illnesses were thought to spread easily.

P22: Yeah, oh yeah my health improved, I have to say yes. I had pneumonia about six times when I was homeless. In terms of getting sick and coming down with things and getting infections, I haven’t had any of that since. I haven’t gotten any colds. I haven’t gotten any infections like physically. You know, I haven’t had any kind of thing that if I was working would cause me to take a sick day off work. (Female, age range 51-55, one episode of homelessness in early 50s, housed for 7 months).
P10: I had a lot of colds, flus, and stuff like that. Since I’ve been housed though, very rarely do I get sick. (*Male, age range 51-55, six episodes of homelessness beginning at the age of 13 years, housed 4 years*).

**Housing promotes feelings of safety and security**

Nearly every participant described homelessness as a traumatic, stressful phase of their life. The absence of a safe, secure home was identified as a major source of emotional distress. For most participants, the shame and embarrassment of losing a home and becoming homeless had also contributed to mental anguish. Stress and trauma were most commonly associated with a decline in mental health, but a few participants blamed stress for deterioration in their physical health as well:

P7: I know my health was affected. I have damage to the left side of my heart. I never had any heart problems before. Since I was 40 years old, I was regularly getting checked for diabetes and high blood pressure, because of my obesity. So when I found out that I’d had a heart attack, they did all the tests again and they said my cholesterol levels were all still good, so it was a stress related heart attack. (*Transgendered male to female, age range 45-50, one episode of homelessness at 42 years of age, housed 17 months*).

P24: All of that exposure to the elements and the improper diet and the stress, the actual psychological stress had serious physical ramifications. (*Male, age range 56-60, six episodes of homelessness beginning at 22 years of age, housed 9 months*).

P27: Not knowing where you’re gonna sleep, not knowing if you’re gonna have a bed or a roof over your head. And not knowing what the weather and environment is going to be like causes mental anguish. (*Male, age range 51-55, one episode of homelessness, housed 2.5 years*).

While they were homeless, several participants had been physically injured in violent attacks and robberies. Although shelters offered some protection from the streets, many participants considered shelters to be unsafe spaces where theft and violence commonly occurred. Personal belongings, clothing, money, and prescription medications were often stolen from shelters, drop-in centres, or on the street. The loss of personal items was viewed by some
participants as a factor in poor health because they owned minimal clothing and faced barriers to replacing prescription medications. Also on the topic of victimization, a few individuals said witnessing violence and crime had negatively affected their mental health during episodes of homelessness:

P3: It was a rude awakening. First time [I was homeless], I came from a really strict home. I crawled out my bedroom window and I decided that I was going to have a better life and low and behold I didn’t know what I was getting myself into! And I used to stay in halfway houses or drop in centres, but the drop-in centres back in those days, the people were hitting themselves up with needles and it was stuff that I’d never seen, with people dying around you, people stealing from you. (Female, age range 36-60, six episodes of homelessness beginning at 16 years of age, housed 10 months).

P5: You can physically withstand the hardships, beatings, whatever. But the mental stuff was just excruciating. (Male, age range 66-70, homeless intermittently, housed 20 years).

P6: Everything can be stolen. My medications have been stolen. (Male, age range 45-50, two episodes of homelessness in late-thirties, housed 2.5 years).

Now stably housed, the majority of participants reported feeling a greater sense of personal safety and security. Reduced feelings of stress, anxiety, and shame were among the most commonly cited reasons for better health, especially when discussing the changes that had occurred in their mental health. Most of the formerly homeless older adults reported experiencing less daily stress, mainly because they were no longer concerned about where to sleep or find a daily meal. Housing also offered protection from the threat of violence and crime that was commonly experienced on the streets and in shelters.

P5: Well the level of anxiety comes down for starters. Just the fact that when you’re living on the street or even in the hostel system, there are so many more high risk situations that you face. Whereas when you live in your own home, it’s a safe secure- for the most part- environment. (Male participant, age range 66-70, homeless intermittently between the ages of 17 and 37 years, housed 20 years).

P19: Well I have a roof over my head. I have some stability, emotional stability is there somewhat, compared to being on the street. Instead of constantly have to worry, worry,
where you’re gonna sleep, where you’re gonna eat your next meal. (Male, age range 51-55, three episodes of homelessness beginning at age 41 years, housed 4 years).

P27: I don’t have to worry about sleeping in the cold, in the snow, in the rain. And I don’t have to fight the elements anymore. So I got a place, and I know I’ve got a place where I can go and rest and calm down from all the stress and the anxiety from on the streets, cause you don’t know if someone’s going to pull out a knife and stab you or anything. (Male, age range 51-55, one episode of homelessness, housed 2.5 years).

**Housing allows for healthier sleeping habits**

Many participants recalled their health declining during periods of homelessness due to irregular sleeping habits. The daily struggle to find a safe, warm place to sleep at night contributed to deterioration in both physical and mental health. Participants explained that emergency shelters often reached their full capacity by early evening, especially during cold weather and this resulted in having to sleep outdoors. Even if shelter beds were available, participants said the quality of sleep was often poor due to crowded facilities, a fear of violence, and their worry over possessions being stolen. The mental stress associated with the homeless lifestyle and concerns over financial problems had also negatively affected some participants’ sleeping habits:

P7: I think the loss of control of your environment causes your body to switch to survival mode. I mean, you don’t eat properly, you don’t sleep properly. There is like a disconnect between your mind and your body and it’s very difficult to cope on a daily basis. You don’t know what tomorrow or tonight will be like. (Transgendered, age range 45-50, one episode of homelessness at 42 years of age, housed 17 months).

Since being re-housed, most participants had developed healthier sleeping habits as a result of experiencing a greater sense of personal safety and security. The improved length and quality of sleep was commonly identified by participants as a reason for better health. In a few cases, participants focused on the tangible aspects of housing that had improved their ability to sleep, including a quiet environment and a comfortable bed. In one case, a female participant
explained that she had sustained back injuries during homelessness and sleeping in a “real bed” had alleviated some of her pain. Some participants also reported improved sleeping habits because of reduced feelings of stress and mental anguish. In a few cases though, individuals who were recently re-housed continued to have trouble sleeping, mainly attributed to residual feelings of stress and trauma.

P24: I’ve slept on fire escapes and in gravel driveways. I’ve slept underneath house porches, I’ve slept on a park bench. Everything has been aggravating my back. I find that my back problems now are so much more aggravated than they ever were. And that comes from sleeping on the sidewalk. You know, from having to stay up longer than you would like to because there is no safe place or warm place to go. It’s been much better because I’m sleeping in a bed. A real bed! Instead of on a couch. Up until the bed, I was sleeping on a couch. And that’s terrible on your back too. (Male, age range 56-60, six episodes of homelessness beginning at the age of 22 years, housed 9 months).

P7: Yes, my health has definitely improved. This month has been pretty good. I’ve been sleeping better, able to do more things. I’m still having a hard time. I’m still on medication, so there is still the fatigue. I can think clearer. My thought process is better. (Transgendered, age range 45-50, one episode of homelessness at 42 years of age, housed 17 months).

P13: Oh today, I mean I have bouts of inability to sleep, like I don’t sleep as sound. I don’t get any REM sleep, you know what I mean? I sleep for like two hours and I wake up, and you know little noises wake me up too, you know. You know that deep sleep that gives the real restful feeling. (Male, age range 45-50, three episodes of homelessness beginning at the age of years, housed 13 months).

Stable housing improves nutrition

It is common for homeless people to obtain their daily meals from soup kitchens and free meal programs provided by social service organizations. Many participants recalled planning their daily activities around the timing and location of free meals while they were homeless. They also described the barriers they had faced to accessing a healthy, free meal. For example, participants rarely had money for transportation and this had limited the location and number of agencies to access food. Many recalled being turned away from free meal programs because the
food supplies had run out. Other competing life needs also took precedent over finding a meal, such as securing a bed in an emergency shelter.

P27: The stress over not knowing where your next meal’s gonna be ‘cause you’ve gotta walk and get in line to get a meal. And then maybe you get in the line-up and then they turn you away, ‘we’ve got too many people’, so that means you gotta go sleep in a bus shelter or somewhere. (*Male, age range 51-55, 1 episode of homelessness, housed 2.5 years*)

P5: Like hunger drives you over here for breakfast, and you are going to be hungry again come 5 o’clock so that drives you to the Salvation Army. You know, so your day is all very chopped up. (*Male participant, age range 66-70, homeless intermittently, housed 20 years*).

There was general agreement that meals offered by social service agencies were neither nutritious nor plentiful enough. Participants recalled the extreme hunger they had experienced during episodes of homelessness. To supplement their diets, many had panhandled for money and food, but this further contributed to feelings of shame and embarrassment. Poor nutrition and weight loss was commonly attributed to a decline in health during homelessness.

P9: Well of course it was stressful because you didn’t know when you were going to get your next meal. You had to scrounge for food, you had to beg for money and food. You had to go to drop-ins. You couldn’t cook your own meals because you didn’t have a permanent address. (*Male, age range 56-60, one episode of homelessness at the age of 41 years, housed 16 years*).

P23: Well [homelessness] affects your health in many ways. Like you don’t know where you next meal is coming from and it doesn’t matter if it’s cold out. (*Male, age range 56-60, 3 episodes of homelessness, housed 14 months*).

Since living in stable housing, most participants reported better nutrition and weight gain as reasons for improved health. Those living in apartments had access to their own kitchens, and most residents of supportive housing facilities had a private or shared kitchen and eating area. Having access to their own kitchen provided participants with greater control over the timing of their meals, portion sizes, and the types of foods consumed. Proper nutrition was not only
attributed to better physical health, but participants also indicated their mental health had improved because they were no longer worried about finding food, or dealing with difficult life situations in a constant state of hunger.

P10: I’m pretty much dealing with everything that I’ve had to deal with and now, I’m eating properly and I’m maintaining what I have to maintain. Whereas when I was on the street, you couldn’t eat properly, you know? Like, you can’t go hungry in Toronto, but you can’t eat properly. (Male, age range 51-55, six episodes of homelessness beginning at the age of 13 years, housed 4 years).

P13: My nutrition is better because I have a place and better sleeping conditions, all that provides you know a healthier- and mentally healthier life. I have a better quality of life. (Male, age range 45-50, three episodes of homelessness beginning at 45 years of age, housed for 13 months).

19 I’m eating healthier, right? My physical health in that sense is better. At least I’m eating on a regular basis. (Male, age range 51-55, three episodes of homelessness beginning at age 41 years, housed for 4 years).

P14: Specific conditions, you know improved. Like my nutrition is better, sleeping conditions, all that provides a healthier life. (Female, age range 45-50, one episode of homelessness for ten years, housed for 7 years).

**Better maintenance of personal care**

Homeless people have limited access to washroom, shower, and laundry facilities and this creates barriers to maintaining personal care. Several participants indicated that poor personal hygiene had contributed to feelings of low self-esteem, embarrassment, and social isolation when they were homeless. Participants described how they had relied on emergency shelters and drop-in centres for places to shower and clean their clothing. Others recalled trying to maintain personal cleanliness and care in public washrooms.

Now stably housed, participants were pleased to have their own washrooms where they could maintain personal care on a regular basis and in privacy. The ability to maintain hygiene was viewed as part of an overall healthier lifestyle, as well as important for improving self-
confidence and restoring a sense of dignity. A number of participants with a bowel disorder said having a private washroom had improved their health and daily lives in particular. In one case, a female participant explained that she required the frequent use of a washroom due to a bowel problem, but this was difficult to manage while homeless. Since living in her own housing, coping with the symptoms of a bowel disorder was an easier and more private matter.

P18: Yeah, actually my health is a lot better. Because of my bowel disorder, I have bowel movements like 10 to 20 times a day. I’ve lived in rooms like hotels rooms and stuff on and off for 10 years. And I’ve had to share a bathroom with other tenants. So like now I have an apartment where I have my own bathroom facilities. (Female, age range 51-55, 15 episodes of homelessness beginning in mid-30s, housed one year).

P9: When you’re homeless, your hygiene isn’t very good because unless you used washrooms or you could find shelters to shower and try to clean or do laundry. You didn’t have clean clothes and your clothes would smell. (Male, age range 56-60, one episode of homelessness at the age of 41 years, housed 16 years).

**Improved access to health care**

Existing research reviewed in Chapter Two established that people who are homeless face significant barriers to accessing primary health care (Hwang et al., 1997; Plum, 2000; Turnbull et al., 2007; Wen et al., 2007; Frankish et al., 2009; Khandor et al., 2011). Similar to findings that appear in the existing literature, two of the most commonly cited barriers to health care in this study were a lost or stolen health card and the absence of a family doctor. Previous studies also suggest that most homeless people receive health care services and treatment from walk-in clinics and hospital emergency rooms (Kushel et al., 2001; 2002; Frankish et al., 2005). However, participants said long wait times at walk-in clinics and the ER, coupled with competing life needs had presented significant barriers to health care while they were homeless. Even if they were able to see a doctor, participants explained that it was difficult to receive
follow-up care afterwards. To complicate matters further, they rarely had money and no health insurance to cover the cost of any medications that were prescribed.

P6: When I was homeless, there were things like the Health Bus. The Health Bus would come around, there were outreach workers, you know people who actually cared. There wasn’t much they could do though ‘cause they don’t have a lot to work with. And I mean the Health Bus, they would give you like a pair of socks and some Tylenol, or get you a referral if you have something more serious, an infection of some sort. (*Male, age range 45-50, two episodes of homelessness in late-thirties, housed 2.5 years*).

The majority of participants reported better access to health care services since being re-housed, and this was one of the most commonly cited reasons for improved health. As mentioned in an earlier section, many participants had been treated throughout the re-housing process for unresolved physical and mental health conditions that had emerged during homelessness. In most cases, social workers had facilitated their interaction with doctors and other health care professionals. With other basic necessities like food and shelter fulfilled, participants could now prioritize their health care needs. Several of the formerly homeless older adults were now eligible for health insurance through their government social assistance and disability support benefits. Insurance coverage for prescriptions, dental care, and other personal supports had helped many participants to fulfill unmet health care needs. Stable housing also offered an environment that was more conducive for maintaining health, such as taking prescription medications on a regular basis. Better access to primary health care was not only considered important for healing from the residual effects of homelessness, but also for maintaining health for the future.

P13: Oh yeah, my health improved, mostly because I’m getting half decent medical attention now. Just getting proper medical care, proper treatments for the fibromyalgia, so I can get sleep at night and be halfway alive during the day. (*Male, age range 45-50, three episodes of homelessness beginning at 45 years of age, housed for 13 months*).
P6: Another thing that probably contributes to my better health is the fact that I am med-compliant\textsuperscript{14}. My health is better. (Male, age range 45-50, 2 episodes of homelessness in late-thirties, housed 2.5 years).

P15: Well I take my medication, everything seems to be helping me quite well. (Female, 61-65, 4 episodes of homelessness, housed 4 years)

P14: I’m pretty healthy except that a car ran over my right leg but I got orthopedic shoes. They’re good, and I did that since I’m housed. They take care of my teeth and find me a dentist [in the supportive housing facility]. I go regularly for my teeth cleaning, and I go the regular checks once a year. When I was homeless, I don’t do those things. (Female, age range 45-50, 1 episode of homelessness for 10 consecutive years, housed 7 years).

As discussed in Chapter Two, hepatitis C. is a growing health concern among the homeless and street-involved populations in Canadian cities (Patrick et al., 2000; Fischer et al., 2006; Street Health Report, 2007; Csete et al., 2008). The survey results in Chapter Two showed 29 percent of the formerly homeless older adults in this study reported hepatitis and the greatest percentage had hepatitis C. (see Table 5.4). Three of the interview participants were undergoing antiviral treatment for hepatitis C. at the time of the study. This was cited as a primary reason for improved health among these participants.

P19: [My health] has gotten much better. Like I said I’m going through a hep C program, right now, right? Which so far, I’m testing 0 to 15 on the scale, which means it’s almost non-existent. So, I’m doing an extra two weeks of treatment on me while they await my blood work. (Male, age range 51-55, 3 episodes of homelessness beginning at age 41 years, housed for 4 years).

P22: I always vaguely knew that I had hepatitis. I thought I have hepatitis B. I thought it would develop into liver sclerosis or liver cancer and start killing me right around when I got to be this age. But because of services like the Health Bus, I went in and started getting treatment of things, so now I’ve gone on a hep C. program. (Female, 51-55, 1 episode of homelessness, housed 7 months).

\textsuperscript{14} Participant is referring to taking his prescribed medication consistently and as directed by a health professional.
**Reduced consumption of alcohol and drugs**

The interview participants were also asked questions about their rates of alcohol consumption and illegal drug use in relation to homelessness and being re-housed. The interviews revealed that histories of substance use and addictions were highly individualized and generalizations could not be made about the participants’ experiences. However, the data collected from the interviews offer some evidence of their histories of substance use, and whether it changed after moving into stable housing. Based on the responses to the interview questions (see Appendix I), 16 of the 29 participants (55%) had an addiction to alcohol at some point in their life course. Twenty-two of the 29 participants (72%) reported using illegal drugs at least once, but not everyone had experienced an addiction. Several participants said they had occasionally used drugs in a social setting, mainly in the context of earlier life, but had never developed an addiction. Among the participants who did report a history of addiction, most had transitioned between periods of heavy-to-reduced use at various points in the life course. In most cases, participants’ heaviest periods of substance use had coincided with episodes of homelessness.

P21: It was bad, it was just stress and I was using [drugs], so a lack of sleep. I would go days sometimes without sleep it was a high stress lifestyle. In terms of sleep and substance abuse, it was pretty bad. *(Female, age range 45-50, two episodes of homelessness beginning at the age of 16 years, housed for 13 years).*

P14: I have addiction problems so I was just panhandling for money and panhandling for drugs and that was my lifestyle when I was homeless, doing drugs right. And then sometimes I would to a shelter. But, sometimes you’re just living for the drug when you are homeless because you have no goal, no friends, no nothing, you’re all by yourself. *(Female, age range 45-50, one episode of homelessness for ten years, housed for 7 years).*

P24: I used to be addicted to pain killers, but I stopped doing that in the ‘80s. I really was just smoking a joint here and there. I really wasn’t doing a lot of drugs. And then when I became homeless I was introduced to crack. Crack is highly addictive. And when you’re
homeless, sometimes that exactly what you need. *(Female, age range 45-50, one episode of homelessness in early-40s, housed two years).*

Seventeen of the 29 (59%) participants reported consuming alcohol within the previous 12 months. The greatest share of participants reported consuming alcohol less than once a week (35%) and only three individuals (10%) currently drank on a daily basis. Half of the participants reported using illegal drugs (including marijuana) at least once in the previous year. The majority of these participants (69%) reported using drugs less than once a week and a quarter reported using daily.

As part of the re-housing process, a number of participants had completed detoxification and recovery programs for substance abuse. Generally speaking, participants with histories of substance abuse viewed stable housing as a critical step towards maintaining sobriety and improving their health. Among those who continued to use alcohol and drugs, most had attempted to reduce their consumption in relation to when they were homeless. A few participants also said they now prioritized money for rent and only purchased drugs or alcohol after fulfilling other financial obligations. Limiting the use of substances not only contributed to better health, but was also important for saving financially and increasing the likelihood of remaining permanently housed. Other positive health outcomes that participants associated with reduced substance use included: weight gain as a result of better nutrition, improved sleeping habits, less emotional and physical strain on their body, and less risk of contracting communicable diseases like hepatitis and HIV/AIDS.

P19: Periodically, I’m getting away from it, but periodically I still smoke crack cocaine. Maybe a couple hours out of the month that’s the time I’ll bust a stone and then I’ll be done, but I usually get my cat food and my cat litter, I usually get cigarettes, I usually get all that first. *(Male, age range 51-55, three episodes of homelessness beginning at age 41 years, housed for 4 years).*
P18: I’ve weaned myself to once a month. Once a month, I will indulge myself on a weekend when my daughters aren’t around and I’ve got that much time to sleep when I want to, no responsibilities, no obligations. So I still indulge, I’ve tried to find the best medium between what I can’t change. (Female, age range 51-55, 15 episodes of homelessness beginning in mid-30s, housed one year).

P5: When I get up in the morning, I feel good. I don’t feel hung over anymore. I don’t feel stressed out. I am at peace with myself. A lot better. A lot better. Physically, I will get better. (Male participant, age range 66-70, homeless intermittently, housed 20 years).

P6: I can say this for sure is that being homeless is not conducive in any way to recovery of any sort, physical, mental, if you want to speak of addictions. Like it’s just there’s no recovery model there. I mean, I guess you’re in a mental state of ‘I don’t care’. I just didn’t care. I just wanted to pass out where it wasn’t raining on me and it wasn’t cold. (Male, age range 45-50, two episodes of homelessness in late-thirties, housed 2.5 years).

Smoking cessation

A much greater percentage of the formerly homeless older adults in this study were daily smokers (67%) compared to the general older population (11%) as reported in the CCHS. Among those who currently smoked, each participant had done so for 10 years or longer and the greatest share (61%) had smoked for more than 30 years. Overall, smoking cessation was cited by only a small number of participants as a reason for improved health. Although a relatively large share of the participants continued to smoke, many had attempted to reduce their level of cigarette smoking compared to when they were homeless. There was general recognition among the participants that smoking posed further risks to their health and several individuals said they hoped to quit in the near future.

P6: It’s just overall a huge improvement. I quit smoking. I’m eating regular, I’m housed. I’m not out in the cold. I don’t drink anymore. Um yeah, it’s just overall a huge improvement. Another thing that probably contributes to my better health is the fact that I am med compliant. (Male, age range 45-50, two episodes of homelessness in late-thirties, housed 2.5 years).

P24: I smoke much less. Homelessness actually probably helped my longevity, quite honestly. I used to smoke 2 packs a day. Now I smoke less than a pack a day. And I also smoke cigarettes in increments. So now I smoke less cause I’ll put out half way. It
Discussing the determinants of health improvement

Most of what is known about the relationship between homelessness and health has emerged from studies employing objective or clinical measures (Kondro, 2007; Turnbull et al., 2007; Wen et al., 2007; Grinman et al., 2007; Frankish et al., 2009). In this study, a group of formerly homeless older people were asked to share their perceptions of health in relation to becoming stably re-housed. When reflecting on their past experiences of homelessness, the participants recalled their health declining for similar reasons as identified in the existing literature (Hwang et al., 1997; Hwang, 2001; Hwang et al., 2001). Based on the qualitative responses, participants had experienced poorer health during episodes of homelessness due to exposure to the physical environment, irregular sleeping habits, poor nutrition, and contact with communicable diseases in unhealthy spaces. Limited access to primary health care, feelings of stress, trauma, and victimization, and the overuse of alcohol and drugs were also commonly identified as reasons for poor health during homelessness.

The formerly homeless older adults were now experiencing better health because stable housing had alleviated their exposure to the stressors identified above. The interviews revealed that housing had provided protection from the physical environment and promoted feelings of safety and security. Housing also helped to improve sleeping habits and nutrition, as well as allowed for better maintenance of personal hygiene and care. With basic necessities like food and shelter fulfilled, participants were able to prioritize health care needs and take preventative measures to maintain their health. Living in stable housing had also helped many participants to reduce their consumption of alcohol and drugs and this was a common reason for improved health. Overall, the majority of participants were experiencing better health since in stable

actually retrained me. *(Male, age range 56-60, six episodes of homelessness beginning at 22 years of age, housed 9 months).*
housing. The theoretical contribution of these findings are discussed in greater detail at the conclusion of this chapter.

**Barriers to Healthy Aging among Formerly Homeless Older People**

Within academic literature and public policy, healthy aging is conceptualized as encompassing quality of life, well-being, independence, self-care, financial security, access to support networks, and coping behaviours (Rowe and Kahn, 1997; Bartlett and Peel, 2005). Defining healthy aging by such normative values and principles raises important questions about the barriers that older people with histories of homelessness face to having positive experiences of aging. A small group of the formerly homeless older adults reported no improvement in their health, or were experiencing worse health since being re-housed. The qualitative results below reflect the participants’ responses when asked to identify the factors preventing their health from improving. Although most reported better health compared to when they were homeless, some continued to have unmet health and social care needs and these are also reflected below.

**Earning a low income**

As reviewed in Chapter Two, a main goal of the study conducted by McDonald et al. (2006) was to identify formerly homeless older people’s barriers to health and wellness in the context of social inclusivity. McDonald et al. (2006) primarily focused on the structural barriers that prevented participants from recovering from the psychosocial effects of homelessness, adjusting to living in housing permanently, and feeling included in broader society. The barriers identified in the McDonald et al. (2006) study included the limited supply of age-appropriate, affordable housing options, ageism in the job and housing market, and inadequate income and
employment supports. It was not surprising that the formerly homeless older adults in this study described similar barriers to accessing affordable housing and income supports. When asked why their health had not improved, the most common barriers cited were related to earning a low income. The survey results in Chapter Five showed the majority of participants reported an annual household income of less than $20,000 (Table 5.1). Although Canada has no official poverty line, research presented in Chapter Three suggests an annual household income of $38,000 is needed to afford a one-bedroom apartment in Toronto (The City of Toronto, 2011a). When describing their unmet health and social care needs, many participants said a lack of affordable housing options and a low income continued to limit their quality of life.

P6: I’m still on a very limited budget ‘cause disability is my income, and it’s actually being cut back, probably by 15 or 18 percent in 2 months. So I’m doing the best I can. (Male, age range 45-50, 2 episodes of homelessness beginning at the age of 35 years, housed 2.5 years).

P9: [Social workers] move homeless people to an apartment on their own. If you’re on welfare, then you don’t have enough money for food. They do not have enough money to live. And if you’re mentally sick, you can’t get a job. (Male, age range 56-60, one episode of homelessness at the age of 41 years, housed 16 years).

P12: Well, you know, I think the main reason I was homeless was cause the rents are so high, and it’s hard to find a room, a reasonable priced room, who have decent conditions...Being at a disadvantage or homeless, it’s hard to find decent affordable housing. The sooner you get housed the better it is for you, health-wise. (Female, age range 51-55, homeless intermittently housed 22 years).

Along with the high cost of rent, many of the formerly homeless older adults were struggling to afford other necessities required for a healthy lifestyle. McDonald et al. (2006) similarly found that low incomes, insufficient social assistance rates, and the high cost of rent prevent formerly homeless people from moving off a “continuum of poverty”. In this study, many participants indicated their financial situations had improved only marginally compared to when they were homeless. There was general agreement that benefits from OW and ODSP are
insufficient to afford the cost of housing, along with food, medications, clothing, heat and hydro. Many participants still continued to access free community services such as meal programs, food banks, and clothing banks as a way of conserving money for rent and other non-variable expenses.

P22: Like at the beginning of the month, you do like one really good grocery shop. But then, by the time your fruit, veggies, cheese and stuff are gone and you don’t have any money or what the food banks give you, carbs. They give ya beans and pasta. (Female, age range 51-55, one episode of homelessness in early 50s, housed for 7 months).

**Socioeconomic and geographical barriers to accessing quality, affordable housing**

The study on income polarization in Toronto by Hulchanski et al. (2010) showed the lowest income households are concentrated in the inner suburbs and outlying areas (see Appendix B). The rental housing in these neighbourhoods tends to be poorer in quality and disconnected from transportation and services in the central city (Hulchanski et al., 2010). The participants in this study indicated their access to quality, affordable housing in safe neighbourhoods was limited by such spatial trends, as well as a low income, no positive reference from previous landlords, and discrimination in the housing market. A few participants had been forced to relocate from the central city to outlying neighbourhoods in order to secure affordable housing. These individuals felt displaced by the high cost of rental housing in the private market and a lack of subsidized housing in the downtown core.

Similar socioeconomic and geographical barriers were described with regards to accessing social services and community supports. A number of participants explained the location of their current housing was isolated from organizations that offered free meal programs and other social services. As Toronto’s urban landscape has spatially evolved, efforts have been made to offer community social supports in low income neighbourhoods scattered throughout the city; however, the greatest share remains concentrated in the central city. Although it is
important for community agencies to be located in the inner city where the homeless population tends to congregate, people with low incomes have limited access in other parts of the city. The fee for public transportation also presents challenges for people with low incomes if they must travel into the central city for services. Health problems and disabilities can also limit older people’s personal mobility and this further contributes to their isolation from the services and supports they might require.

P18: When I was homeless, it was easier to be downtown, and there’s a lot more services and places you can go for free food and stuff like that. If you spend all day going from place to place, like you’re definitely going to get a salad and some fruit. *(Female, age range 51-55, 15 episodes of homelessness beginning in mid-30s, housed 1 year).*

The findings presented above illustrate the various economic, social, and geographical barriers that formerly homeless older people face to accessing quality, affordable housing and other social supports. The dissatisfaction that participants felt with their current housing situations, locality, and income levels were identified as barriers to recovering from the physical and mental health outcomes of their past homelessness.

**Awaiting health care services and insurance benefits**

As previously discussed in this chapter, the majority of participants indicated they had better access to health care since being stably housed. Some participants, though, especially among the recently re-housed continued to face barriers to receiving the health care services or treatment they required. A few participants were missing a health card and this delayed care or treatment while they awaited a replacement. Although most recipients of social assistance and disability support programs are entitled to health insurance benefits, some individuals were awaiting the approval of applications to OW and ODSP. Until approval was granted, they could not afford to treat their dental problems, fill eye glass prescriptions, or afford other personal
supports. In many cases, participants were forced to choose between paying rent and addressing their unmet health care needs. Most indicated they prioritized money for rent and bills over medical and health care costs because they feared eviction and another episode of homelessness.

Researcher: Do you have unmet health and social care needs?

P24: Teeth. And my glasses. Without an OHIP card I can’t get glasses, even though disability will pay for them, that’s not the issue. It’s not always an issue of money. It’s an issue of accessibility to services. (Male, age range 56-60, six episodes of homelessness beginning at 22 years of age, housed 9 months).

P1: Uh yeah, I need a prescription. I have enough money this month, so I should probably fill it. I don’t have enough money for a place to live and everything I need. I got extra assistance, so it will help to get last month [of rent] paid and $250 extra a month. (Male, age range 51-55, 1 episode of homelessness beginning in mid-40s, housed 2 years).

P7: I need dental care. I haven’t had dental care and I need to get some dental care, because I have a lot of damage to my teeth since becoming homeless. As soon as I can afford it, I will see a dentist and start taking care of that. (Transgendered male to female, age range 45-50, one episode of homelessness at 42 years of age, housed 17 months).

Inadequate psychiatric care in the community

A number of participants continued to experience negative mental health outcomes as a result of their past homelessness. In a few cases, participants had been professionally diagnosed with post-traumatic stress disorder (PTSD), or described symptoms akin to PTSD. Other studies also confirm that residual feelings of stress and trauma are common among the homeless and formerly homeless population (McDonald et al., 2006). For those coping with mental illness, a lack of access to psychiatric care in the community was a common barrier to health improvement. Many community agencies in Toronto offer counseling services for people who are homeless or newly housed. However, after people are housed for a period of time they often become disconnected from the services and supports provided in the initial phases of the re-housing process.
P21: After getting housing, like I, I have Post Traumatic Stress Disorder, um so I was dealing with a lot of stuff about my past. I think I sort of did well during my youth cause I just didn’t really look at anything, I just sort of you know, lived my life. And so when it all came out, it made things tough. Um, my eating disorder returned, um. I actually, I went to school and everything which was great. I went to college and I graduated. But uh, it was all very stressful. *(Female, age range 45-50, two episodes of homelessness beginning at the age of 16 years, housed for 13 years).*

A related barrier is that many insurance plans do not cover the complete cost of treatment from a psychologist or psychiatrist. Some participants were frustrated they had been prescribed medications for anxiety and depression, but could not afford to visit a mental health care professional on a regular basis. These participants strongly emphasized the importance of addressing such gaps in the mental health care system. They also recommended that access to free or low-cost psychiatric care in the community be improved, especially for formerly homeless people at various stages of the re-housing process.

P7: I think the biggest problem is getting good psychiatric help. There doesn’t seem to be a solution. I’ve been on waiting lists the whole time I’ve been homeless and the only psychiatric help I was able to get was through urgent, emergency care through hospitals. For some reason, they prescribe medication to you and send you out to cope, where I think my mental health is the worst problem that needs to be addressed. *(Transgendered, age range 45-50, one episode of homelessness at 42 years of age, housed 17 months).*

**The continued overuse of alcohol and drugs**

The continued overuse of alcohol and drugs had prevented a few participants’ health from improving, or contributed to a further decline. For some participants, a long history of addiction presented significant obstacles to becoming and remaining sober in older age. Although many participants had attempted to reduce their drug and alcohol consumption since moving into stable housing, some continued to over use. The common reasons for continuing to use substances included: dissatisfaction with life and dealing with residual feelings of trauma. In two cases, participants said their current housing situations presented barriers to maintaining
sobriety. Each of these individuals were living in their own housing and regularly exposed to substance use by family members or roommates:

P3: I was living in a house and I had the upstairs and some gentlemen had the downstairs. It was all cool, fine, and then these young 27 year olds came around [to visit my roommate]. So the house started to fill up with young kids and I’m old. They started doing a lot of drugs around me, excessive drinking. Yea, I have a drinking problem, but if it’s not around me, I can say no. I don’t have to spend my money on it. *(Female, age range 56-60, six episodes of homelessness beginning at 16 years of age, housed 10 months).*

**Discussing the barriers to health improvement**

The findings presented above are not intended to be an exhaustive list of formerly homeless older people’s barriers to healthy, positive aging. These findings generally reflect why some participants had experienced no improvement, or a further decline in health despite living in stable housing. Even though the majority reported better health, many participants had unresolved health and social care needs. These findings align with the theory of McDonald et al. (2006) that ending “house-lessness” does not always ensure formerly homeless people are living in a safe, secure environment (p. 225). In the McDonald et al. (2006) study, formerly homeless older adults generally viewed their present housing situations as transitional or temporary until they could find a more ideal place to live. In this study, several participants described a similar feeling but the limited supply of quality, affordable housing in Toronto posed barriers to finding an ideal home.

These findings suggest that concepts like “stably housed” and “formerly homeless” are actually subjective, fluid terms. Despite having a physical roof over their head, participants continued to experience personal and systemic barriers. These barriers were not only described as limiting participants’ recovery from past episodes of homelessness, but also created further obstacles to aging healthily. Low incomes and high rents play an obvious role in creating unstable housing situations. Other factors like addictions, mental illness, and physical health
problems can also increase the risk of becoming homeless again. Unlike other studies on homelessness, domestic abuse did not emerge as a key theme in this research. A large proportion of the participants were living alone, in supportive housing facilities, or reported their marital status as single, which might account for this trend. It is important though to acknowledge that domestic abuse can create precarious housing situations and homelessness at any stage of the life course.

Ageism in the job market and other barriers to employment did not emerge as major themes either, although they were dominant in the study by McDonald et al. (2006). This is likely a limitation of the study design since participants were not explicitly asked about issues related to employment beyond whether they were currently employed and sources of income. As mentioned in a previous chapter, the majority of participants indicated they were unable to work full-time due to chronic health problems and disabilities. The focus on older adults also meant that many participants had surpassed Canada’s age of retirement (65 years) and were therefore, collecting benefits from CPP and OAS. Formerly homeless people, however, are likely to receive fewer benefits from pension plans than the average older person due to a sporadic work history or long-term unemployment.

On a final note, the natural aging process and chronological aging should not be discounted as a factor in some participants’ worsening health. Two participants explained their health had declined since being re-housed because the symptoms of a chronic illness had worsened over time. These individuals did not expect their physical health would improve, regardless of how long they were stably housed. In the first case, a participant had experienced a decline in their health as a result of a bowel disorder, which would require additional surgeries. A second participant said their health had declined due to rheumatoid arthritis and osteoarthritis
of the spine. He commented, “My health has pretty much stayed the same. Like it’s not gonna improve. The conditions I have aren’t gonna improve”.

**Chapter Discussion**

A wide range of experiences of homelessness and health were reported among the participants in this study. Characteristics like the number of homeless episodes and the age when homelessness occurred, as well as their individual health statuses and specific health conditions, varied extensively from one participant to another. Yet despite such personal and contextual differences, the 29 interview participants identified similar reasons for a health decline during past episodes of homelessness. They also identified the same types of factors as having contributed to better health since being stably re-housed. The qualitative interviews provide evidence that housing as a physical structure is a crucial determinant of health improvement for formerly homeless people. Other aspects of housing though are also important factors for improving health, such as personal safety, security, access to food, and health care.

The findings reflect the participants’ experience of health in relation to being homeless and then re-housed. The findings also offer some insight into the role that stable housing can play in improving health over time. To date, most research has been conducted on people who are presently homeless, or very recently re-housed. This study is unique because it examines experiences of health among formerly homeless people who have been housed for an extended period of time- in some cases upwards of 10 to 25 years. The factors that are commonly attributed to better health in the initial phases of being re-housed (shelter, food, medical care, personal security) were still regarded as having a positive effect on health among those housed for several years. These findings suggest that people who have been homeless continue to have more positive experiences of health as time goes on. However, further research is needed to
understand how such progress and recovery might plateau over time, or be inhibited by the natural aging process.

The literature on healthy aging has generally overlooked the experiences and needs of older people with histories of homelessness. Although stable housing was described as having an improving effect on health, the qualitative results show many participants face ongoing barriers to healthy aging. Formerly homeless older people are not only at a disadvantage for successful aging with regards to their health, but also in terms of their socioeconomic situations, housing options, availability of family and social support networks, level of social inclusion and participation, and general satisfaction with life. The factors that had improved their health reflect the most basic, fundamental qualities of life, such as shelter, food, safety, security, and a sense of belongingness. While the majority of older Canadians possess the material and non-material resources to choose where and how they live in older age, those with histories of homelessness struggle to meet their most basic needs. The values and standards by which formerly homeless older people evaluate their health and opportunities for positive aging appear to be different than the average older person. The participants tended to self-evaluate their current health in reference to their former homeless lives, and not in relation to other people their age.

Overall, the participants did not generally expect moving into stable housing to reverse the negative, accumulative effects of homelessness and its related lifestyles on their health. They did, however, perceive stable housing and its various positive attributes as an opportunity to achieve better health today. Stable housing was also regarded as important for maintaining their health in the future. In the next chapter, participants’ subjective views about the relationship between their past homelessness, current health, and expectations for aging are explored in greater detail.
Chapter Seven

Challenging Normative Ideals and Expectations about Aging, Health, and Home

Introduction

The theme of this chapter is challenging normative ideals and expectations about health and aging by considering the perspectives of formerly homeless older people. The research presented in Chapter Six showed the majority of participants reported better health since moving into stable housing, relative to when they were homeless. The purpose of this chapter is to explore the long-term effects of homelessness on experiences of health and aging. The first part of the chapter describes the six different perspectives that emerged among participants when asked how their past homelessness affects their current experiences of health and aging. Many reported more than one negative health outcome. In light of such findings, the second part of this chapter explores the participants’ expectations for their health as they continue to age. The third and final section considers the challenges that formerly homeless people face when making decisions about housing and care in the later-elderly years. Overall, the research presented in this chapter contributes to a better understanding of how a history of homelessness can affect experiences of health and aging in later stages of the life course.

What are the Long-Term Effects of Homelessness on Experiences of Health and Aging?

A component of the interview asked participants to share their subjective view of the relationship between being homeless in earlier life and their current health. Only four of the 29 (14%) interview participants said their history of homelessness was having no effect on their current health. The remaining 25 (86%) participants said some aspect of their past homelessness continued to affect their current experiences of health and aging. Among the interview
participants, six different perspectives on the long-term effects of homelessness emerged and many identified more than one negative outcome (see Table 7.1).

The first perspective was that the physical state of homelessness increases the risk of certain chronic health conditions in older age (10 of 25 participants, 40%). This was primarily heard from participants who reported physical conditions such as arthritis, asthma, chronic bronchitis and other serious respiratory problems. As described in Chapter Six, it was common for participants to have slept outdoors, or in other health damaging environments throughout the time they were homeless. Conditions like arthritis and asthma are common among the general older population, but many participants thought past exposure to cold, damp weather had increased the likelihood of developing such conditions. From this viewpoint, the implications of living outdoors can have negative effects on health in older age.

The second perspective was that current health problems are the outcome of substance abuse, more so than the actual state of homelessness. This group of participants (9 of 25, 36%) generally perceived their health as poorer than the average older person as a result of overusing alcohol, drugs, and cigarette smoking throughout their life. Most however, recognized their histories of substance abuse and past experiences of homelessness were inextricably linked. This point is illustrated by one case where a participant reportedly contracted hepatitis C. from practicing unsafe drug use. He described this as part of the “homeless lifestyle”. From this perspective, physical health problems in older age are indirectly related to past episodes of homelessness, and more closely associated with the negative implications of substance abuse.

The third way that homelessness was identified as affecting health in older age is by increasing the risk of poor mental health (10 of 25, 40%). The findings presented in Chapter Six showed residual feelings of trauma and stress are common barriers to healthy aging among
people with histories of homelessness. Although most participants are experiencing better mental health today in relation to when they were homeless, many continued to cope with the emotional and psychosocial impact of earlier experiences (see Table 7.1). Some also thought their past substance use had contributed to poorer mental health today.

Similar to other studies (Hwang, 2000; Crane et al., 2005; McDonald et al., 2006), the participants perceived homelessness to have had an accelerating effect on the rate at which they are aging (three of 25, 12%). The term “accelerated aging” was not explicitly used, but most participants demonstrated an awareness that homeless people typically have poorer health than the housed population. In this fourth perspective, current health problems would have occurred regardless of being homeless, but the unhealthy lifestyle had accelerated the process. For example, one participant in his late 40s thought he had a genetic predisposition to chronic obstructive pulmonary disease as his father had passed away from the same illness. However, this participant believed the stress and unhealthy behaviours associated with homelessness had caused an earlier onset of the condition.

In a fifth perspective, neglecting health care needs while homeless in earlier life can contribute to worse health in older age (three of 25, 12%). Many participants recalled ignoring symptoms of an illness, not taking prescription medication as directed, and going for long periods of time without a physical check-up. Some wondered if their health was poorer today because they had not received appropriate health care interventions while homeless. From this viewpoint, health problems would have occurred regardless of housing history, but the state of homelessness prevents the prioritization of health care needs. In turn, this can contribute to more negative experiences of health and aging in later life. These types of behaviours, however, must
be understood within the context of the broader barriers that homeless people face in accessing primary health care services, as reported in Chapter Six.

Finally, the state of homelessness not only poses negative implications for health in older age, but so does a lifetime of socioeconomic disadvantage (three of 25, 12%). Many participants had grown-up in a household with parents who earned a low-income, meaning their history of poverty and housing insecurity was intergenerational. Even in times when they were housed, they had experienced circumstances that reflected an unfair distribution of income, education, employment opportunities, access to nutritious food, and other requirements for a healthy lifestyle. These types of material and non-material resources are known to be important determinants of health and well-being (Dunn, 2000; Dunn and Hayes, 2000). From this perspective, the opportunity for good health was limited across the entire life course, and not only in periods of homelessness. These findings parallel other studies that have shown economic strain, repeated hardships, and discriminatory experiences can have a negative, accumulative effect on health in later stages of life (Dunn, 2000; Pearlin et al., 2005). The results presented in the next section explore the participants’ expectations for their health as they continue to grow older.
| **Table 7.1: Subjective views of the long-term effects of homelessness on health and aging** |
|-------------------------------------------------|-----------------|--------------------|-----------------|------------------------------------------------|--------------------------------------------------|
| **Physical state of homelessness increases risk of chronic health conditions** | **Outcome of substance abuse** | **Increases the risk of mental health problems** | **Homelessness has an accelerating effect on health & aging** | **Poor health is the outcome of having ignored health & health care during episodes of homelessness** | **Poor health in older age is an outcome of a lifetime of socioeconomic disadvantage** |
| P27: See, I think being out in the cold increased my physical disorders. Yea, from my legs to my coughing to my respiratory. | P1: Drinking has affected my health. Drinking affected my health more than being homeless. | P5: Well the older I get, the more I realize, I don’t think it has the impact physically. What I realize is that emotionally it was really quite traumatic. I think emotionally it has a huge impact. | P6: My lungs will never be what they were. [COPD] is like a degenerative, chronic, irreversible condition. I’m not sure the shelter system or being homeless caused it, but it probably accelerated it. I believe there is a genetic component to it. My father died of COPD. But he died when he was in his 70s. I mean I’m 50 years old and I can’t even walk up a flight of stairs. | P5: I don’t think it’s “homelessness” exactly, just is uh, neglect. Just, unable to get access to proper medical attention. | P12: Well, see the rough people always have to struggle to make ends meet and it’s hard, if were just trying to succeed when it’s hard to get jobs. It’s hard to find a room, a reasonable priced room with decent conditions. In one home, there was no heat and it was too cold. Being at a disadvantage or homeless, it really impacts your health, and it’s hard to find decent affordable housing. |
| Examples of common qualitative responses | | P3: I don’t think being homeless hurt my health, I hurt my health. It’s not being homeless that hurt me, it’s me who hurt me. Doing the drugs. | | | |
| P25: I’ve always got a stuffed up nose. I mean, I find that coming in from the outside, I’m constantly affected by weather like that. I have bronchitis. So, they told me it would be chronic, I’ve had it every year. | | | | |
| P8: I’d like to get some surgery in my feet, which isn’t covered [by OHIP]. It’s just a problem that developed because it wasn’t really looked after before it became serious. Now I’ve got these, these heel spurs. (Male, 45-50, two episodes of homelessness, housed 17 years). | | | | |
Expectations for Future Health and Aging

During the interview, the question “how do you think your past homelessness will affect your experiences of health and aging in the future?” was posed. A comment by one individual that homelessness “weakens the framework” articulates the general view of many participants. They acknowledged that homelessness is bad for health, but most participants were optimistic about their health and future experiences of aging. However, it was also recognized that the opportunity to age healthily is contingent upon remaining stably housed. This point is illustrated by quotes from several participants who said they would not survive another episode of homelessness. If they did transition back into homelessness, they anticipated the health outcomes would be even more severe in older age.

P14: Oh I well, I have to keep my housing you know and stay good. If I get kicked out of here, if I lose my housing this time, I will die. Like, I will not make it because I’m getting old. If I lose my housing right. (Female, age range 45-50, 1 episode of homelessness for 10 consecutive years, housed 7 years).

P15: Well, as long as I am in stable housing and don’t go into the same situation. I mean, if I get in the same situation again, I’m older now, right? I would get worse. (Female, 61-65, 1 episode of homelessness, housed 4 years)

Some participants thought their chances for healthy aging could be improved by maintaining their current health. As described in the previous chapter, many participants had made positive lifestyle changes since becoming re-housed. These included eating a more nutritious diet, sleeping better, reducing their substance use, and prioritizing their health care needs. From this perspective, developing healthier habits in the immediate term would promote more positive experiences of health in future stages of the aging process.

Maintaining mental health was also perceived as critical for promoting positive experiences of aging. Participants considered this to include: following the advice of mental
health care professionals, taking medications for mental illness consistently, avoiding stressful situations and known triggers for substance abuse, as well as continuing to address residual feelings of trauma and insecurity. Maintaining mental health was complicated, however, by the barriers that formerly homeless people face to accessing appropriate psychiatric care and treatment to overcome such residual feelings.

P7: Um, I definitely consciously exercise. Now, I’m aware that I need to go bike riding for exercise or I need to walk, just for the sake of walking to become active and stay active. It’s a pretty good time. Being 47 is probably a good time to start taking care...well it’s too late to start taking care, but at least be aware that you must start taking care of your body. (Transgendered male to female, age range 45-50, one episode of homelessness at 42 years of age, housed 17 months).

P13: I’m just trying to keep myself, you know, in the best shape that I can, considering. But I’m not getting any younger, right? So, you know what I mean? But it uh, I’m finding it’s harder to maintain. (Male, age range 45-50, three episodes of homelessness, housed 13 months).

P8: I know what not to do now. Like you know, I try and eat as well as I can. Obviously I’m on disability now because of the lungs and because of the alcoholism, but I’m doing, you know, way better than I was. I mean in my case, its driven me to succeed, cause I don’t ever want to go back there. (Male, age range 45-50, 2 episodes of homelessness, housed 17 years).

The research presented in this dissertation demonstrates that people with histories of homelessness contend with significant barriers of affording quality housing and other requirements for a healthy lifestyle. Participants anticipated having more positive experiences in the elderly years if they remain stably housed, if they can afford nutritious food, and if they can access proper health care. Regardless of personal capacity, systemic barriers and low incomes continue to limit the chances that formerly homeless older people have to age in a healthy, positive context. The next section explores some of the challenges that people with histories of homelessness face when deciding about housing and care in the later-elderly years.
Challenges Regarding Housing and Care in the Later-Elderly Years

Previous studies have found that homeless people rarely live beyond the age of 70 years (Hwang, 2000, Crane et al., 2005; McDonald et al., 2006). In this study, only one participant was over the age of 70, and the majority were between 45 and 60 years (see Table 5.1). The perspectives of the oldest-elderly are not reflected in this research, and this is a common limitation to studying homelessness and aging. Despite the low survival rate among the homeless elderly, greater consideration is required of the challenges they will face to accessing housing and care towards the end of life. To understand better such potential challenges, participants were asked to think ahead and describe their expectations for the later-elderly years. The qualitative interview data was analyzed to understand if participants were planning for the elderly years, and any challenges they anticipated with regards to their options for housing and care.

While most people make decisions about where to live and receive care in later stages of the elderly years, those with histories of homelessness are often confronted with such decisions in their 50s and 60s. This is mainly due to accelerated aging and relatively poor health. At the time of the study, most participants were preoccupied with maintaining their current housing, dealing with current health problems, and trying to recover from past episodes of homelessness. There appeared to be little time and personal capacity to plan for future housing, financial, and care needs. One participant explained that homeless people are conditioned to deal with only immediate, short-term needs and this presents difficulties when planning for the future.

P5: Looking back, I have a heightened need for security. And, I, still think in very much sort of short term kind of time frames. Like, long term planning isn’t my forte. Because I’ve moved around so much, it isn’t part of how I think. You know what I mean? *(Male participant, age range 66-70, homeless intermittently, housed 20 years).*
P4: I didn’t plan for this. You know I had money in the bank for my retirement, I was going to stay in my own house. Um, I almost had a heart attack from living in one place because it was so awful, I couldn’t stay there. (*Female, age range 56-60, one episode of homelessness, housed 19 years*).

More than one-third of participants resided in a supportive housing facility and unique concerns emerged among this group. Many supportive housing programs allow residents to stay for an indefinite period of time. Several long-term residents raised concerns about whether their health care needs could be met in this type of living environment towards the end of life. A review of supportive housing facilities in Toronto reveals most offer only moderate levels of care and assistance with daily activities, such as personal care, transportation to medical appointments, and some basic nursing services. A small number of spaces in most facilities are designated for the frail elderly, but there are typically waiting lists for such vacancies in Toronto’s facilities.

Formerly homeless elderly people who live independently also face challenges when attempting to age-in-place. As reviewed in Chapter Two, a host of literature has considered the obstacles that older people within the general population contend with when aging at home (Harper and Laws, 1995; Rosenberg and Everitt 2001; Andrews and Phillips 2004; Andrews et al., 2007). Common challenges include declining health and mobility, limited availability of publicly-funded home care services, and overburdened family and social support networks as a result. Older people with histories of homelessness are presented with the same types of challenges, but a low income and limited health insurance benefits are barriers to affording home care services beyond what is provided publicly. In this study, the largest proportion of participants were also single, separated, or divorced and many were estranged from children and family members. As informal caregivers play an increasing role in the provision of care for the
elderly, important questions are raised about formerly homeless older people’s access to social support networks to facilitate aging at home.

In Canada, most elderly people with limited financial resources transition to publicly-funded long-term care facilities when they can no longer live independently. Long-term care facilities, however, are not traditionally designed to meet the complex needs of elderly people with histories of homelessness, addictions, social isolation, and serious mental illness. For example, an elderly person with a mental illness like schizophrenia might require complex levels of care as their needs are compounded by the natural aging process, physical illness, and dementia or other neurocognitive disorders. The previous study by McDonald et al. (2006) determined the need for more age-appropriate housing options intended specifically for formerly homeless older people. The findings from this study further demonstrate the need for innovative approaches to housing and long-term care for the formerly homeless, especially those requiring unique, complex levels of care. At the present time, further research is needed to understand the most appropriate setting in which the formerly homeless can have the most positive experience of aging.

Like the general older population, the formerly homeless are a heterogeneous group in terms of their demographic backgrounds, as well as individual health statuses and health care needs. At a policy level, this presents challenges when forecasting and planning for the needs of older people and the elderly from within this vulnerable population. For example, some formerly homeless people in their 40s and 50s will require levels of care similar to a person in their 60s and 70s in the general population. Other formerly homeless people in their 60s and 70s will be in relatively good health and can live independently in the elderly years. Therefore, chronological aging is not always a clear indictor of the health and long-term care needs of formerly homeless
older people. Individual characteristics like the duration and frequency of homelessness, as well as the living conditions during past episodes of homelessness are more likely relevant indicators. Overall, this research suggests that approaches to housing and long-term care options for the formerly homeless cannot easily be based upon normative ideals and expectations about age, the body, and the life course.

**Chapter Discussion**

The survey results in Chapter Five showed the sample of formerly homeless older adults reported poorer health than the general population. The findings in Chapter Six revealed the majority of participants reported better health since living in stable housing. Yet, the findings in this chapter show 25 of the 29 (86%) participants identified at least one negative outcome of homelessness. The participants’ perspectives of the long-term effects of homelessness on health and aging fell into six general categories: (1) the physical state of homelessness increases the risk of chronic health conditions like arthritis, asthma, bronchitis, and other respiratory problems; (2) the connection between substance abuse and homelessness increases the risk of poor physical and mental health outcomes; (3) the trauma and stress related to homelessness contributes to poorer mental health in older age; (4) homelessness has an accelerating effect on health and aging; (5) neglecting health and health care needs during episodes of homelessness can delay proper diagnosis and treatment, which might increase the seriousness of health problems in later life and; (6) poor health in older age is not only the outcome of homelessness, but due to a lifetime of socioeconomic disadvantage. Despite the negative health outcomes that were reported, stable housing was thought to offer a better opportunity for healthy aging compared to the homeless lifestyle. Ongoing obstacles to having positive experiences of aging though include
remaining housed, maintaining health, and addressing the types of personal and structural barriers that were reported in Chapter Six.

The underlying theme of this chapter was challenging normative ideals and expectations about aging. Formerly homeless people are confronted with the same types of decisions in older age as the general population, but most have fewer options for housing and care. Factors like minimal savings for retirement, multiple and complex health problems, a history of addiction, mental illness, and little connection to family and informal caregivers are common circumstances that limit the opportunities for formerly homeless older people to age positively and healthily. The existing literature shows homeless people rarely live into their late-elderly years (Hwang, 2000, Crane et al., 2005; McDonald et al., 2006), but the perspectives and situations of the formerly homeless have received very little consideration in research and policy. In the coming decades, it is likely that advancements in health care and technology will increase life expectancy in developed countries, along with improving the relative health of people who are homeless. Optimistically, a growing awareness about homelessness in public policy and academic research will reduce the health disparities currently found in this population. Therefore, it is crucial to consider the unique challenges that elderly people with histories of homelessness face when deciding about housing and care in later life, as discussed throughout this chapter.
Chapter Eight
Conclusions

Introduction

To date, academic research and public policy have generally failed to consider the opportunities that older people with histories of homelessness have for healthy aging. In response to the lack of current research and knowledge on this topic, this dissertation has sought to achieve three broad objectives. First, the research contributes an original conceptualization of the long-term effects of homelessness on people’s experiences of health and aging. Second, it explores how stable housing can improve homeless people’s opportunities for healthy, positive aging. And third, the research has provided a better understanding of how being homeless in earlier life can affect experiences of health and aging. In this final chapter, the findings are summarized and applied to address the objectives of this study. The chapter closes by offering recommendations for future policy and academic research in health geography.

Revisiting the Research Questions

Objective 1: To contribute an original conceptualization of the long-term effects of homelessness on experiences of health and aging.

The research presented in this dissertation provides evidence that people with histories of homelessness are aging in a more disadvantaged context than Canada’s general older population. Drawing on the work of Bailey (2009), these findings are important to human and health geographers as they demonstrate how the structure and sequence of events and transitions across the life course can shape experiences of health and aging. The majority of formerly homeless older adults reported poorer physical and mental health than the average older person in Toronto and Canada. These findings are perhaps best understood within theories from the health sciences.
that show life circumstances, environmental factors, and human behaviours have an accumulative effect on health throughout the life course (Kawachi et al., 2002). In this study, many participants were exposed to negative life circumstances such as poverty, trauma, abuse, stress, and victimization at multiple stages of the life course. The homeless state exposed them to harmful environmental factors such as extreme weather, damp settings, and other unhealthy spaces. Homelessness and its related lifestyles were also associated with unhealthy human behaviours like the overuse of alcohol, drugs, cigarette smoking, and poor nutrition and sleeping habits. These findings suggest that being homeless in earlier life can increase the risk of experiencing accelerated aging, poorer physical and mental health outcomes, higher rates of chronic conditions, and decreased mobility in older age.

The results also reveal that formerly homeless older people are not only disadvantaged with regards to their health, but in terms of their housing options and socioeconomic status. By situating these findings within the concept of healthy aging, further attention can be drawn to the challenges formerly homeless older people face in affording quality housing and other requirements for a healthy lifestyle. To review, the concept of healthy aging is defined as encompassing physical health, mental wellbeing, satisfaction with life, self-care, coping behaviours, access to support networks, and social participation (Rowe and Kahn, 1997; Bartlett and Peel, 2005). Successful aging is also defined by economic achievement and the accumulation of income and assets in later life (Rowe and Kahn, 1997; Bartlett and Peel, 2005). The portrayal of formerly homeless older people’s experiences of aging in this dissertation reconfirms the concept of healthy aging mainly reflects normative, middle-upper class ideals about the life course, the body, and personal wealth and resources. Evaluating opportunities for healthy aging by such normative principles presents challenges in the context of homelessness.
The majority of participants in this study earned less than $20,000 a year, most were residing in a supportive housing facility or subsidized apartment, and homeownership was exceptionally rare. A sporadic work history and reliance on government social assistance and disability benefits means formerly homeless people will have minimal entitlement to benefits from pension plans. People who have been homeless often cope with low incomes in older age, a phase of the life course when most seniors experience a period of relative financial security. As a result of these circumstances, this segment of the older population is likely to have minimal financial savings and equity for their elderly years. Therefore, homelessness not only poses serious implications for health, but also limits opportunities for having positive experiences of aging in general.

**Objective 2: To understand better how stable housing can improve homeless people’s opportunities for healthy, positive aging.**

One of the most original and interesting aspects of this dissertation is that it examines the perspectives of older people with a wide range of experiences of homelessness and health. The specific characteristics of their experiences range from person to person, but similar views were shared about the connection between homelessness, stable housing, and health. The factors associated with homelessness that were most commonly identified as being damaging to physical and mental health included: exposure to the physical environment and unhealthy spaces, irregular sleeping habits, poor nutrition, feelings of stress, trauma, and victimization, and the overuse of alcohol and drugs. The majority of participants reported better health since moving into stable housing, mainly because they were no longer exposed to the types of stressors listed above. Housing was described as providing protection from the physical environment, promoting feelings of safety and security, allowing for healthier sleeping habits, better maintenance of personal care, as well as improving nutrition and access to health care. Stable housing was also
found to offer a more positive environment for reducing the consumption of alcohol and drugs for those with substance abuse issues.

The dissertation also offers some original insights into the improving effect that stable housing can have on homeless people’s health over time. To date, most research on homelessness and health has been conducted on those who are presently without a home, or within the early phases of the re-housing process. Although a longitudinal approach was not possible, this study is unique because it examines experiences among participants who have been re-housed for various lengths of time, ranging from six months to several decades. The results from a cohort analysis in Chapter Six suggests the longer a person is housed, the more likely they are to experience better health. Overall, stable housing was found to improve the health of homeless people by not only providing physical shelter, but also by allowing for a healthier lifestyle. The security that housing offers extends beyond its four walls and into other important domains such as health care. With basic needs like food and shelter fulfilled, formerly homeless people have a greater opportunity to maintain their health and prioritize their health care needs. Generally speaking, it was not expected that stable housing would reverse the negative health effects of homelessness that may have accumulated over the life course, but it does encourage more positive, healthy experiences of aging.

Objective 3: To explore how being homeless in earlier life might affect experiences of health and aging in later life.

The findings from this study revealed several ways that homelessness can negatively affect health in older age. Nearly every participant was currently experiencing at least one negative health outcome which they attributed to homelessness. The physical state of living outdoors, and in other unhealthy environments, was believed to increase the risk of developing
health conditions like arthritis, asthma, and chronic bronchitis. The stress and trauma related to living in a state of homelessness was also perceived as having long-lasting effects on both physical and mental health. Some participants associated their current health problems with the overuse of alcohol, drugs, and cigarette smoking and this was inextricably linked to experiences of homelessness. This study also shows the homeless lifestyle can prevent the prioritization of health care needs, which ultimately poses implications for future health. Aside from the physical state of being without a home, a lifetime of socioeconomic marginalization can also put people at a disadvantage with regards to their health and wellbeing in older age.

As Canada’s population continues to age over the next 30 years, this dissertation explains the types of challenge that older people with low incomes and unstable housing histories may experience. Although they reported better health since being re-housed, many participants continued to face ongoing barriers to healthy aging. Having a low income was one of the most commonly identified barriers to affording quality housing as well as food, clothing, and medication not covered by insurance. To cope with a low income, formerly homeless people often continue to access social and community supports from agencies throughout Toronto. However, aside from economic barriers, this study also identified geographical barriers to accessing quality, affordable housing and community supports. Throughout the re-housing process, many participants had relocated to the outlying suburbs of Toronto where housing is typically cheaper (see Appendix B) and the availability of subsidized housing tends to be greater. The neighbourhoods with affordable rental housing, though, typically have poorer connection to public transportation, which complicates access to services located in the central city (Hulchanski et al., 2010).
In the coming decades, advances in health care, technology, and improved policies regarding the health of vulnerable populations may increase the life expectancy of people who are homeless. With that in mind, it is imperative to consider formerly homeless people’s challenges when deciding about housing and care towards the end of life. Common challenges for the general older population include: declining health and mobility, limited availability of publicly-funded home health care services, and overburdened family and social support networks. Older people with histories of homelessness will have fewer options for housing and care due to limited financial means, improper access to family and social support networks, and the other barriers described in the dissertation. While most older people have planned well for their elderly years, the participants in this study were preoccupied with maintaining their current housing. Their narratives also revealed they continue to deal with existing health problems and recovery from earlier experiences of homelessness, leaving little time and capacity to plan for future needs.

Despite their disadvantaged opportunities, the participants were generally optimistic their experiences of health and aging will be more positive in stable housing. Most appeared to recognize the negative implications of homelessness on health and aging, and there was a better chance to maintain health when stably housed. Participants though shared the recognition that their life expectancy was likely to be shorter if they transitioned back into a state of homelessness. Therefore, formerly homeless older people’s opportunities for healthy aging are contingent upon remaining permanently housed, as well as their ability to overcome the ongoing barriers identified throughout the dissertation.
Recommendations for Future Policy

The purpose of this dissertation was to contribute to the academic literature on aging in human geography by exploring the relationship between homelessness, stable housing, and opportunities for healthy aging. The goal was not to offer specific recommendations to improve service delivery for formerly homeless older people. As reviewed in Chapter Two, this was a primary intention of the previous study by McDonald et al. (2006). Based on the research presented in this dissertation, many of the recommendations for public policy parallel those made by McDonald et al. (2006) in the early 2000s. The most important recommendation emerging from this dissertation, and the McDonald et al. (2006) study, is for the creation of more permanent, affordable housing for formerly homeless older people. McDonald et al. (2006) suggest this can be achieved at the federal level of government by continuing to support policies like the National Homelessness Initiative. The federal government must also continue to increase funding and support for affordable housing at the provincial and municipal levels. Housing and social supports should be designed to be age-appropriate, meaning the health outcomes of homelessness like accelerated aging and the long-term psychosocial effects need to be taken into account (McDonald et al., 2006). This dissertation provides additional evidence that housing for formerly homeless people should include supports that address and minimize the impact of their barriers to healthy aging.

In terms of housing options, McDonald et al. (2006) recommended housing be constructed and retrofitted to promote aging-in-place among the formerly homeless population. The research presented in this dissertation, though, draws attention to the challenges of formerly homeless people when aging at home, or in a supportive housing facility. One key finding was

15 The National Homelessness Initiative is still in existence in 2013 and provides funding and support to communities to address the challenge of homelessness. Further information can be found on the Government of Canada website: http://www.hrsdc.gc.ca/eng/communities/homelessness/index.shtml.
that formerly homeless people often become disconnected from social service agencies once they are housed for an extended period of time. However, social service agencies provide important health, social, and financial supports that can help formerly homeless people to remain housed and better afford a healthy lifestyle. In the future, programs and services must be designed to address social isolation among this segment of the older population. For those aging-in-place, programming for home care services must also be adapted to meet the unique needs of older people who are socioeconomically marginalized. For example, the number of publicly-funded hours of home care service should be increased for people who cannot afford privatized care. This will help to lessen the financial burden of aging at home, as well as address barriers such as limited family and social support networks.

Revisiting the recommendations of McDonald et al. (2006) underscores that little has changed with regards to the health status, housing options, and socioeconomic status of the formerly homeless older population over the last five years. McDonald et al. (2006) recommended an increase in income supports for older people who rely on government social assistance and disability benefits. The findings from this study also provide evidence of the important linkages between income and opportunities for healthy aging. In the timeframe since the McDonald et al. (2006) study was conducted, rates of government social assistance benefits in Ontario were increased minimally. In 2011, social assistance rates were increased by one percent, but housing researchers and poverty activists argue this does not equal the cutbacks made during the 1990s. At the present time, social assistance and disability support benefits remain too low for most recipients to afford the cost of housing, even with a government subsidy. In Toronto, this can be seen by the extensive waiting list for social housing with more than 65,000 households actively on the list, and seniors accounting for nearly 30 percent
Since the early 2000s, there has also been some recommitment by the provincial government in Ontario to reinvest in the construction of affordable housing, following nearly two decades of devolving responsibility to the municipal level (Drummond et al., 2004). Housing researchers, however, question whether the amount of construction in Ontario will compensate for the erosion of affordable housing support that occurred throughout the 1980s and 1990s (Drummond et al., 2004). In the Toronto context, the *Housing Opportunities Toronto Action Plan 2010-2020 (HOT)* is an encouraging step forward in recent years. A specific component of the *Action Plan* also intends to address the housing needs of low income and vulnerable groups of seniors and the elderly, including the formerly homeless. At the time of this study, the effectiveness of the *Action Plan* in meeting the needs of such vulnerable segments of the older population remain generally unknown. Additional research is needed into the specific types of supports and mechanisms that can help formerly homeless people to plan for their elderly years. At a service delivery level, such mechanisms and supports could potentially be built directly into the re-housing process. The implementation of *HOT* by City Council in 2010 provides hope that older people with histories of poverty and homelessness are beginning to receive greater consideration in public policies regarding aging, housing, and health. Over the next three decades, it is imperative that policy and programming continue to take into account the diversity of backgrounds, experiences, and financial situations of different segments within the older population.
**Recommendations for Future Academic Research**

Several avenues for future academic research also emerged from this dissertation. First, the findings in Chapters Five and Six offer evidence that stable housing has an improving effect on health over time. A limitation of this study is that it relies on retrospective, self-perception measures of health. In the future, clinical research could help to understand better the mitigating effect that stable housing can have on the negative outcomes of homelessness over time. A longitudinal approach would also be beneficial to track the changes in homeless people’s health throughout the re-housing process and over the years that followed. However, the methodological obstacles to recruiting and retaining participants for a longitudinal study remains an almost insurmountable challenge.

Second, further research is needed to identify and understand the most appropriate housing environment for older people with histories of homelessness. Some attention was given to this issue in the study by McDonald et al. (2006; 2009). Research on housing environments though should be revisited specifically in the theoretical context of promoting healthy experiences of aging. At the present time, formerly homeless older people tend to reside in supportive housing and other congregate living facilities. Yet, questions remain about the ability of staff and resources to meet the complex health needs of residents in their later-elderly years, especially in palliative stages. Additional research is also needed to explore the experiences of formerly homeless people who are aging in traditional long-term care settings.

Third, a limitation of the dissertation is that it does not include the perspectives of formerly homeless older people with symptoms of severe mental illness. A future avenue of research should be to examine experiences of health and aging-in-place among this segment.
of the formerly homeless older population. Shibusawa and Padgett (2009) have done some research on this topic in the U.S. context. Further research is needed in Canada to understand the types of support services that are required and how these can be integrated into housing options. Future research should also determine how such housing might be offered to formerly homeless people with mental illness without returning to previous ideas and models of institutionalization.

Finally, this dissertation has considered the unique types of challenges that formerly homeless people experience when planning for their elderly years. As discussed in Chapter Seven, researchers must explore how supports and mechanisms can be built directly into the re-housing process as a way of helping formerly homeless older people to prepare for their future housing, financial, and care needs. In human geography and other academic literature, greater theorization is needed about the role that Canada’s health and social care systems should play in assisting socioeconomically marginalized persons to prepare for the elderly years.
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Appendix A: Glossary of terms and definitions

**Arthritis:** Arthritis includes rheumatoid arthritis and osteoarthritis, but excludes fibromyalgia. The term 'arthritis' describes many conditions that affect joints, the tissue surrounding joints, and other connective tissue. The most common types are osteoarthritis and rheumatoid arthritis. The resulting pain, stiffness, swelling and/or deformity of the joints can substantially reduce quality of life (Stedman’s Medical Dictionary, 2006).

**Asthma:** An inflammatory disease of the lungs. An acute or chronic disorder characterised bronchi and bronchioles, due in varying degrees to smooth muscle spasm, mucosal edema, and excessive mucus in the lumens of airways. Basic symptoms are dyspnea, wheezing, and cough (Stedman’s Medical Dictionary, 2006).

**Borderline Personality Disorder:** A mental disorder characterized by disturbed and unstable interpersonal relationships and self-imaged, along with impulsive, reckless, and often self-destructive behaviour (Harris and Thackerey, 2003).

**Cataracts:** Complete or partial opacity of the ocular lens (Stedman’s Medical Dictionary, 2006).

**Chronic obstructive pulmonary disease (COPD):** A disease that especially affects people over the age of 45 years with a history of smoking or inhalation of airborne pollution, characterized by airflow obstruction that is not fully reversible. The disease has features of emphysema, chronic bronchitis, and asthmatic bronchitis (Oxford Concise Medical Dictionary, 2012).

**Depression or depressive disorder:** Mental illnesses characterized by a profound and persistent feeling of sadness or despair and/or a loss of interest in things that were once pleasurable. Disturbance in sleep, appetite, and mental processes are a common accompaniment (Harris and Thackerey, 2003).

**Diabetes:** Diabetes occurs when the body does not produce enough insulin, or when the insulin produced is not used effectively. Diabetes may lead to a reduced quality of life as well as complications such as heart disease, stroke and kidney disease (CCHS, 2010).

**Emphysema:** A condition of the lung characterized by increase beyond the normal in the size of air spaces distal to the terminal bronchiole (those parts containing alveoli), with destructive changes in their walls and reduction in their number. Clinical manifestation is breathlessness on exertion, due to the combined effect (in varying degrees) of reduction of alveolar surface for gas exchange and collapse of smaller airways with trapping of alveolar gas in expiration; this causes the chest to be held in the position of inspiration ("barrel chest"), with prolonged expiration and increased residual volume. Symptoms of chronic bronchitis often, but not necessarily, coexist (Stedman’s Medical Journal, 2006).

**Fibromyalgia:** A common syndrome of chronic widespread soft tissue pain accompanied by weakness, fatigue, and sleep disturbances; the cause is unknown (Stedman’s Medical Dictionary, 2006).
**Formerly homeless**: A participant was considered to be *formerly homeless* if they had been living in stable housing for six or more consecutive months at the time of the study.

**Generalized Anxiety Disorder (GAD)**: Characterized by persistent worry that is excessive and that the patient finds hard to control (Harris and Thackerey, 2003).

**Hepatitis**: Inflammation of the liver, due usually to viral infection but sometimes toxic agents. Acute viral hepatitis is characterized by varying degrees of fever, malaise, weakness, nausea, and abdominal distress (Stedman’s Medical Dictionary, 2006).

**High blood pressure**: High blood pressure, also known as hypertension, increases the risk of stroke, heart attack and kidney failure. It can narrow and block arteries, as well as strain and weaken the body's organs (CCHS, 2010).

**HIV/AIDS**: A virus that destroys a subgroup of lymphocytes, the helper T cells, resulting in suppression of the body’s immune response (Oxford Concise Dictionary, 2012).

**Housing Affordability Stress**: A rent-to-income ratio measure is typically used to measure housing affordability stress. In Canada, a household is considered to be experiencing housing affordability stress if they are spending more than 30 percent of their pre-tax income on shelter costs (Hulchanski and Shapcott, 2004).

**Low Income Cut-Offs (LICO)**: is a common measure used by Statistics Canada to determine the incidence of poverty. Low income cut-off points vary depending on household size, and are adjusted annually in relation to the consumer price index (Statistics Canada, 2008). A household spending 70 percent or more of their income on shelter, food, and clothing are considered to be low-income status (Statistics Canada, 2005).

**Migraine**: A familiar, recurrent syndrome characterized usually by unilateral head pain, accompanied by various focal disturbance of the nervous system (Stedman’s Medical Dictionary, 2006).

**Mood disorder**: depression, bipolar disorder, mania or dysthymia (CCHS, 2010).

**Obsessive compulsive disorder (OCD)**: Currently classified as an anxiety disorder marked by the reoccurrence of intrusive or disturbing thoughts, impulses, images or ideas (obsessions) accompanied by repeated attempts to suppress these thoughts through the performance of certain irrational and ritualistic behaviours or mental acts (compulsions) (Harris and Thackerey, 2003).

**Ontario Disability Support Program**: The Ontario Disability Support Program (ODSP) is a government-funded social assistance program in Ontario that helps people with disabilities who are in financial need pay for living expenses like food and housing. (The Ontario Ministry of Community and Social Services, 2012a).

**Ontario Works**: Ontario Works is a government-funded social assistance program in Ontario, which provides financial assistance and job seeking assistance. In 2012, Ontario Works
payments include an amount for basic needs, maximum shelter allowance, and if a recipient has dependent children maximum Ontario Child Benefit (OCB) (Ontario Ministry of Community and Social Services, 2012).

**Perceived physical health:** Perceived health is an indicator of overall health status. It can reflect aspects of health not captured in other measures, such as incipient disease, disease severity, physiological and psychological reserves as well as social and mental function. Perceived health refers to a person's health in general- not only the absence of disease or injury, but also physical, mental and social well-being (CCHS, 2010).

**Perceived mental health:** Population aged 12 and over who reported perceiving their own mental health status as being excellent or very good or fair or poor, depending on the indicator. Perceived mental health refers to the perception of a person's mental health in general. Perceived mental health provides a general indication of the population suffering from some form of mental disorder, mental or emotional problems, or distress, not necessarily reflected in perceived health (CCHS, 2010).

**Perceived life stress:** Population aged 15 and over who reported perceiving that most days in their life were quite a bit or extremely stressful. Perceived life stress refers to the amount of stress in the person's life, on most days, as perceived by the person or, in the case of proxy response, by the person responding. Stress carries several negative health consequences, including heart disease, stroke, high blood pressure, as well as immune and circulatory complications. Exposure to stress can also contribute to behaviours such as smoking, over-consumption of alcohol, and less-healthy eating habits (CCHS, 2010).

**Post-Traumatic Stress Disorder (PTSD):** A complex disorder in which the affected person’s emotional responses, intellectual responses, intellectual processes, and nervous system have all been disrupted by one or more traumatic experiences (Harris and Thackerey, 2003).

**Primary health care:** Primary health care refers to a spectrum of services that play a part in health, including health services, income, housing, education, and environment. Primary care is a component within primary health care that includes health promotion and the prevention, diagnoses, and treatment of illness and injury. Primary care services include direct contact with doctors, nurses practitioners, pharmacists, and telephone advice lines, as well as the integrated movement to more specialized services if required. Other services that are considered primary care include emergency services, referrals to other levels of care, mental health care, palliative care, health promotion, and rehabilitation services (Health Canada, 2013).

**Regular medical doctor:** For many Canadians, the first point of contact for medical care is their doctor. Being without a regular medical doctor is associated with fewer visits to general practitioners or specialists, who can play a role in the early screening and treatment of medical conditions (CCHS, 2010).

**Rent-geared-to-income housing (RGI)**- is subsidized housing. The rent is based directly on the tenant’s income, usually 30 percent of the gross monthly household income. If you receive social assistance, the rent charged are based on the rent benefit set by the Ontario government. RGI
housing subsidies are most often available in publicly-owned social housing, but are also available in co-operative, non-profit and private housing (The City of Toronto, 2012d).

**Rent Supplement:** A rent supplement is a subsidy paid directly to landlords in private, non-profit, co-operative, and privately owned buildings to bridge the gap between the monthly market rent charged for a unit and the rent-geared-to-income portion paid by the tenant (The City of Toronto, 2012d).

**Schizophrenia:** is the most chronic and disabling of the severe mental disorders, associated with abnormal brain structure and function, disorganized speech and behaviour, delusions, and hallucination (Harris and Thackerey, 2003).

**Social housing:** Social housing can also be provided by a rental supplement program, commonly referred to as rent-geared-to-income (RGIs). A rental supplement is typically given to households living in buildings that are owned and operated by private landlords (The City of Toronto, 2012d). A housing allowance program also offers subsidies to households who are in need of financial assistance for a short period of time (The City of Toronto, 2012d).

**Social housing delivery in the City of Toronto:** Currently, the City of Toronto uses a number of approaches to deliver subsidized housing. The majority (63%) of social housing is operated by the Toronto Community Housing Corporation (TCHC), a non-profit corporation owned by the city and governed by a board of directors. The remaining social housing is operated by various co-operative and non-profit community organizations throughout the city (The City of Toronto, 2011a; p.1). For example, social housing can be provided by non-profit corporations like churches, seniors’ organizations, and ethno cultural groups. In some instances, social housing is offered in co-operative buildings with residents serving as board members (The City of Toronto, 2012d). To receive social housing or a subsidy, households must have an active application on Housing Connection’s centralized waiting list (The City of Toronto, 2012d).

**Stable housing:** defined as being housed for six or more consecutive months at the time of the study. This can include any type of permanent housing (either private market or government subsidized), such as a house, an apartment, or a room in a shared house. This also includes supportive housing facilities with private rooms or apartments, long-term care facilities, and retirement homes. Excluded are emergency shelters, hostels, and staying temporarily with family or friends.

**Tuberculosis:** A specific disease caused by infection with Mycobacterium tuberculosis which can infect almost any tissue or organ of the body, the most common site of the disease being the lungs (Stedman’s Medical Dictionary, 2006).

**Ulcer:** A lesion through the skin or a mucous membrane resulting from the loss of tissue, usually with inflammation (Stedman’s Medical Dictionary, 2006).
Appendix B: Spatial distribution of average individual income change in the City of Toronto 1970 to 2005 (Hulchanski et al., 2010)

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(Reproduced with the permission of David J. Hulchanski and colleagues at Cities Centre & Faculty of Social Work, University of Toronto, Neighbourhood Change Community University Research Alliance, and St. Christopher House, www.NeighbourhoodChange.ca.)
Appendix C: Letter of information for gatekeepers

An Exploratory Study of the Relationship Between Homelessness, Health and Aging

Contact: Natalie Waldbrook, PhD candidate
Department of Geography, Queen’s University, Mackintosh-Corry Hall,
Kingston, Ontario K7L 3N6
Telephone: (613) 533-2000 (ext. 75721), email: 7nw8@queensu.ca

Dear Sir or Madam:

I am a PhD candidate in the Department of Geography at Queen’s University in Kingston, Ontario. I am conducting research on formerly homeless, older adults’ experiences with health and aging in the City of Toronto, Ontario. I will be conducting my research beginning in fall 2010 until spring 2012. Please find below a detailed description of my PhD research, tentatively titled “A Study of the Relationship Between Former Homelessness and Health in Older Age”.

Background and Purpose of Research

An aging population in conjunction with the rising levels of poverty and homelessness in western nations since the 1970s, suggests that a growing proportion of the elderly will have experienced homelessness at some point in their lives. The baby-boom generation has lived through various social, spatial and economic transformations that have increased the potential for homelessness. These transformations have included economic and labour restructuring, reductions to social support and housing assistance programs, and the deinstitutionalization of mental health services. In past research, few attempts have been made to understand how older adults feel their earlier housing experiences are affecting their current health and aging. Considering the potential number of baby boomers who may have been homeless during their lifetime, it is important and timely to study the relationship between (un)stable housing histories, health statuses and aging. Given these concerns, the purpose of my PhD research is to understand how homelessness in earlier stages of life can affect health in older age. As the baby-boomers continue to age, it is imperative to determine the unique health and social care needs of different segments within this greying population. Therefore, my research also aims to provide insight into any unique or unmet health and social care needs of formerly homeless, older adults. The findings from my research will be relevant to academics from a wide array of health-related and social science
disciplines, as well as to those responsible for providing health and social care services to the most vulnerable populations in Canada and elsewhere.

**Conducting the Research**

This research will be conducted in two stages: The first stage of research involves a health survey to be completed by formerly homeless adults, aged 45 years and older in the City of Toronto, Ontario. My participants will be considered “formerly homeless” if they were homeless at a previous point in their lives, but have been housed for six or more consecutive months. The survey takes approximately 15 to 20 minutes to complete and asks participants to rate their general health status and identify any current health problems or chronic conditions. The survey will be conducted in-person, at a mutually agreed upon location, such as a meeting room at the agency from which participants were recruited or another agreed upon location (coffee shop, public library meeting room, etc.). The second stage of my research involves an interview of approximately 30 minutes with the same participant. Participants will be given the option to take part in a follow-up interview upon completion of the health survey. The purpose of this semi-structured interview is to ask qualitatively the same group of participants to reflect back on their housing histories, health behaviors, and whether they think their current health status is related to their past homelessness. Follow-up interviews can be conducted on the same day as the health survey or at a more convenient time for the participant. Participants will not be asked for a follow-up interview if they experience any stress, anxiety, or emotional discomfort when filling out the health survey. Interviews will only be conducted between the participant and myself, Natalie Waldbrook.

**Your Role**

I am contacting you to ask if you are aware of any clients who were formerly homeless, but now currently housed. If so, if you would be willing to notify them of my research. I understand the issues regarding confidentially about disclosing your clients’ identity; therefore, I was hoping you could notify your clients of my research and help to facilitate interaction between myself and formerly homeless individuals who demonstrate interest in participating in my research. If you are unaware of your clients’ housing histories, perhaps you would be willing to announce my research via an email list, newsletter, word of mouth, or other form of communication. I am recruiting both men and women over the age of 45 who were homeless at some point during their lives, but who have been housed for six or more months.

**Participants’ Privacy and Confidentiality**

Participation in both the health survey and follow-up interview is strictly voluntary. Participants may choose not to answer any question and may withdraw from the research during either the survey or interview without penalty. By participating in the health survey, individuals are not obligated to participate in the follow-up interview and may choose to withdraw from the research at any stage. If a participant chooses to withdraw from the research, any information they have provided will be destroyed. Their name and identifying information will remain strictly confidential and will be known only to myself, Natalie Waldbrook and my PhD thesis.
supervisor, Dr. Mark Rosenberg. With participants’ consent, the interviews will be audio taped or otherwise, I will take notes. If they choose to withdraw, any information they have provided will be destroyed. Since you may be aware of clients who participated in my research, I ask that you please sign a confidentiality statement to agree that you will not disclose participants’ identity to anyone else. Any information provided by participants in the survey or during the interview will not be available to anyone but myself, Natalie Waldbrook and my thesis supervisor, Dr. Mark Rosenberg. Participants themselves will have the right to review any materials that result from this project. The information gathered during this study will not be used for any purposes other than the objectives of this research. The results of this research may be published in standard academic outlets such as journals, books, and papers for presentation at academic conferences. Names and identifying information will not appear in any written materials, publications, or presentations at academic conferences. The information collected will be retained for seven years in a secure location.

This research project has been reviewed and received ethics approval by the General Research and Ethics Board at Queen’s University. In the event that participants experience any emotional distress when talking about your health and past homelessness while participating in this research or afterwards, I will provide contact information and a list of counseling services to be accessed, such as the toll-free number for Mental Health Service Information Ontario (MSHIO). The MSHIO provides free, confidential information about mental health services and supports in any community across Ontario, 24 hours/day.

Questions?
If you have any questions regarding this study, or would like additional information, please contact myself, Natalie Waldbrook at 613-876-6814 or 7nw8@queensu.ca. You may also contact my Ph.D. thesis supervisor, Dr. Mark Rosenberg at (613) 533-6046 or via email at mark.rosenberg@queensu.ca. If you have any questions or concerns resulting from your participation in this study, you may also contact the Chair of the General Research and Ethics Board, Dr. Joan Stevenson, telephone 613-533-6081 or email chair.GREB@queensu.ca. Thank you.

Sincerely,

Natalie Waldbrook, PhD candidate.
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e-mail 7nw8@queensu.ca
website http://geog.queensu.ca/grads/waldbrook.asp
Letter of Information for Participants

An Exploratory Study of the Relationship Between Homelessness, Health and Aging

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Telephone: (613) 533-2000 (ext. 75721), email: 7nw8@queensu.ca

Dear Sir or Madam:

My name is Natalie Waldbrook and I am a PhD student in the Department of Geography at Queen’s University in Kingston, Ontario. This letter is an invitation to participate in my PhD research, titled “A Study of the Relationship between Former Homelessness and Health in Older Age”.

Background and Purpose of Research

An aging population in conjunction with the rising levels of poverty and homelessness in Canada since the 1970s, suggests that a growing proportion of older adults will have experienced homelessness at some point in their lives. Considering the potential number of older adults who may have been homeless during their lifetime, it is important and timely to study the relationship between housing histories, health, and aging. Given these concerns, the purpose of my PhD research is to understand how homelessness in earlier stages of life can affect health in older age. As the baby-boomers continue to age, it is imperative to determine the unique health and social care needs of different segments within this greying population. Therefore, my research also aims to provide insight into any unique or unmet health and social care needs of formerly homeless, older adults. The findings from my research will be relevant to academics from a wide array of health-related and social science disciplines, as well as to those responsible for providing health and social care services to older adults in Canada and elsewhere.

Your Participation

My research will be conducted in two different stages. The first stage of research involves a health survey to be completed by formerly homeless adults, aged 45 years or older living in the City of Toronto, Ontario. I am asking individuals who were once homeless, but now living in their own housing for at least six months to fill out a confidential health survey. If you agree to participate, you will be asked to meet myself, Natalie Waldbrook at an agreed upon time and location to complete the survey in-person, such as at the agency that contacted you about my
research or another agreed upon location (coffee shop, public library meeting room, etc.). The survey takes approximately 15 to 20 minutes to complete and asks you to rate your general health status and identify any current health problems or conditions. The second stage of my research involves a follow-up interview. The interview will last approximately 30 minutes and will only be conducted with you and myself, Natalie Waldbrook. I will ask you questions about your experiences with being homeless earlier in your life, how you feel this has affected your current health, and feelings about your current health care needs. Follow-up interviews can be conducted on the same day as the health survey or at a more convenient time for you. If you would like to meet at another time, you may be asked to provide a telephone number or other contact information to be used only for the purpose of scheduling an interview.

Your Privacy and Confidentiality

Your participation in both the health survey and follow-up interview is strictly voluntary. You may choose not to answer any question and you may withdraw from the research during either the survey or interview without penalty. By participating in the health survey, you are not obligated to participate in the follow-up interview and may choose to withdraw from the research at any stage. If you choose to withdraw, any information you have provided will be destroyed. Your name and any identifying information will remain strictly confidential and will be known only to myself, Natalie Waldbrook and my thesis supervisor, Dr. Mark Rosenberg. If you were informed of my research by someone other than myself, such as a worker or volunteer at a health centre or social service agency, that person may be aware that you participated in my research; however, that individual will be required to sign a confidentiality agreement to agree not to disclose your name or inform anyone else that you participated in this study. With your consent, the interview will be audio taped to document the conversation and will be transcribed at a later date. If you choose not to be audio taped, then notes will be taken by the interviewer. You will have the right to review any materials that result from this project. The information gathered during this study will not be used for any purposes other than the objectives of this research. The results of this research may be published in standard academic outlets such as journals, books, and papers for presentation at academic conferences. Your name will not appear in any written materials, publications or presentations that result from this project. The information collected will be retained for seven years in a secure location.

This research project has been reviewed and received ethics approval by the General Research and Ethics Board at Queen’s University. In the event that you experience any emotional distress when talking about your health and past homelessness while participating in this research or afterwards, I will provide contact information and a list of counseling services to be accessed, such as the toll-free number for Mental Health Service Information Ontario (MSHIO). MSHIO provides free, confidential information about mental health services and supports in any community across Ontario, 24 hours/day.

Questions?
If you have any questions regarding this study, or would like additional information, please contact myself, Natalie Waldbrook at 613-876-6814 or email 7nw8@queensu.ca. You may also contact my PhD thesis supervisor, Dr. Mark Rosenberg at (613) 533-6046 or via email at mark.rosenberg@queensu.ca. If you have any questions or concerns resulting from your
participation in this study, you may also contact the Chair of the General Research and Ethics Board, Dr. Joan Stevenson, telephone 613-533-6081 or email chair.GREB@queensu.ca. Thank you.

Sincerely,

Natalie Waldbrook, PhD candidate.  tel. 613-876-6814
Queen's University e-mail 7nw8@queensu.ca
Department of Geography website
Kingston, Ontario, Canada, K7L 3N6 http://geog.queensu.ca/grads/waldbrook.asp
Appendix D: Participant recruitment poster

FORMERLY HOMELESS OLDER ADULTS
Health Study
LOOKING FOR PARTICIPANTS

Who? Anyone 45 years & older, who were once homeless in their lives

Why? To talk about how you feel being homeless has affected your health & aging

Involves a completely confidential 15-20 minute survey & 30-45 min. follow-up interview

Where? At a mutually-agreed upon time & location in Toronto area (including Scarborough & North York)

Detailed information can be provided at this organization & call Natalie Waldbrook, PhD candidate at Queen’s University 613-876-6814 or email 7nw8@queensu.ca

This research has been approved by the Queen’s University Research & Ethics Board
Appendix E: Queen’s University’s General Research and Ethics Board approval letter

December 6, 2010

Ms. Natalie Waldbrook
Ph.D. Candidate
Department of Geography
Queen’s University

Dear Ms. Waldbrook:

GREB Ref #: G GEO-116-10
Title: “An Exploratory Study of the Relationship Between Unstable Housing Histories and Health in Older Age”

The General Research Ethics Board (GREB), by means of a delegated board review, has cleared your proposal entitled “An Exploratory Study of the Relationship Between Unstable Housing Histories and Health in Older Age” for ethical compliance with the Tri-Council Guidelines (TCPS) and Queen’s ethics policies. In accordance with the Tri-Council Guidelines (article D.1.6) and Senate Terms of Reference (article G), your project has been cleared for one year. At the end of each year, the GREB will ask if your project has been completed and if not, what changes have occurred or will occur in the next year.

You are reminded of your obligation to advise the GREB, with a copy to your unit REB, if applicable, of any adverse event(s) that occur during this one year period (details available on webpage http://www.queensu.ca/ors/researchethics/GeneralREB/forms.html - Adverse Event Report Form). An adverse event includes, but is not limited to, a complaint, a change or unexpected event that alters the level of risk for the researcher or participants or situation that requires a substantial change in approach to a participant(s). You are also advised that all adverse events must be reported to the GREB within 48 hours.

You are also reminded that all changes that might affect human participants must be cleared by the GREB. For example you must report changes in study procedures or implementations of new aspects into the study procedures on the Ethics Change Form that can be found at http://www.queensu.ca/ors/researchethics/GeneralREB/forms.html - Research Ethics Change Form. These changes must be sent to the Ethics Coordinator, Gail Irving, at the Office of Research Services or irvingg@queensu.ca prior to implementation. Mrs. Irving will forward your request for protocol changes to the appropriate GREB reviewers and / or the GREB Chair.

On behalf of the General Research Ethics Board, I wish you continued success in your research.

Yours sincerely,

Joan Stevenson, PhD
Professor and Chair
General Research Ethics Board

e.c.: Dr. Mark Rosenberg, Faculty Supervisor
Dr. Ann Godlewka / Dr. John Holmes, Co-Chairs, Unit REB
Joan Knox, Dept. Admin.

JS/gi
Appendix F: Health questionnaire

An Exploratory Study of the Relationship Between Homelessness, Health and Aging

HEALTH QUESTIONNAIRE

General Health Questions
First, I want to ask you some questions about your overall health. By health, I mean not only the absence of disease or injury but also physical, mental and social well-being.

GEN__01
In general, would you say your health is:
1__ Excellent
2__ Very good
3__ Good
4__ Fair
5__ Poor

GEN_ 02
Compared to one year ago, how would you say your health is now? Is it:
1__ Much better now (than 1 year ago)
2__ Somewhat better now (than 1 year ago)
3__ About the same (as 1 year ago)
4__ Somewhat worse now (than 1 year ago)
5__ Much worse now (than 1 year ago)

GEN_ 03
How satisfied are you with your life in general?
1__ Very satisfied
2__ Satisfied
3__ Neither satisfied nor dissatisfied
4__ Dissatisfied
5__ Very dissatisfied

GEN _04
In general, would you say your mental health is?
1__ Excellent
2__ Very good
3__ Good
4__ Fair
5. Poor

GEN_04a
Have you ever been homeless?
1. Yes
2. No
3. Don’t know
4. Refuse

GEN_05
Do you have any mental health conditions?
1. Yes
2. No
3. Don’t know
4. Refuse

GEN_05a
If you answered yes to previous question, please specify your mental health condition:

GEN_05b
Do you have any difficulties remembering past events in your life, such as your experiences while you were homeless?
1. Yes
2. A bit of difficulty sometimes
3. No
4. Never

GEN_05c
Did you have this mental health condition prior to becoming homeless?
1. Yes
2. No
3. Don’t know
4. Refuse

GEN_06
Thinking about the amount of stress in your life, would you say that most days are:
1. Not at all stressful
2. Not very stressful
3. A bit stressful
4. Quite a bit stressful
5. Extremely stressful

GEN_07
How would you describe your sense of belonging to your local community? Would you say it is:
1. Very strong
2. Somewhat strong
3. Somewhat weak
4. Very weak

GEN_08
What type of housing do you currently living in?
1. Apartment, living alone
2. Apartment, living with family or friends
3. Apartment, living with roommates
4. Supportive or transition housing
5. Shelter
6. House, living alone
7. House, living with family or friends
8. House, living with roommates
9. Other, please specify:

__________________________.
GEN_ 09
How long since you were last homeless? ______________________________________________

GEN_ 10
How many times in total have you been homeless in your life?
________________________________

GEN_ 11
Do you recall how long you were homeless for each of these times?
_________________________________________________________________________________

GEN_ 12
Do you recall the different ages at which you were homeless? (Please include your age when you were homeless for the first time)
_________________________________________________________________________________

Chronic Conditions
Now I would like to ask questions about certain chronic health conditions which you may have. I am interested in “long-term” conditions which are expected to last or have already lasted 6 months or more and that have been diagnosed by a health professional.

Do you have:
CC_01 Food allergies?
1__ Yes
2__ No
3__ Don’t know
4__ Refuse

CC_02 Any other allergies?
1__ Yes
2__ No
3__ Don’t know
4__ Refuse

CC_03 Asthma?
1__ Yes
2__ No
3__ Don’t know
4__ Refuse

CC_04 Do you have fibromyalgia?
1__ Yes
2__ No
CC_05
Do you have arthritis?
1__ Yes
2__ No
3 __ Don’t know
4__ Refuse

CC_06
If you answered yes to the previous question, what kind of arthritis do you have?
1__ Rheumatoid arthritis
2__ Osteoarthritis
3__ Rheumatism
4__ Other? (specify): ___________

CC_07
Do you have back problems, excluding fibromyalgia and arthritis?
1__ Yes
2__ No
3 __ Don’t know
4__ Refuse

CC_08
Do you have high blood pressure?
1__ Yes
2__ No
3 __ Don’t know
4__ Refuse

CC_09
Have you ever been diagnosed with high blood pressure?
1__ Yes
2__ No
3 __ Don’t know
4__ Refuse

CC_10
If you answered yes to the previous question, have you taken any medicine for high blood pressure in the last year?
1__ Yes
2__ No
3 __ Don’t know
4__ Refuse
CC_11
In the past month did you do anything else, recommended by a health professional, to reduce or control your blood pressure?
1__ Yes
2__ No
3__ Don’t know
4__ Refuse

CC_12
If you answered yes to the previous question, what did you do?:
1__ Changed diet (e.g., reduced salt intake)?
2__ Exercised more?
3__ Reduced alcohol intake?
4__ Other? (please specify):________________

CC_13
Do you have migraine headaches?
1__ Yes
2__ No
3__ Don’t know
4__ Refuse

CC_14
Chronic bronchitis?
1__ Yes
2__ No
3__ Don’t know
4__ Refuse

CC_15
Emphysema?
1__ Yes
2__ No
3__ Don’t know
4__ Refuse

CC_16
Chronic obstructive pulmonary disease (COPD)?
1__ Yes
2__ No
3__ Don’t know
4__ Refuse

CC_17
Diabetes?
1__ Yes
2__ No
3__ Don’t know
4__ Refuse
CC_17b
If you have diabetes, are you currently taking insulin to control your blood sugar?
1__ Yes
2__ No
3 __ Don’t know
4 __ Refuse

CC_17c
If you have diabetes, are you currently taking pills to control your blood sugar?
1__ Yes
2__ No
3 __ Don’t know
4 __ Refuse

CC_18
Do you have epilepsy?
1__ Yes
2__ No
3 __ Don’t know
4 __ Refuse

CC_19
Heart disease?
1__ Yes
2__ No
3 __ Don’t know
4 __ Refuse

CC_20
Cancer?
1__ Yes
2__ No
3 __ Don’t know
4 __ Refuse

CC_21
Have you ever been diagnosed with cancer?
1__ Yes
2__ No
3 __ Don’t know
4 __ Refuse

CC_22
If you answered yes to the previous question, what type of cancer did or do you have? Indicate all that apply:
1__ Breast
2__ Colorectal
3 __ Skin- Melanoma
4__ Skin- Non-melanoma
5__ Prostate
6__ Other (specify) ________________

Do you have intestinal or stomach ulcers?
1__ Yes
2__ No
3 __ Don’t know
4__ Refuse

Have you ever had a stroke?
1__ Yes
2__ No
3 __ Don’t know
4__ Refuse

Do you suffer from a bowel disorder?
1__ Yes
2__ No
3 __ Don’t know
4__ Refuse

If you answered yes to the previous question, what type of bowel disorder do you suffer from? Indicate all that apply.
1__ Crohn’s Disease
2__ Ulcerative colitis
3__ Irritable Bowel Syndrome
4__ Other (specify)______________

Do you have Alzheimer’s Disease or any other dementia?
1__ Yes
2__ No
3 __ Don’t know
4__ Refuse

Cataracts?
1__ Yes
2__ No
3 __ Don’t know
4__ Refuse

Glaucoma?
1__ Yes
2__ No
3 __ Don’t know
4__ Refuse

CC_30
A thyroid condition?
1__ Yes
2__ No
3 __ Don’t know
4__ Refuse

CC_31
Chronic fatigue syndrome?
1__ Yes
2__ No
3 __ Don’t know
4__ Refuse

CC_32
Do you have autism or any other developmental disorder?
1__ Yes
2__ No
3 __ Don’t know
4__ Refuse

CC_33
If you answered yes to the previous question, what kind of developmental disorder do you have?
1__ Down’s syndrome
2__ Asperger’s syndrome
3__ Rett syndrome
4__ Other (specify)________________

CC_34
Do you have a learning disability?
1___Yes
2___ No
3____ Don’t Know
4____ Refuse

CC_34a
If you answered yes to the previous question, what type of learning disability do you have?
1__ Attention Deficit Disorder (ADD)
2__ Attention Deficit Hyperactivity Disorder (ADHD)
3__ Dyslexia
4__ Other (specify)_______________
CC_35
Do you have an eating disorder, such as anorexia or bulimia?
1__ Yes
2__ No
3 __ Don’t know
4__ Refuse

CC_36
Do you have a mood disorder?
1__ Yes
2__ No
3 __ Don’t know
4__ Refuse

CC_37
Do you have an anxiety disorder?
1__ Yes
2__ No
3 __ Don’t know
4__ Refuse

CC_38
Do you have Hepatitis?
1__ Yes
2 __ No
3 __ Don’t know
4__ Refuse

CC_38a
If you answered yes to the previous question, what type of Hepatitis do you have?
1__ Hepatitis A
2__ Hepatitis B
3 __ Hepatitis C

CC_39
Do you suffer from obesity?
1__ Yes
2 __ No
3 __ Don’t know
4__ Refuse

CC_40
Do you suffer from chronic skin ailments?
1__ Yes
2__ No
3 __ Don’t know
4 __ Refuse
CC_41
Do you have chronic foot sores?
1__ Yes
2__ No
3 __ Don’t know
4__ Refuse

CC_42
Do you have HIV or AIDS?
1__ Yes
2__ No
3 __ Don’t know
4__ Refuse

CC_43  Do you have trouble with your teeth or gums?
1__ Yes
2__ No
3 __ Don’t know
4__ Refuse

CC_44
Do you have trouble with your vision?
1__ Yes
2__ No
3 __ Don’t know
4__ Refuse

CC_45
Do you have trouble with your hearing?
1__ Yes
2__ No
3 __ Don’t know
4__ Refuse

CC_46
Do you have any other health condition that has been diagnosed by a health professional?
1__ Yes, please specify: _______________________
2__ No
3 __ Don’t know
4__ Refuse
Socio-Demographic Characteristics- Now, I am going to ask you some background questions and remember that you do not have to answer any question that makes you feel uncomfortable.

SDC_01 What is your gender?
1 __ Male
2 __ Female
3 __ Other
4 __ Refuse

SDC_02
Which age category do you belong to?
1 __ 45 to 50
2 __ 51 to 55
3 __ 56 to 60
4 __ 61 to 65
5 __ 66 to 70
6 __ 71 to 75
7 __ 76 to 80
8 __ 81 to 85
9 __ 85 and older

SDC_03
What is your marital status?
1 __ Single
2 __ Married / common law
3 __ Separated / divorced
4 __ Widow(er)
5 __ Same sex partnership
6 __ Don't know
7 __ Refuse

SDC_04
In what country were born?
1 __ Canada
2 __ China
3 __ France
4 __ Germany
5 __ Greece
6 __ Guyana
7 __ Hong Kong
8 __ Hungary
9 __ India
10 __ Italy
11 __ Jamaica
12 __ Philippines
13 __ Netherlands/Holland
14 __ Poland
15 __ Portugal
16 __ United Kingdom
17 __ United States
18 __ Viet Nam
19 __ Sri Lanka
20 __ Grenada
21 __ Other
(specify): ____________________

SDC_05
People living in Canada come from many different cultural and racial backgrounds. What cultural or racial background do you identify with:
1 __ White
2 __ Chinese
3 __ South Asian (e.g., East Indian, Pakistani, Sri Lankan)?
4 __ Black
5 __ Filipino
6 __ Latin American
7 __ Southeast Asian (e.g., Cambodian, Indonesian, Laotian, Vietnamese)
8 __ Arab
9 __ West Asian (e.g. Afghan, Iranian)
10 __ Japanese
11 __ Korean
12 __ Other (please specify):
(specify): ____________________

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Did you graduate from high school?
1.__ Yes
2.__ No
3.__ Don’t know
4.__ Refuse

Have you received any other education that could be counted towards a degree, certificate or diploma from an educational institution?
1.__ Yes
2.__ No
3.__ Don’t know
4.__ Refuse

What is the highest degree, certificate or diploma you have obtained?
1.__ No post-secondary degree, certificate or diploma
2.__ Trade cert. or diploma from a vocational school or apprenticeship training
3.__ Non-university cert. or diploma from a community college, CEGEP, school of nursing, etc
4.__ University cert. from below bachelor’s level
5.__ University degree or certificate above bachelor’s level

What is/was your main occupation or vocation?
1.__ agriculture
2.__ business
3.__ education
4.__ industry
5.__ homemaker
6.__ self-employed
7.__ skilled trade
8.__ civil service
9.__ health care
10.__ unemployed
11.__ other, please specify ___________

From which of the following sources did you (and your family) receive any income during the last year?
1.__ Paid full-time employment
2.__ Paid part-time employment
3.__ Income from self-employment
4.__ Ontario Works
5.__ Employment Insurance
6.__ Benefits from the Canadian Pension Plan
7.__ Old Age Security
8.__ Ontario Disability Support Program
9.__ Long-term Disability
10.__ Retirement pensions
11.__ Other (Please specify) ___________
12.__ Don’t know
13.__ Refuse

Which household income category do you belong to?
1.__ Less than $10,000
2.__ $10,000 to less than $20,000
3.__ $20,000 to less than $30,000
4.__ $30,000 to less than $40,000
5.__ $40,000 to less than $50,000
6.__ $50,000 to less than $60,000
7.__ $60,000 to less than $80,000
8.__ $80,000 to less than $100,000
9.__ $100,000 to less than $150,000
10.__ $150,000 to less than $200,000
11.__ $200,000 or more
12.__ Don’t know
13.__ Refuse
Thank you for participating in my survey, would you be willing to participate in a follow-up interview about your housing history?

1__ Yes
2__ No
3__ Decline

Do you know of anyone else who has also been homeless who would be willing to participate in my research?

Thank you for participating in my research
Appendix G: Consent form for survey participants

An Exploratory Study of the Relationship Between Homelessness, Health and Aging

Contact: Natalie Waldbrook, PhD candidate
Department of Geography, Queen’s University, Mackintosh-Corry Hall, Kingston, Ontario K7L 3N6
Telephone: (613) 533-2000 (ext. 75721), email: 7nw8@queensu.ca

CONSENT FORM FOR SURVEY

I have read the information presented in the information letter regarding the project “An Exploratory Study of the Relationship Between Unstable Housing Histories and Health in Older Age”, being conducted by PhD candidate, Natalie Waldbrook and supervised by Dr. Mark Rosenberg of the Department of Geography at Queen’s University. I have had the opportunity to ask any questions related to this study and have received satisfactory answers to my questions and to any additional concerns.

I understand that I am meeting with Natalie Waldbrook to fill out a survey about my current health at an agreed upon time and location. I am aware that my participation in this research is strictly voluntary. I understand that I may be contacted for a follow-up interview after filling out the survey, but I am not obligated to participate in an interview at a later date. I was informed that I may withdraw my consent at any time without penalty and any information I have given will be destroyed upon my withdrawal. I am aware that I can choose not to answer any question and any information I provide will remain confidential. I understand that if I was contacted by someone other than the researcher to participate, such as a worker or volunteer from a health centre or social care agency, that person may be aware that I participated in this project; however, they will be required to sign a confidentiality statement about contacting me to participate and will not have access to any information I provide. I understand that only Natalie Waldbrook and her thesis supervisor, Dr. Mark Rosenberg will be able to match the information I provide to my identity.

I understand that the information gathered during this study will not be used for any purposes other than the objectives of this research. I understand that the information collected will be retained by Natalie Waldbrook for seven years in a secure location. This research project has been reviewed and received ethics approval by the General Research and Ethics Board at Queen’s University. I have been provided with contact information and a list of counseling services.
services to be accessed in the City of Toronto if I experience any distress, anxiety or emotional
distress when talking about my health and past homelessness or afterwards. I understand that
this information includes the toll-free number for Mental Health Service Information Ontario
(MHSIO), which provides free, confidential information about mental health services and
supports in any community across Ontario (24 hours a day), as well as contact information for
the Gerstein Centre, and numbers for hostel and housing services in the City of Toronto. I am
aware that I can contact the researcher, Natalie Waldbrook at Queen’s University, Kingston,
Ontario by telephone at 613-533-6000 (extension 75721) or email 7nw8@queensu.ca. I can also
contact Natalie’s Ph.D. supervisor, Dr. Mark Rosenberg at Queen’s University, Kingston,
Ontario by telephone at 613-533-6046 or email at mark.rosenberg@queensu.ca. I was informed that
if I have any comments or concerns resulting from my participation in this study, I may contact
the Chair of the General Research and Ethics Board, Dr. Joan Stevenson, telephone 613-533-
6081 or email chair.GREB@queensu.ca.

I agree to participate in the survey:
☐YES  ☐NO

I would like to participate in a follow-up interview
☐YES  ☐NO

I would like to participate in the follow-up interview
☐TODAY  ☐AT A LATER DATE

I would like to meet _____________ at ___________ at __________________
(date)  (time)  (location)

OR Telephone number and/or email address  where I can be reached to schedule an interview?
__________________________________________________________________________

Participant’s Name: ___________________________ (Please print)

Participant’s Signature: __________________________

Researcher’s Name: ___________________________ (Please print)

Researcher’s Signature: __________________________

Date: __________________________
Appendix H: Consent form for interview

An Exploratory Study of the Relationship Between Homelessness, Health, and Aging

Contact: Natalie Waldbrook, PhD candidate
Department of Geography, Queen’s University, Mackintosh-Corry Hall,
Kingston, Ontario K7L 3N6
Telephone: (613) 533-2000 (ext. 75721), email: 7nw8@queensu.ca

CONSENT FORM FOR INTERVIEW

I have read the information presented in the information letter regarding the project “An Exploratory Study of the Relationship Between Unstable Housing Histories and Health in Older Age”, being conducted by PhD candidate, Natalie Waldbrook and supervised by Dr. Mark Rosenberg of the Department of Geography at Queen’s University. I have had the opportunity to ask any questions related to this study and have received satisfactory answers to my questions and to any addition concerns.

I understand that I am meeting with Natalie Waldbrook at an agreed upon time and location to participate in a follow-up interview to my health survey. I am aware that my participation in this research is strictly voluntary. I was informed that I may withdraw my consent any time without penalty and any information I provided in the health survey or during my interview will be destroyed upon my withdrawal. I am aware that I can choose not to answer any question and any information I provide will remain confidential. I understand that my name and any other identifying information will not appear in any materials resulting from this study. I understand that if I was contacted by someone other than the researcher to participate, such as a worker or volunteer from a health centre or social care agency, that person may be aware that I participated in this project; however, they will be required to sign a confidentiality statement about contacting me to participate and will not have access to any information I provide. I understand that only Natalie Waldbrook and her thesis supervisor, Dr. Mark Rosenberg will be able to match the information I provide to my identity.

I understand that the information gathered during this study will not be used for any purposes other than the objectives of this research. I understand that the information collected will be retained by Natalie Waldbrook for seven years in a secure location. This research project has been reviewed and received ethics approval by the General Research and Ethics Board at Queen’s University. I have been provided with contact information and a list of counseling services to be accessed in the City of Toronto if I experience any distress, anxiety or emotional
distress when talking about my health and past homelessness or afterwards. I understand that this information includes the toll-free number for Mental Health Service Information Ontario (MHSIO), which provides free, confidential information about mental health services and supports in any community across Ontario (24 hours a day), as well as contact information for the Gerstein Centre, and numbers for hostel and housing services in the City of Toronto. I am aware that I can contact the researcher, Natalie Waldbrook at Queen’s University, Kingston, Ontario by telephone at 613-533-6000 (extension 75721) or email 7nw8@queensu.ca. I can also contact Natalie’s Ph.D. supervisor, Dr. Mark Rosenberg at Queen’s University, Kingston, Ontario by telephone at 613-533-6046 or email at mark.rosenberg@queensu.ca. I was informed that if I have any comments or concerns resulting from my participation in this study, I may contact the Chair of the General Research and Ethics Board, Dr. Joan Stevenson, telephone 613-533-6081 or email chair.GREB@queensu.ca.

I agree to participate in this follow-up interview:
☐ YES  ☐ NO

I consent to having my interview audio taped:
☐ YES  ☐ NO

Participant’s Name: ____________________________ (Please print)

Participant’s Signature: ____________________________

Researcher’s Name: ____________________________ (Please print)

Researcher’s Signature: ____________________________

Date: ____________________________
Appendix I: Interview guide

An Exploratory Study of the Relationship Between Homelessness, Health, and Aging

Contact: Natalie Waldbrook, PhD candidate
Department of Geography, Queen’s University, Mackintosh-Corry Hall,
Kingston, Ontario K7L 3N6
Telephone: (613) 533-2000 (ext. 75721), email: 7nw8@queensu.ca

Reflecting on Housing History

I want to begin by asking you some questions about your housing history and homelessness. Please remember that you do not have to answer any questions that make you uncomfortable. (This section will be audio taped with proper consent).

Hous_His_01
What is your current housing situation. Please explain.

Examples of living situation:
1___ Living with spouse or partner
2___ Living with your children
3___ Living with your parents
4___ Living with other family member
   (please specify)__________________.
5___ Living with someone other than family
   (please specify)__________________.
6___ Living alone
7___ Don't know
8___ Refuse
9___ Other (please explain) ____________.

Hous_His_02
What type of dwelling do you live in?

1___ Single-detached
2___ Double
3___ Row or terrace
4___ Duplex
5___ Low-rise apartment of fewer than 5 stories or a flat
6___ High-rise apartment of 5 or more stories
7___ Institution
8___ Mobile home
9___ Other (please specify)__________________.
Hous_His_03
Is your home:
1___ Owned
2___ Owned by a member of the household
3___ Rented
4___ Rented combined with a housing subsidy
5___ Other
(please specify)__________________.

Hous_His_04
Have you ever owned your own home?
1__ Yes
2__ No
3__ Don’t know
4__ Refuse

Hous_His_05
Were you ever homeless?
1__ Yes
2__ No
3__ Don’t know
4__ Reject

Hous_His_05
How long since your last episode of homelessness? How long since you moved back into stable housing? Please explain.

Hous_His_06
Can you remember the first time you became homeless? Please explain.

Hous_His_07
Do you recall how many times have you been homeless in your life?

___|___|___ Number of times homeless. Please explain.

Hous_His_08
Do you remember how long you were homeless each time? Please explain.

Hous_His_09
How many years have you lived in Toronto (Kingston in pilot study)?

___|___|___ Please explain.

Hous_His_10
Where you ever homeless in another city than Toronto? Please explain.
Hous_His_11
If yes, do you recall the other towns or cities where you have been homeless? Please explain.

Hous_His_12
Can you tell me about your life when you were homeless?

Hous_His_13
Where did you typically sleep/stay while you were homeless? Please explain.

Hous_His_14
What events or factors led to you becoming homeless?

Hous_His_15
What types of strategies did you use to secure housing and resolve your homeless situation(s)?

Hous_His_16
Was a social service agency involved in helping you to find housing?

Hous_His_17
Is there anything else you would like me to know?

Questions about Health Behaviours
Now I want to ask you some questions about your health and behaviours, such as smoking and drinking.

Heal_beh_02
Do you smoke?
1. Yes
2. No
3. Don’t know
4. Reject

If answered yes to previous question:

Heal_beh_03
Would you say you smoke_____?

1. Daily
2. Occasionally
3. Rarely
4. Other (please specify).

Heal_beh_04
How long have you smoked for?

[ ] [ ] [ ]
Heal_beh_06
Do recall at what age you smoked your first whole cigarette?

If participant is not a smoker:

Heal_beh_07
Have you ever smoked cigarettes daily?  Please explain.

Heal_beh_08
Have you ever smoked cigarettes occasionally?

Heal_beh_09
If a previous smoker, do you recall how many years ago you quit smoking cigarettes?

Heal_beh_10
In the last 12 months, have you had a drink of beer, wine, liquor or any other alcoholic beverage?

Heal_beh_11
How often do you drink alcoholic beverages?

1__ Less than once a month
2__ Once a month
3__ 2 to 3 times a month
4__ Once a week
5__ 2 to 3 times a week
6__ 4 to 6 times a week
7__ Everyday

Heal_beh_12
If you do not presently drink alcohol, did you ever?

1__ Yes
2__ No
3__ Don’t know
4__ Reject

Heal_beh_13
Did you ever regularly drink more than 12 drinks a week?

1__ Yes
2__ No
3__ Don’t know
4__ Reject
Heal_beh_15
Have you ever used or tried illegal drugs?
1__ Yes
2__ No
3__ Don’t know
4__ Reject

Heal_beh_16
What types of drugs have you used or tried?

Heal_beh_17
How often did you use illegal drugs in the past 12 months?
1__ Less than once a month
2__ Once a month
3__ 2 to 3 times a month
4__ Once a week
5__ 2 to 3 times a week
6__ 4 to 6 times a week
7__ Everyday

Heal_beh_18
If you do not presently use drugs, did you ever?
1__ Yes
2__ No
3__ Don’t know
4__ Reject

Heal_beh_19
When you were using drugs, do you recall how often you took drugs? Please explain.

Heal_beh_20
Do you recall how old you were when you started taking drugs? Please explain.

Heal_beh_21
Do you recall how many years you used drugs for? Please explain.

Experiences of current health and aging.
Now I want to ask you some questions about how you think your past homelessness is affecting your current health.

Cur_Hlth_1
Would you say that you are in better, the same, or worse health today than while you were homeless? Please explain.
Cur_Hlth_2
How would you describe your physical health like before you were homeless?

Cur_Hlth_3
How would you describe your mental health like before you were homeless?

Cur_Hlth_4
How would you describe your physical health like while you were homeless?

Cur_Hlth_4
How would you describe your mental health like while you were rehoused?

Cur_Hlth_5
How would you describe your health been like since you were rehoused?

Cur_Hlth_6
Do you think your health has improved since you became housed? Please explain.

Cur_Hlth_7
Do you think your current health is affected by your past experiences with homelessness?

Cur_Hlth_8
How do you think homelessness has affected your physical health today?

Cur_Hlth_9
How do you think homelessness has affected your mental health today?

Cur_Hlth_10
How do you think your past experiences with homelessness will affect your health as you continue to age?

Cur_Hlth_11
How would you described your experiences with growing older so far?

Cur_Hlth_12
What are you biggest health concerns right now?

Cur_Hlth_13
Do you have any health or social care needs that are not currently being met? Please explain what these unmet needs are.

Cur_Hlth_14
Is there anything else you would like me to know?

Thank you for participating in my research
Appendix J: List of counseling services for participants

An Exploratory Study of the Relationship Between Homelessness, Health, and Aging

Contact: Natalie Waldbrook, PhD candidate
Department of Geography, Queen’s University, Mackintosh-Corry Hall,
Kingston, Ontario K7L 3N6
Telephone: (613) 533-2000 (ext. 75721), email: 7nw8@queensu.ca

List of Counseling Services for Participants
If you experience any distress, anxiety or other emotional discomfort and would like someone to speak to, please contact:

Mental Health Service Information Ontario (MHSIO): The MHSIO can provide you with information about mental health services and supports in any community and across Ontario. This service is free, confidential and 24 hours.

Telephone: 1-866-531-2600
Website: http://www.mhsio.on.ca/

The Gerstein Centre: The Gerstein Centre provides crisis intervention to adults, living in the City of Toronto, who experience mental health problems. The Centre provides supportive counseling for immediate, crisis issues and referrals to other services for on-going, non-crisis issues. Our service is a community mental health service and is non-medical. Crisis calls of a medical nature (psychiatric assessment, severe self-harm or suicide attempts) are referred to a hospital. The service has three aspects, telephone support, community visits and a ten-bed, short-stay residence. The Gerstein Centre is located in downtown Toronto, at 100 Charles Street East, (at Jarvis Street), a few blocks from the TTC Subway and the downtown core.

Crisis Line: (416) 929-5200
Referrals Only: (416) 929-9897
Residents' Line: (416) 929-1117
E-mail: admin@gersteincentre.org
Gerstein on Bloor is located in downtown Toronto, at 1045 Bloor Street West, between Dufferin and Dovercourt.

Do you need emergency shelter? The City of Toronto and dozens of community partners provide about 3,800 permanent shelter beds for men, women, families, couples, and youth in
over 57 locations, including nine operated by the City. Meals and basic necessities are provided in a secure environment as well as case management, counseling and support programs. For more detailed information, see the Guide to Services for People (http://www.toronto.ca/housing/pdf/guide-to-services_2010.pdf) who are homeless.

To make an inquiry or get information about shelter services, please call Hostel Services' general line: 416-392-8741.

Or call Toronto Hostel Services at 3-1-1 or Central Intake 416-338-4766 or Out of the Cold 416-699-OOTC (extension 6682).
### Appendix K: Current health status ratings and experiences of health change by length of time re-housed

<table>
<thead>
<tr>
<th></th>
<th>Total ( n=29 ) (%)</th>
<th>Recently housed (6 months &lt; 3 years) ( n=13 ) (%)</th>
<th>Mid-length housed (3 years &lt; 10 years) ( n=9 ) (%)</th>
<th>Long-term housed ( &gt;10 years) ( n=7 ) (%)</th>
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<td><strong>Physical health status rating</strong></td>
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<tr>
<td>Poor</td>
<td>4 (14)</td>
<td>1 (8)</td>
<td>3 (33)</td>
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<tr>
<td>Fair</td>
<td>10 (35)</td>
<td>6 (46)</td>
<td>4 (14)</td>
<td>3 (43)</td>
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<td>Good</td>
<td>10 (35)</td>
<td>6 (46)</td>
<td>1 (11)</td>
<td>2 (29)</td>
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<tr>
<td>Very good</td>
<td>2 (7)</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Excellent</td>
<td>3 (10)</td>
<td>0</td>
<td>1 (11)</td>
<td>2 (29)</td>
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<td><strong>Experiences of physical health change</strong></td>
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<tr>
<td>Worse</td>
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<td>2 (15)</td>
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<td>1 (14)</td>
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<tr>
<td>Same</td>
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<td>1 (8)</td>
<td>2 (22)</td>
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<tr>
<td>Better</td>
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<td>10 (77)</td>
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<td>5 (71)</td>
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<tr>
<td>Poor</td>
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<td>1 (8)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Fair</td>
<td>8 (28)</td>
<td>5 (39)</td>
<td>2 (22)</td>
<td>1 (14)</td>
</tr>
<tr>
<td>Good</td>
<td>8 (28)</td>
<td>23 (3)</td>
<td>3 (33)</td>
<td>2 (29)</td>
</tr>
<tr>
<td>Very good</td>
<td>6 (21)</td>
<td>23 (3)</td>
<td>1 (11)</td>
<td>2 (29)</td>
</tr>
<tr>
<td>Excellent</td>
<td>6 (21)</td>
<td>8 (1)</td>
<td>3 (33)</td>
<td>2 (29)</td>
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<td><strong>Experiences of mental health change</strong></td>
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<td>Worse</td>
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<td>2 (15)</td>
<td>1 (11)</td>
<td>1 (14)</td>
</tr>
<tr>
<td>Same</td>
<td>4 (1)</td>
<td>0</td>
<td>1 (11)</td>
<td>0</td>
</tr>
<tr>
<td>Better</td>
<td>59 (17)</td>
<td>7 (58)</td>
<td>6 (67)</td>
<td>4 (57)</td>
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<td>Did not know</td>
<td>24 (7)</td>
<td>4 (31)</td>
<td>1 (11)</td>
<td>2 (29)</td>
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Appendix L: Characteristics of the interview sample

<table>
<thead>
<tr>
<th>Participant</th>
<th>Gender</th>
<th>Age range</th>
<th>Marital status</th>
<th>Racial/cultural background</th>
<th>Income</th>
<th>Housing situation</th>
<th>No. of homeless episodes</th>
<th>Length of time rehoused</th>
<th>Chronic health conditions</th>
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<tbody>
<tr>
<td>1</td>
<td>M</td>
<td>51-55</td>
<td>Separated/divorced</td>
<td>White</td>
<td>&lt;$10,000</td>
<td>SHF</td>
<td>1</td>
<td>2 years</td>
<td>asthma, back problems, intestinal/stomach ulcers, had a stroke, bowel disorder, learning disability, anxiety disorder, chronic skin sores, chronic foot sores, dental troubles, vision trouble, hearing problems.</td>
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<tr>
<td>2</td>
<td>M</td>
<td>56-60</td>
<td>Single</td>
<td>White</td>
<td>$10,000 &lt;20,000</td>
<td>Shared accommod.</td>
<td>2</td>
<td>1 year</td>
<td>allergies, vision trouble</td>
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<td>F</td>
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<td>White</td>
<td>$20,000 &lt;$30,000</td>
<td>Shared accommod.</td>
<td>6</td>
<td>10 months</td>
<td>asthma, fibromyalgia, cancer, mood disorder, anxiety disorder, dental problems, vision trouble, hearing problems</td>
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<tr>
<td>4</td>
<td>F</td>
<td>56-60</td>
<td>Single</td>
<td>White</td>
<td>&lt;$10,000</td>
<td>Apartment</td>
<td>1</td>
<td>19 years</td>
<td>anxiety disorder, mood disorder</td>
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<tr>
<td>5</td>
<td>M</td>
<td>66-70</td>
<td>Same sex partnership</td>
<td>White</td>
<td>$50,000 &lt;$60,000</td>
<td>Owns home</td>
<td>Intermittently for several years</td>
<td>20 years</td>
<td>COPD, prostate cancer, dental troubles</td>
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<td>White</td>
<td>$10,000 &lt;$20,000</td>
<td>Apartment</td>
<td>2</td>
<td>2.5 years</td>
<td>depression, asthma, chronic bronchitis, emphysema, COPD</td>
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<tr>
<td>7</td>
<td>T</td>
<td>45-50</td>
<td>Separated/divorced</td>
<td>White</td>
<td>&lt;$10,000</td>
<td>SHF</td>
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<td>17 months</td>
<td>depression, anxiety, back problems, heart disease, obesity, dental troubles, joint and knee pain, vision problems</td>
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<td>8</td>
<td>M</td>
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<td>Single</td>
<td>White</td>
<td>&lt;$10,000</td>
<td>Apartment</td>
<td>2</td>
<td>17 years</td>
<td>rheumatoid arthritis, back problems, hepatitis, dental troubles</td>
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<tr>
<td>Participant</td>
<td>Gender</td>
<td>Age range</td>
<td>Marital status</td>
<td>Racial/cultural background</td>
<td>Income</td>
<td>Housing situation</td>
<td>No. of homeless episodes</td>
<td>Length of time rehoused</td>
<td>Chronic health conditions</td>
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<td>9</td>
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<td>16 years</td>
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<td>Apartment</td>
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<td>4 years</td>
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<td>11</td>
<td>M</td>
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<td>SHF</td>
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<td>7 years</td>
<td>migraine headaches, eating disorder, mood disorder, anxiety disorder, hepatitis A, dental problems, vision trouble, kidney problems</td>
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<td>Single</td>
<td>Chinese</td>
<td>$10,000-$20,000</td>
<td>Apartment</td>
<td>Intermittently for three years</td>
<td>22 years</td>
<td>arthritis, anxiety disorder, chronic skin sores, kidney problems, osteopenia</td>
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<td>M</td>
<td>45-50</td>
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<td>White</td>
<td>$10,000-$20,000</td>
<td>SHF</td>
<td>3</td>
<td>13 months</td>
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<td>SHF</td>
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<td>arthritis, back problems, vision problems</td>
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<td>15</td>
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<td>SHF</td>
<td>4</td>
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<td>high blood pressure, diabetes, heart disease, previously had a stroke, anxiety disorder, obesity,</td>
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<td>4</td>
<td>4 years</td>
<td>previously had a stroke, vision trouble</td>
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<td>White</td>
<td>Unknown</td>
<td>SHF</td>
<td>1</td>
<td>10 years</td>
<td>thyroid condition</td>
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239
<table>
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<tr>
<th>Participant</th>
<th>Gender</th>
<th>Age range</th>
<th>Marital status</th>
<th>Racial/cultural background</th>
<th>Income</th>
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<th>No. of homeless episodes</th>
<th>Length of time rehoused</th>
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<td>18</td>
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<td>White</td>
<td>&lt;$10,000</td>
<td>SHF</td>
<td>3</td>
<td>4 years</td>
<td>asthma, arthritis, back problems, migraine headaches, epilepsy, eating disorder, mood disorder, Hepatitis C., dental trouble, vision trouble</td>
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<tr>
<td>20</td>
<td>M</td>
<td>51-55</td>
<td>Single</td>
<td>White</td>
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<td>Apartment</td>
<td>3</td>
<td>3 years</td>
<td>asthma, mood disorder, Hepatitis C., chronic skin ailments, chronic foot sores, dental trouble, vision trouble</td>
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<td>White</td>
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<td>Apartment</td>
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<td>7 months</td>
<td>asthma, rheumatoid arthritis, high blood pressure, migraine headaches, chronic bronchitis, COPD, anxiety disorder, Hepatitis C., obesity, dental trouble</td>
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<td>Participant</td>
<td>Gender</td>
<td>Age range</td>
<td>Marital status</td>
<td>Racial/ cultural background</td>
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<td>SHF</td>
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<td>9 months</td>
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<td>White</td>
<td>Unknown</td>
<td>SHF</td>
<td>1</td>
<td>7 months</td>
<td>back problems, chronic bronchitis, mood disorder, anxiety disorder, dental trouble, vision trouble</td>
</tr>
<tr>
<td>26</td>
<td>M</td>
<td>61-65</td>
<td>Single</td>
<td>White</td>
<td>&lt;$10,000</td>
<td>Apartment</td>
<td>Unknown</td>
<td>4 years</td>
<td>back problems, migraine headaches, cancer, bowel disorder, chronic skin ailments, dental problems, vision trouble, osteoarthritis of the spine</td>
</tr>
<tr>
<td>27</td>
<td>M</td>
<td>51-55</td>
<td>Widow</td>
<td>White</td>
<td>$60,000</td>
<td>Apartment</td>
<td>1</td>
<td>2.5 years</td>
<td>back problems, migraine headaches, heart disease, had a stroke, chronic fatigue syndrome, anxiety disorder, dental troubles, vision trouble, hearing trouble,</td>
</tr>
<tr>
<td>28</td>
<td>M</td>
<td>66-70</td>
<td>Separated/ divorced</td>
<td>White</td>
<td>Refuse</td>
<td>Apartment</td>
<td>Intermittently</td>
<td>7 months</td>
<td>bowel disorder, chronic fatigue syndrome, chronic skin ailments, chronic foot sores, dental trouble, vision trouble, hearing trouble,</td>
</tr>
<tr>
<td>29</td>
<td>M</td>
<td>51-55</td>
<td>Separated/ divorced</td>
<td>White</td>
<td>$10,000</td>
<td>Apartment</td>
<td>2</td>
<td>10 years</td>
<td>arthritis, high blood pressure, hepatitis C.,</td>
</tr>
</tbody>
</table>