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Pathways into and out of Housing Insecurity and Homelessness: Relationships between Age, Public Program Use, and Housing Stability

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Abstract

Adults 65 and older are the fastest growing age group of people experiencing homelessness, yet housing insecurity and homelessness is especially dangerous for them. This project uses a mixed methods approach, including a review of the literature, an analysis of Homelessness Management Information System (HMIS) data for the Commonwealth of Massachusetts, and interviews with service providers around Boston, to understand the distinct, age-related needs of older adults who utilize the homelessness service system. We find that adults 50 and older, who comprise about a third of the Massachusetts residents experiencing homelessness, are particularly vulnerable to housing insecurity that results from age-related changes. These changes can include a deterioration in financial resources, social networks, and health and abilities, all of which complicate their capacity to maintain existing housing or navigate benefits systems. Benefits use of older adults also diverge by race and ethnicity, with lower SSDI utilization among Black, Hispanic, and Asian individuals, compared to White or Indigenous people 50 and older experiencing homelessness. This raises concerns about disparities in benefits access. Programs might improve housing security for older adults and increase equity by acknowledging the unique needs of older adults and constructing administrative processes that better align with these needs. Broadly, this would include increasing access to affordable housing, subsidy and home modification programs, streamlining and coordinating application processes, and providing better service continuity to address changes as they arise and prevent significant disruptions to benefits, services, or housing that can result from age related life or health changes.

Keywords: older adults, housing insecurity, homelessness, public assistance

JEL classification codes: H4, I38

1. Introduction

Housing insecurity and homelessness can be particularly dangerous for older adults, yet the fastest growing age group of people who experience homelessness comprises adults 65 and older (Culhane et al. 2019; Kushel 2020; Airgood-Obrycki 2019). Being unhoused takes a devastating toll on an individual’s physical and mental health, so a person experiencing homelessness might be diagnosed with age-related health conditions that are comparable to someone up to 20 years older (Grenier et al. 2016). People experiencing homelessness prematurely exhibit conditions associated with much older age, including memory loss, falls, and functional impairment (Brown et al. 2016; Gelberg, Linn, and Mayer-Oakes 1990). Indeed, in the homelessness field, “older adult” typically refers to a person who has reached age 50. In line with these premature health problems, mortality risks are three to four times higher for people experiencing homelessness (O’Connell 2005).

This project utilizes a mixed-methods approach to explore how age-related circumstances and conditions contribute to housing insecurity and homelessness in Boston and to identify service needs specific to older adults, paying particular attention to the role of benefits in improving housing stability as well as barriers to benefits uptake. To motivate and contextualize this work, we use novel administrative data to assess trends in Massachusetts. We then use in-depth interviews with service providers who support diverse older residents in Boston to surface practitioners’ perceptions of older adults’ needs, the barriers they experience in accessing services and benefits, and the role of benefits in their achievement of housing security, either to prevent homelessness or to re-establish housing after they experience homelessness.

We that find a large and relatively stable share of people seeking homelessness services in Boston and across the Commonwealth are 50 and older. Our research describes how age-related factors exacerbate older adults’ vulnerability to housing insecurity and homelessness by increasing their risk of becoming unhoused, increasing the risks to their health and safety if they lose their home, and making it more difficult to stabilize their housing once it has been lost. We then explain how the design of public benefit programs and services, which might mitigate these many risks, often create barriers for older participants to receive needed support. Finally, using the framework of trauma-informed social work practice and examples surfaced in our interviews, we highlight various opportunities for service systems to be more inclusive.

We offer background to contextualize this work, clearly articulate our research question and the methods we used, and then describe our results before interpreting our findings in a discussion section.

2. Background

2.1. Defining Housing Insecurity and Homelessness

Housing insecurity refers to a set of factors that make it difficult for people to maintain safe, consistent housing. Routhier (2018) describes several aspects of housing insecurity including housing that is unaffordable, overcrowded, and of poor physical quality in addition to individuals experiencing recent forced moves. Housing might also be described as insecure if it does not meet residents' needs in some other way, for example, if it is physically inaccessible to a person with a mobility disability. In this paper, we use housing insecurity to describe situations in which people have housing but are struggling to maintain it as well as housing situations that are not long-term or reliable, such as couch-surfing with friends or family.

Unlike housing insecurity, there are a number of administrative definitions of homelessness. The Social Security Administration (SSA) describes homelessness as the experience of an individual who has no permanent living arrangement, while the Homeless Management Information Systems (HMIS) data from the Department of Housing and Urban Development (HUD) defines it as situations in which people don't have a fixed, regular, or adequate nighttime residence. Inadequate can mean the space is unsafe or substandard such as an abandoned building, or that it is public or not designed for people live in such as a bus station. HUD considers an episode of homelessness as ending once someone has been securely housed for a week, and people who experience chronic homelessness are

defined by HUD to have had a series of homeless episodes that add up to 12 months in total over the prior three years. In this research, we employ HUD’s definition.

Housing Insecurity:

A situation in which a person has housing, but it is unreliable or they struggle to maintain it due to factors such as unaffordability or inaccessibility.

Homelessness:

A situation in which a person does not have a fixed, regular, or adequate nighttime residence.

2.2. Pathways into Housing Insecurity and Homelessness at Any Age

Research has explored pathways into and out of homelessness with a focus on structural factors—broad social or environmental conditions related to resource distribution in society—and on individual factors, as well as the interactions between these. Structural factors include poverty, discrimination, housing costs, and access to adequate medical care, while individual factors include mental health issues, substance use disorder, experience of violence, and others. As these interact, a person’s health, for example, might affect their ability to navigate employment and earn a wage that allows them to afford housing. Structural factors may also create barriers to people trying to exit homelessness (Piat et al. 2015). A brief summary of these micro/individual and related macro/policy factors is provided in **Appendix Figure 1** along with references to relevant literature.

2.3. Older Adult Homelessness and Housing Insecurity

Though the literature has not documented aging as a risk factor for homelessness, housing insecurity and homelessness among older adults is a growing concern. According to HUDs 2019–2020 “Annual Homeless Assessment Report,” 30 percent of people who have been chronically unhoused were aged 55 or older; fully 58 percent were aged 45 or older in 2020. With an aging US population, many people who have been exposed to individual and structural risk factors for housing insecurity and homelessness are getting older. There is also a specific cohort effect in that the younger half of the baby boom cohort (born 1955–1964), who came of age into tight housing and labor markets, have

had an elevated risk of homelessness ever since they first became adults (Culhane et al. 2019). Many have experienced chronic housing insecurity through their lives.

In addition, a growing group of unhoused older adults also includes people experiencing homelessness for the first time later in life. For these older adults, homelessness is often related to some setback or trigger, such as loss of income or support brought on by illness, divorce, or the death or illness of a family member (Grenier et al. 2016; Kushel 2020). Researchers in the HOPE Home study find that later-onset homelessness is often preceded by some amount of housing insecurity that tips into homelessness when a person experiences one of these triggering events.

A number of factors can make people more vulnerable to trigger events. Some of these are related to the individual, such as lack of savings or limited social network. Some reflect local market conditions, including high housing costs. Others affect older people more generally, such as chronic health conditions and disability or ageism and other experiences of discrimination.

Research has shown that older people who do experience homelessness and are living in shelters or on the streets may have more difficulty managing geriatric health conditions; it may also be more difficult to maintain adaptive equipment like glasses or hearing aids while unhoused (Brown et al. 2015).

2.4. Access to Public Supports and Housing Security

Public programs offer opportunities to bolster the housing security of older adults and assist those seeking to exit homelessness. Programs include subsidies related to housing, which can help people access and pay for safe, permanent shelter. While eligibility varies by program and location, eligible households typically must earn under 80 percent of area median income, although in practice most assistance is targeted to those earning less than 50 percent. Since housing assistance is not an entitlement, few people who qualify for assistance receive it. Only about one-third of households headed by someone aged 62 and over receive housing subsidy, with rates even lower for younger households. Many older adults are eligible and need support but do not receive any housing subsidy (US Department of Housing and Urban Development 2021).

Other public supports are entitlement programs but are means-tested, and some may require extensive documentation of economic circumstances and of disability. These programs add to or free up resources that can be put toward housing. At the same time, Medicaid and other supports can help people maintain health or enable them to better weather health emergencies that can threaten housing

stability. However, in reality, barriers to accessing these benefits can mean that eligible older adults do not receive them.

2.4.1. Healthcare and related supports.

While Medicaid is an entitlement program for low-income people, it may not cover all health-related costs and typically does not pay for services and supports in private homes. States may offer home and community-based services (HCBS) through Medicaid waiver programs for those meeting eligibility requirements, such as the provision of home health aides or homemaking services. However, waiting lists for HCBS and services vary by state, and with a nationwide average wait time of 45 months, many applicants wait years for needed support (Watts and Meghana 2022). Additionally, the Department of Health and Human Services notes on their website, that people experiencing homelessness can often benefit from third-party assistance in applying for the Medicaid, a means tested program, particularly in documenting income, assets, and, if relevant, disability (US Department of Health and Human Services n.d.). Older people eligible for Medicare have some health subsidies, but Medicare does not cover at home services and supports.

2.4.2. Nutrition benefits.

The Supplemental Nutrition Assistance Program (SNAP), housed at the USDA, offers low-income people assistance acquiring food. Estimates suggest that while SNAP is an entitlement program, millions of older adults who qualify for food assistance have not applied for the benefit (Hartline-Grafton 2019). One study suggests that the high administrative burden of applying to the program and increased cognitive impairment in older age can reduce people's use of the program; indeed, SNAP uptake declines over the life course (Zuo and Heflin 2023), even as income, and presumably eligibility, increases.

2.4.3. Disability benefits.

People with disabilities, who made up half of those experiencing homelessness in 2020, may also access Supplemental Social Security (SSI) or Social Security Disability Insurance (SSDI) (Henry et al. 2020). Disability rates rise with age, though they often occur earlier in life for renters, people with low-income, and Hispanic and Black individuals (Joint Center for Housing Studies 2015). However, these resources can be extremely difficult for people experiencing homelessness to access, and

approval rates for first time SSI/SSDI applicants who are homeless are extremely low at just 10 percent of applicants (Dennis et al. 2011). Benefit approval decisions can also take time; new applicants wait, on average, over seven months for an initial determination, during which time they receive no benefits. An estimated three out of five applications are denied and about half of denials are successfully appealed, taking additional months or years (USAFacts 2023). Targeted investments can make this process more efficient. One study found an average 91 days from application to decision for people who were homeless or at risk of homelessness who applied for SSI or SSDI using the SSI/SSDI Outreach, Access, and Recovery (SOAR) program offered by the Substance Abuse and Mental Health Services Administration (Dennis et al. 2011).

2.4.4. Cash benefit programs.

Income-based benefits are flexible and efficient since the recipient is able to spend resources in ways that prioritize their most pressing housing and care needs. Social Security Retirement Income benefits are paid to retired workers, surviving spouses, and eligible children based on lifetime earnings. However, these benefits cannot be claimed until age 62, which is a relatively advanced age for people unhoused people who prematurely experience chronic health conditions and disability. Many adults whose age is considered advanced by service systems for homeless people do not meet the age criteria for this program.

2.5. The Boston Context

The city of Boston offers a rich case study for exploring the intersection of aging, housing insecurity and homelessness, and the provision of benefits and services. It is a high-cost area with high rates of housing cost burdens, particularly among low-income renters, but also a place where there are formal efforts and resources to reduce homelessness and ensure housing stability, with a number of entities focused specifically on older adults.

Massachusetts overall ranked third for housing unaffordability by the National Low Income Housing Coalition in its “Out of Reach” analysis, and the Federal Reserve Bank of Boston in 2019 reported that there were fewer than one affordable and available housing units for every two very low-income households (earning under 50 percent of area median income) in the state (Chiumenti 2019; Boston 2019). As of 2021, nearly 50 percent of renters in the Boston metro area faced housing cost burdens, paying more than 30 percent of their income for housing. Among older renters (aged

65 and over), the share rises to 54 percent, with more than half of those with cost burdens paying over 50 percent of their income on housing.¹

Massachusetts has the twelfth highest rate of homelessness among all states, with 22.2 people experiencing homelessness out of 10,000 residents in 2022. However, services in the Commonwealth may be relatively robust as, at 93 percent, it ranks sixth of all states in the share of people experiencing homelessness who are sheltered (de Sousa et al. 2022). Housing insecurity and homelessness is a particular concern in Boston, where weather makes outdoor living unsafe part of the year. As of the 2022 annual point-in-time count, the Boston Continuum of Care (CoC) reported 4,439 homeless individuals, 2,370 of whom were over the age of 24. Just over 2,250 of these adults were sheltered and 119 were unsheltered. These numbers are down from 2019, the year before the pandemic, when Boston CoC reported 6,242 unhoused individuals, 3,448 of whom were over the age of 24. Point-in-time counts do not allow for finer-grained analysis of trends by age than an account of children (under 18), youth (aged 18–24), and adults over age 24, so it is difficult to assess trends for older adults experiencing homelessness—and even more difficult to measure levels of housing insecurity in this age group.

As in other high-cost cities, homelessness has been the focus of a concerted effort by a succession of Boston mayors. In 2015, under then Mayor Walsh, the city released its plan to end veteran and chronic homelessness. The plan is based on a “housing first” approach that emphasizes the provision of housing and then providing services to help individuals and families regain stability. Part of the plan involved coordination of housing resources. The city’s website in August of 2023 reported that 2,115 single adults were unhoused on January 30th of that year; it also noted that 2 percent of people experiencing homelessness (of all ages) were sleeping outside at night, the lowest rate of any major US city. In 2022, the Boston CoC reported 1,955 total beds (emergency, transitional, and safe haven) available to households without children.

Boston’s plan does not specifically address the unique needs of older adults experiencing housing insecurity or homelessness. However, Boston has a rich network of service providers for people experiencing housing insecurity or homelessness, some of which are tailored to older adults. For example, the nonprofit Hearth, founded in 1991, focuses on older adults who have experienced housing insecurity and homelessness, offering services and supports to those who are facing

¹ Joint Center for Housing Studies analysis of the 2021 American Community Survey.

homelessness or who are unhoused, as well as permanent supportive housing. Hearth was among the first in the nation to target services to older unhoused people.

Something about health resources might also be unique to Boston: Boston Healthcare for the Homeless Program (BHCHP) provides care for people who are unhoused or were formerly homeless at a network of sites throughout greater Boston. BHCHP was one of 19 homeless healthcare programs piloted in the 1980s and MassHealth, the state's Medicaid program, offers Home and Community-Based Service Waivers.

3. Research Questions and Methods

3.1. Research Questions

This research investigates later-life housing insecurity and homelessness in Boston, focusing on these specific questions:

1. What are the characteristics of older adults who seek services for housing insecurity and homelessness in Boston?
2. How do age-related characteristics and experiences increase risks for housing insecurity and homelessness among older adults in Boston?
3. How do housing stability service needs differ for older adults?
4. What is the relationship of benefits uptake and housing security for older adults living in Boston?
5. How are programs and services supporting older adults who are housing insecure or unhoused? How can they be improved to address age-related needs in Boston and across Massachusetts?

We propose that age specifically increases risk of housing insecurity and homelessness, particularly in the presence of a triggering event such as a health crisis, loss of a spouse or other key support, or a large rent increase. Further, older adults experiencing insecurity and homelessness may need access to unique programs tailored to challenges related to aging as well as additional support accessing services and benefits. We assert that well-designed public benefits and programs could moderate these impacts and help to stabilize older adults' housing experiences.

3.2. Methods

We use a mixed-method approach to understand late-life housing insecurity and homelessness in Boston. Homelessness Management Information System (HMIS) data provide insight into characteristics of older adults seeking housing and related services over the past decade. Interviews with service providers illuminate common challenges and barriers faced by older clients in maintaining stable housing and in navigating the landscape of services and benefits.

3.2.1. Homelessness Management Information System (HMIS) data.

We utilized HMIS data to identify trends in homelessness among older adults in Boston. Every Continuum of Care (CoC) is required to maintain a client-level record of housing and services provided to individuals experiencing homelessness using an HMIS database that meets HUD's standards for collection, management, and reporting. Data are intended to be utilized locally to assess needs and practices and direct resources, and they are typically maintained at the CoC level. The Commonwealth of Massachusetts has recently organized CoC HMIS data into a statewide database called the Rehousing Data Collective. These data represent demographics and information about services delivered to unhoused people across the Commonwealth.

Our project made one of the first applications to utilize these data for research. Under a negotiated data use agreement, researchers gained access to data ranging from 2012 to 2022 for every CoC throughout the Commonwealth. The data represent 173,346 unique adults, 30 percent of whom were over age 50, with the number of older individuals ranging from less than 6,000 in some years to closer to more than 9,000 in others. The data allowed us to characterize the population seeking services over the past decade, compare older and younger clients' characteristics, and compare those seeking services in Boston to those seeking services in the rest of Massachusetts.

HMIS data is a living database which can be updated retroactively. Our data was drawn in May 2023 and does not reflect later updates. We made a number of decisions for this analysis. We reported findings only for years that we had data from all four quarters, excluding both 2012 and 2022 which we did not have in full. To identify a client who received services in a certain calendar year, we flagged any service recipients with an entry date or an exit in that year, as well as anyone with an entry date prior to and an exit date following the year of interest. Our data included each client's age at entry, a variable derived by the data vendor using the client's birthdate. We used this

variable to approximate the client's age in each year following entry into service. Using HUD's definition of homelessness, we considered individuals as experiencing homelessness if they received services through Emergency Shelter, Transitional Housing, Street Outreach, or Safe Haven services. Finally, for any clients whose circumstances changed throughout the year (for instance, their self-reported health or income sources differed across events of service), we used the response associated with the first homelessness service they received in that year.

3.2.2. Semi-Structured interviews.

The core of our research involved in-depth, semi-structured interviews with providers of services to older adults experiencing housing insecurity or homelessness in Boston. We first mapped the landscape of organizations that support older adult housing security within the Boston Continuum of Care (CoC), focusing on 10 sectors most relevant to housing access and stability (**Figure 1**).

With oversight from the Harvard University Institutional Review Board, the research team then contacted each organization and asked it to participate in an hour-long, virtual, semi-structured interview. We allowed organizations to decide which of their staff members should participate in the interview. With consent from participants, interviews were recorded and transcripts were created using the Zoom transcription feature. After the interview, participants were given the opportunity to review transcripts and clarify or add further comments.

Researchers conducted interviews with 20 organizations and a total of 31 individual participants. We ensured that we interviewed organizations that represented each sector, though some worked across several. The sectors of aging service providers and supportive housing providers were best represented across our participants (**Figure 1**).

Figure 1. Organizations Interviewed by Sector

Sector	Description	Number Identified	Number Interviewed
Aging Services	Area Agencies on Aging/Older Americans Act services	6	6
Assisted, Rehabilitation, Institutional	Link to/provide housing and services that help residents perform functional activities	2	2

Case Management	Assess client needs and link them to benefits and resources	11	6
Day Program, Day Center	Provide temporary daytime shelter, often including services or resources	4	2
Government/Public Organization	Local or state organizations	4	3
Health Services	Provide healthcare to people with housing insecurity/who are unhoused	2	2
Issue Advocacy	Advocate for policies and programs supporting people with housing insecurity or who are experiencing homelessness	1	1
Permanent Supportive Housing	Provide affordable housing with services that is not time-limited	8	5
Night Shelter	Provide temporary, overnight shelter for unhoused people	6	6
Tenant Advocacy and Organizing	Provide legal services for people experiencing housing insecurity	3	1

Note: Organizations that performed among multiple sectors appear in multiple rows.

To analyze the interview data, the research team reviewed transcripts and identified a set of recurring themes using an inductive process. The team presented these themes to a working group at the Center for Financial Security at the University of Wisconsin-Madison and incorporated comments into a revised set of themes. Next, the team used these themes to code the transcripts in NVivo. The analysis involved some iterative development and refinement of the themes and their subcodes.

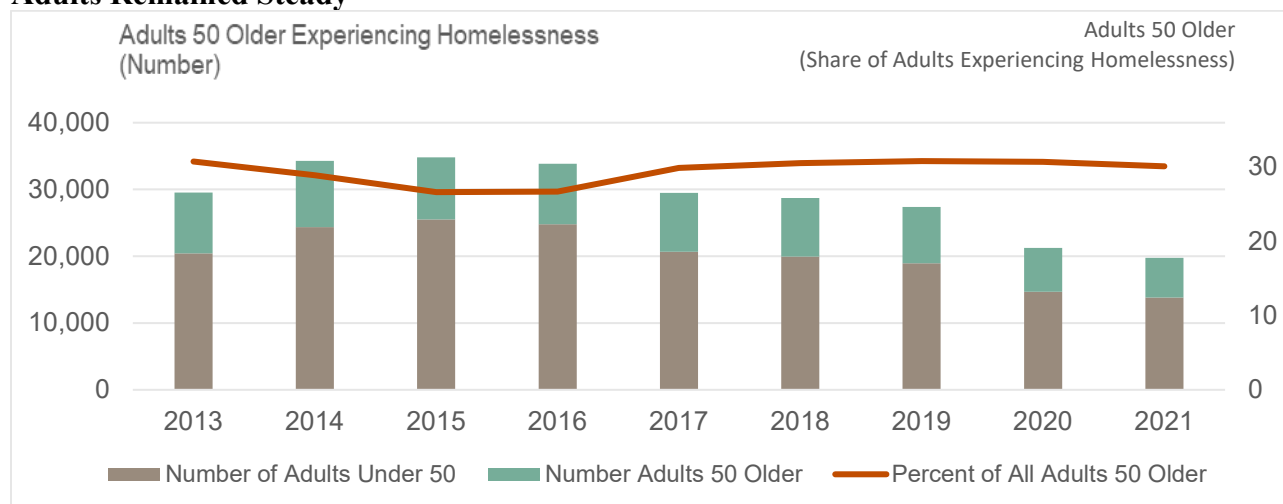
4. Findings

4.1. Research Question 1: What Are the Characteristics of Older Adults Who Seek Services for Housing Insecurity and Homelessness in Boston?

Over the period 2013–2021, HMIS data report 173,346 unique adult service recipients across Massachusetts, with yearly totals ranging from a low around 19,700 adults in 2021 to a peak of nearly 34,700 in 2015. On average, thirty percent of service recipients over these ten years were at least 50 years old (**Appendix Table 1**). Though the total number of unhoused people decreased steadily starting in 2015, the share of older adults has held fairly constant (**Figure 2**). By 2021, the most recent

year in the data, 30.1 percent of unhoused adults in Massachusetts were 50 or older (**Appendix Table 2**).

Figure 2. While Total Number of Unhoused Adults Fell in Recent Years, Shares of Older Adults Remained Steady

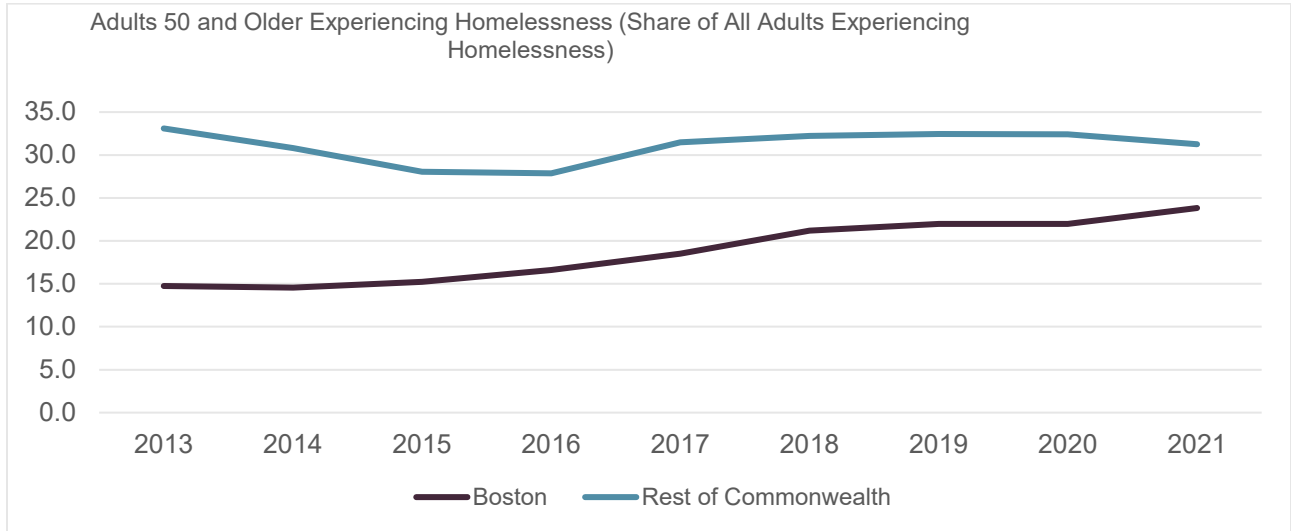


Notes: This figure includes only adults considered homeless because they utilized Emergency Shelter services, Transitional Housing, Street Outreach, or Safe Haven services. Clients were considered homeless if they either entered or exited services in a year or if they entered prior and exited after that year. Though birthdate was masked, age was calculated based on age at entry.

Source: JCHS Analysis of Massachusetts HMIS data 2013-2021.

The share of adults experiencing homelessness who are 50 or older has been steady throughout Massachusetts on the whole, but in the earlier years of analysis, rates were much lower in Boston. However, this gap has narrowed significantly in recent years as the share of older unhoused adults in Boston rose from 15 percent in 2013 to 24 percent in 2021 (**Figure 3**). While not identical, demographics were broadly similar between Boston and the rest of the Commonwealth, increasing confidence in the generalizability of findings (**Appendix Table 3**).

Figure 3. A Rising Share of Older Adults Experience Homelessness in Boston; Rates Remain Steady Across the Rest of Massachusetts

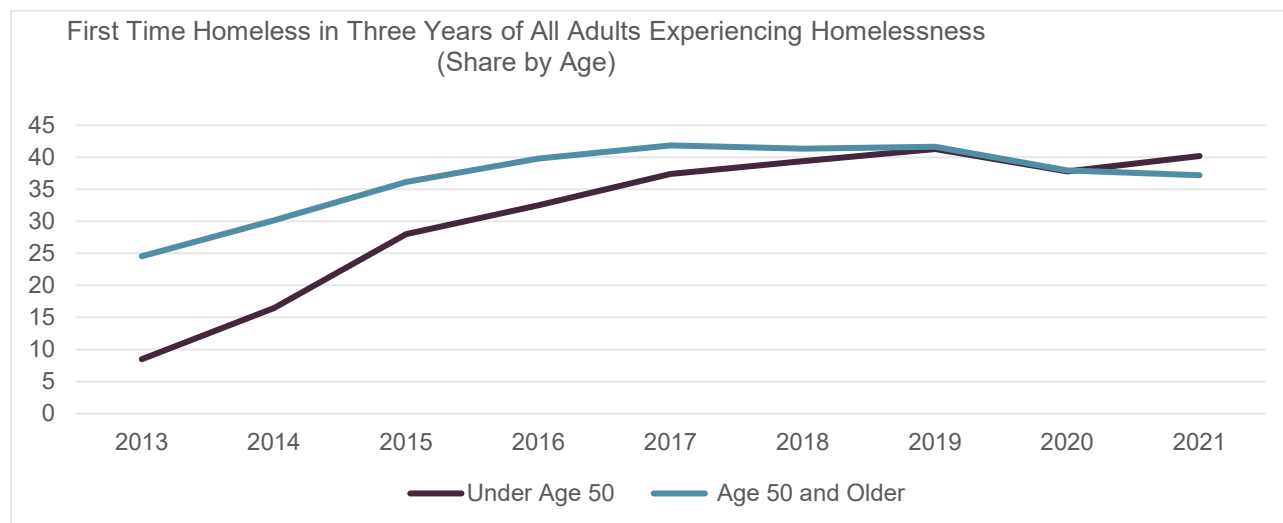


Notes: This figure includes only adults considered homeless because they utilized Emergency Shelter services, Transitional Housing, Street Outreach, or Safe Haven services. Clients were considered homeless if they either entered or exited services in a year or if they entered prior and exited after that year. Though birthdate was masked, age was calculated based on age at entry.

Source: JCHS Analysis of Massachusetts HMIS data 2013-2021.

Trends in first-time homelessness are also evolving. In the first five years of our data, older adults experiencing homelessness were more likely than adults younger than 50 to have become unhoused for the first time in three years (**Figure 4**). However, these differences by age cohort had disappeared by 2019. Overall, more than 7,900 individuals experienced homelessness for the first time in three years in 2021, and nearly 6,600 experienced at least their second episode of homelessness.

Figure 4. In Recent Years, Rates of First Time Homelessness Have Been Similar Between Age Groups



Notes: This figure includes only adults considered homeless because they utilized Emergency Shelter services, Transitional Housing, Street Outreach, or Safe Haven services. Clients were considered homeless if they either entered or exited services in a year or if they entered prior and exited after that year. Though birthdate was masked, age was calculated based on age at entry. This variable counts people experiencing homelessness for the first time in three years. Source: JCHS Analysis of Massachusetts HMIS data 2013-2021.

Older adults experiencing homelessness were much more likely to be male, with only half as many women experiencing homelessness at older ages. A very small number identified as transgender or gender nonconforming, though these people were largely under age 50. Gender ratios were similar in Boston and the rest of Massachusetts (**Appendix Table 3**). Older adults experiencing homelessness were also less diverse than the younger cohort was, with 60 percent of those 50 and over identifying as White as compared with 36 percent of those under 50. Fewer were Black, at 20 percent compared to 26 percent of the younger group, and a much smaller share of older unhoused adults were Hispanic, at 17 and 36 percent, respectively (**Appendix Table 3**). However, older adults experiencing homelessness were much more diverse in Boston where 37 percent were Black and 25 percent were Hispanic between 2013 and 2021.

4.2. Research Question 2: How Do Age-Related Characteristics and Experiences Increase Risks for Housing Insecurity and Homelessness among Older Adults in Boston?

Interview data helped us address our second research question about how age-related characteristics and experiences increase risks for housing insecurity and homelessness among older adults in Boston. While interviewees mentioned pathways to housing insecurity and homelessness common to all age

groups, they also identified the ways that older age, particularly deterioration in financial capacity, social networks, and health and abilities, contribute to and complicate older adults' abilities to maintain housing and to navigate systems set up to support people who are unhoused.

4.2.1. Older adults may be more vulnerable to rising rents.

Older adults are particularly vulnerable to sudden increases in housing costs. Our interviewees pointed to two reasons: first, at older ages, rent increases can easily outpace income, even for those receiving benefits with cost-of-living adjustments like Social Security. While the Joint Center and others have documented the challenge of keeping up with rising housing costs at older age, when incomes are fixed (and sometimes with incomes that fall with the loss of a spouse or partner), there can be extreme examples of divergence in high-cost areas, particularly in neighborhoods that are seeing development pressures. Second, many older people have lived in the same home for years, sometimes decades, paying rents that increasingly lag behind market rate, so that sudden increases to a market rate can be particularly disruptive. Several interviewees noted how long-time renters in Boston, who may have been stably housed for decades, faced sudden significant increases in rents when their landlords—often themselves aging—sold to new owners or passed management responsibilities onto adult children.

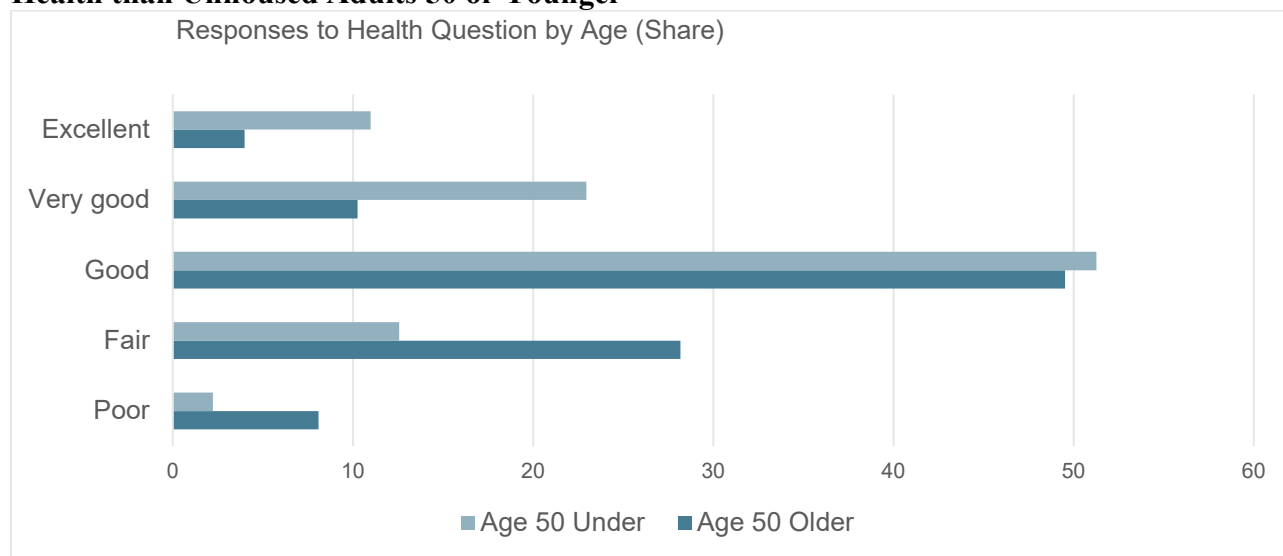
An older adult may also rely on retirement savings that, with price inflation, become inadequate to support them or income that is not indexed to living costs. As one interviewee explained, “The increase in Social Security or some of their other benefits are not matching how fast [costs] are increasing. So, people just don't have enough funds to make it work.” Another noted that though a renter may have anticipated their housing costs in retirement, they did not foresee dramatic house price inflation. “[Older residents have] lived in these homes for 20–30 years with a rent of \$700, and all of a sudden the landlord realizes that [the apartment is worth more] and folks are hit with drastic rent increases.” Interviewees pointed out that older adults in these situations included those with work histories and pensions that were insufficient to cover rising rents. As one interviewee described, “A [neighborhood that starts to] gentrify [pushes out] people who have lived there for years.” A participant sums up this trend, saying, “I feel that I am seeing this more ... people that are getting displaced, people that maybe had a work history.”

A related problem is that once someone must leave their housing, there is little that is affordable in their current neighborhood. It can be particularly difficult for someone to find housing that is within budget but also meets other needs arising with age, such as for accessibility and proximity to services.

4.2.2. Housing insecurity can increase as evolving needs for accessibility and assistance make current housing unsuitable.

Health issues arising in older age, including mobility difficulties, chronic conditions, and cognitive decline, can make it difficult for people to maintain stable housing. Across Massachusetts, 37 percent of unhoused adults 50 and older said they were in fair or poor health as compared with 15 percent of younger adults experiencing homelessness (Figure 5).²

Figure 5. Older Adults Experiencing Homelessness Are More Likely to Report Fair or Poor Health than Unhoused Adults 50 or Younger



Notes: This figure includes only adults considered homeless because they utilized Emergency Shelter services, Transitional Housing, Street Outreach, or Safe Haven services. Clients were considered homeless if they either entered or exited services in a year or if they entered prior and exited after that year. Though birthdate was masked, age was calculated based on age at entry.

Source: JCHS Analysis of Massachusetts HMIS data 2013-2021.

² While the HMIS data includes both disability status and type, the variables were not reliable. We chose to report self-reported health statistics to identify rates of health concerns experienced by unhoused people and compare these rates between age groups.

Age-related health conditions can introduce mobility challenges, including difficulty climbing stairs, reaching and bending, or turning faucets or doorknobs. Yet interviewees emphasized that “a lot of older buildings in Boston don’t have elevators, or you know, even wheelchair [accessibility].” Modifying homes can be difficult or expensive, and the need for an accessible space significantly restricts available housing.

Age and associated cognitive and physical conditions can also increase the likelihood of needing support for instrumental activities of daily living (IADLs), such as shopping, cooking, housekeeping, and bill paying, as well as activities of daily living (ADLs), including bathing, dressing, and eating. One interviewee described an older man with dementia who lost his home when his caregiving partner died. They said someone brought him to the shelter, and “He didn't remember anything. He had a phone that was dead. It was kind of an ordeal.”

Though most older adults fill gaps in professional assistance by getting help from family, our interviewees explained that many older adults experiencing housing insecurity do not have family to fill in these gaps. One interviewee mused about “the amount of people 50 and older, particularly 60 and older, that are almost completely alone, with no family support, not even an emergency contact that’s still relevant if you call the number...” Another remarked, “Our folks don't have families that they're going to move in with. They're staying [in their home] as long as they can, and most of the time, what drives them out is they can't manage the apartment. They can't manage their medical needs, getting from the bed to the bathroom. They can't manage that any longer, and that's why they can't stay.”

Affordable housing programs can include very specific lifestyle rules that misalign with the needs of some older residents, putting their tenancy or that of a relative in jeopardy. Subsidized rental housing leases may specify the number of full-time residents permitted and thus not allow family and friends to move in for more than a couple of weeks to provide assistance. An interviewee described a client who lives in subsidized housing and receives 24-hour care from their family, however, problems arose because “property management, [does not understand] what it takes to have family members and community care for someone who requires 24/7 care. For example, they've gotten a few lease violations for having multiple people in the apartment, not really understanding that this person [needs] total care.” Another considered the impact of these limitations for older adults who needed to move in with family or friends living in subsidized housing. The interviewee asked, “Where do they go [after 2 weeks]? So that's how a lot of times they end up homeless. We've had people who

were sleeping in their cars because they couldn't stay anywhere anymore... I never forget this woman. She chose to stay in her car ... I think it was over eight months she lived in that car before she was able to find some temporary housing a shelter had for women.”

Several interviewees also mentioned issues such as hoarding that might create unhealthy situations for older adults and trigger eviction warnings from property managers. While interviewees could not say whether hoarding was a challenge more common for older adults than younger, many mentioned their older clients struggling with the condition and facing loss of housing as a result. One interviewee described homes filled to capacity, where the underlying structure had rotted and there were no egresses, “no heat ... no water; there’s no sleeping quarters, there’s no cooking quarters. The house is completely unlivable.” They continued: “The property manager goes in for outreach, certification, or inspection, or to fix anything, and they see it.” This should trigger a report to Boston’s Age Strong Commission, which is able to offer “heavy chore” services to help return the home to a livable state. However, one interviewee noted that if the client does not accept those services, “that’s one of the ways [clients] lose their homes.”

4.2.3. Vulnerabilities can compound over time.

Changes accumulating over time can lead to a misalignment between older adults’ resources and their needs. As we noted above, incomes may not keep up with rising rents. In addition, community and social networks can shift over time, reducing an older adult’s social capital and increasing isolation. As people leave the workforce and as social experiences increasingly revolve around technology, older adults may struggle to adapt and remain connected. We learned that many experience loss from their social network related to the aging of their cohort or the dispersion of their network as people move and as habits shift. Relationships may also become strained and exhausted over time for people living on the margins who have relied on their network for stability. People are often “housing unstable for a long time before [they become homeless], and there’s a lot of couch surfing ... when you’ve done that for 10 or 15 years ... you lose those connections.”

Finally, poorly managed chronic health and mental health conditions can compound and create increasingly significant barriers in later life. “People who are homeless or who have lived experience with homelessness just age quicker. They tend to have more medical issues going on, especially ones that haven’t been tended to,” explained one interview participant. These require

increasingly complex care regimens. Chronic conditions can be associated with increased difficulties with self-care and independent living.

4.3. Research Question 3: How Do Housing Stability Service Needs Differ for Older Adults?

Related to our third research question, interviews surfaced that a scarcity of centrally located, affordable, accessible housing led to poor-fit arrangements that threaten housing stability and that program exclusions created support systems gaps. Age-related changes in health, physical ability, economic circumstances, and social capital narrow older residents' tolerance for housing inadequacy. Given higher rates of age-related health and disability problems, circumstances that create difficulties for younger residents, such as a steep stairway entry or an inconvenient geographic location, could rise to the level of threatening the housing security of an older adult.

4.3.1. Lack of affordable, accessible housing in central locations impedes rehousing.

At a most basic level, there is not enough affordable housing that is also accessible and adequate for older residents seeking to move out of homelessness or from unsuitable to suitable housing. Noted one respondent, "The number one barrier ... for everybody in all age groups is the lack of affordable housing. And I think it's really important that we keep that in perspective ... You know that we want to end homelessness, person by person. We have to remember the fact that there's just not enough units.... There's just a huge a huge gap in what's needed." The scarcity of affordable places for older adults to live makes it even more difficult to assist a resident who is experiencing a housing crisis. An interviewee expanded on this situation, "There's not enough housing. There is not affordable housing for our elders ... So an elder shows up at [organization name masked] saying 'I lost my housing. I need a place to stay.' There's no place we can just pick up the phone and call and say, 'Can you get them a room that day?' "

It is particularly hard for providers to identify housing for older adults that is near public transportation and other supports. Housing within Boston, and therefore connected to transit and nearby older adults' providers and social networks, is often more costly than housing outside the city. One interviewee explained, "Our folks need to be able to get to their doctors and get to jobs and the further out you are the harder that is [because] our folks don't have cars. They don't have family

members that can drive them to an appointment.” Another noted: “When you push them farther and farther out of the city, then [it’s] harder to access public transportation. It’s also harder to get to their doctors’ appointments ... all this stuff that living in the urban setting provides relatively closely.”

Sometimes adults who have moved away from their network of resources try to return to their former neighborhoods as they age. An interviewee who primarily supports members of an immigrant community described how clients move away from the city center to find affordable housing when they are younger, but they try to move back to the city core as they age to live in a place that better fits their needs. She observed that with aging, “Needs for service increase ... and ... shorter travel times [become important] because transportation is the issue [as] mobility becomes decreased ... so they started looking for services in the central area again ... [where] food shopping [is] much easier and also [access to] health centers, hospitals, and home care services ...” As a respondent observed, older clients want affordable “housing in the communities that they belong to around their family, their friends or culture, in places that they can like to walk to ... [Older people want] social lives and [access to] places they enjoy going ... that’s huge for mental health and staying active.”

In addition to cost and location, homes must also align with older people’s functional needs and abilities. However, few affordable units are accessible to those with physical challenges, further limiting the units available to older residents trying to exit homelessness. Explained one participant, “[Older applicants] have to give up a unit because the unit is not handicap accessible or doesn’t have some of the accommodations that they would need to live comfortably, which you know, honestly, being in a unit is better than being homeless. But [you have to refuse] a unit that’s not functional ... because the ... manager is not going to allow you, as a disabled person, to go into a unit without a reasonable accommodation.” Additionally, some systems do not prioritize rehousing residents who are living in a place that is inaccessible to them. One interviewee described their limited ability to help an inadequately housed client: “[T]hat person, you know, lives in a fourth floor walkup, and ... they have to go up on their tushy, and somebody will say, ‘Well, they’re housed, though ... We can’t serve [you] if you have a roof over your head.’ ”

Home modifications, such as adding ramps or lifts to facilitate access or adding grab bars to increase safe use of rooms and appliances, can help an older adult stay in their home. Yet even when resources are available to help clients with home modifications, the process can be time consuming. A caseworker explained that the process to “get ... doorways widened or have a ramp put in, it’s a lot more coordinating with hospitals and other providers [and with the] landlord to ... get that unit ready

so that they can move in or back in if they've been in the hospital ...” Another pointed out that approval processes for modifications are complex and resources inadequate: “[Getting a ramp] becomes a 3-month process of just waiting for approvals and appealing things that are denied, and ... there isn't enough money to do the proper home modifications that we need done in a lot of cases.” Delays are concerning since a resident only qualifies for a modification that has become absolutely necessary for health and safety. While a resident waits for approval, they live in a poorly fit home and risk falls or isolation, or they increase reliance on others to meet daily needs.

4.3.2. Most shelters are not designed for older clients.

If a resident does lose their home, the shelter system is poorly designed to support an older adult with functional differences. As one participant explained, the challenges begin before the client even gets in the door of a shelter:

The challenge is an elder is frail.... Most times they are handicapped in some form. And so, they are fighting for the same bed an able-bodied adult is fighting for, so they have to stand in the line just like an able-body person. Some of them are in [a] wheelchair. We have the challenge of the weather depending on the time of year. And so a lot of times they don't get the bed. So, then they are sleeping under bridges and in doorways.

Another participant expressed concern for the vulnerabilities experienced by an older adult with disabilities relying on the shelter system, “Why should an elder have to go to a shelter with able-bodied people? Why isn't there a shelter that caters to them so that they can feel safe? They are being abused. They are being robbed. They are being pushed aside.” Another described the implications of these vulnerabilities, saying that “you're putting a 20 year old strong boy with a 65 year old senior, you know there's bullying that happens with them in those shelters. That's why a lot of my seniors refuse to go to [shelters]. So they will prefer to sleep on the streets, take their chances, or [sleep in] cars or couch surf.”

The shelter itself is unlikely to be physically accessible to people with functional differences, as one participant noted, “We do not have accessible shelters. It's an issue.” Additionally, older adults may need assistance that shelter staff cannot provide. One interviewee explained:

You need to be able to take a shower by yourself, go to the bathroom by yourself, feed yourself, and get in and out of bed. Can you do those things? Most people will say yes, and then come to find out [in some cases, they actually cannot]. And our shelter staff,

they're not gonna let somebody not be able to pull up their pants at the bathroom... But as time goes on, we have to have some of those really hard conversations with folks about what kind of housing they really need, and what we can provide. We don't have home health aides. We can't take care of people who are really much more eligible for, or becoming more eligible for, a nursing home. Sometimes ... it's that dribbling effect, like [their needs grow] over time.

4.3.3. Access to in-home support is limited.

Inadequate resources for assistance are a problem not only in the shelter system. Interviewees agreed that professional services are often a lynchpin to stabilize older adults' housing experience. Yet it can be difficult to access appropriate supports as needs evolve; as one said, "There's not a lot of kind of step down apartment situations where you start out in a market or like an independent living and then, as you age a little bit it steps down into... a more supportive living, and then, as you age a little bit, it steps down into like even more support, so that it's not just so extreme from one situation to another..." This interviewee spoke about successes with a housing stabilization program that adjusts services in the home as needed: "It's usually about 50 percent retention rate. We've been able to keep about 95 percent [of clients in housing stabilization]."

Some interviewees named affordable assisted living as an important resource; as one interviewee noted, "Usually when people move into assisted living it's because there was an emergency. They might have a spouse who was their ... caregiver pass away, and now they need assistance ..." Yet, assisted living that is affordable to low-income older adults is in short supply. A participant explained that some states allow Medicaid to fund assisted living units, but this service is not available in Massachusetts. As a result, benefits must often be layered for older adults to meet living costs (housing, food) and also to afford care and support. One respondent described the advantage of combining veteran disability benefits with Social Security programs to ensure a client's ability to live in a place that meets their chronic care needs: "Community living centers tend to be kind of an assisted living ... [for residents] who need some sort of skilled nursing ... but they're expensive. So SSDI is not going to cover it... The [only] folks that we tend to be able to in place in places like that ... have full VA benefits.... Anybody with SSI or SSDI needs a voucher to live in subsidized housing. There's no way around it."

Locating public transportation and key services near affordable housing can also increase older adults' independence by creating an option for older residents to get around without a car. But

many will also need assistance in their homes. Since Massachusetts has more services to provide home supports than many other states do, connecting older adults to services can be really important. However, there are various limitations to services. Qualification standards (such as age) vary between programs, so people who qualify for housing assistance may not yet be eligible for the assistance that they need. Additionally, it is difficult to provide home-based care to a person who has no stable residence. A centralized and coordinated set of services could align these systems and improve access. In the absence of affordable assisted living or affordable services delivered to the home, older adults may go to nursing homes, even if they do not need that level of care, which Medicaid will generally cover.

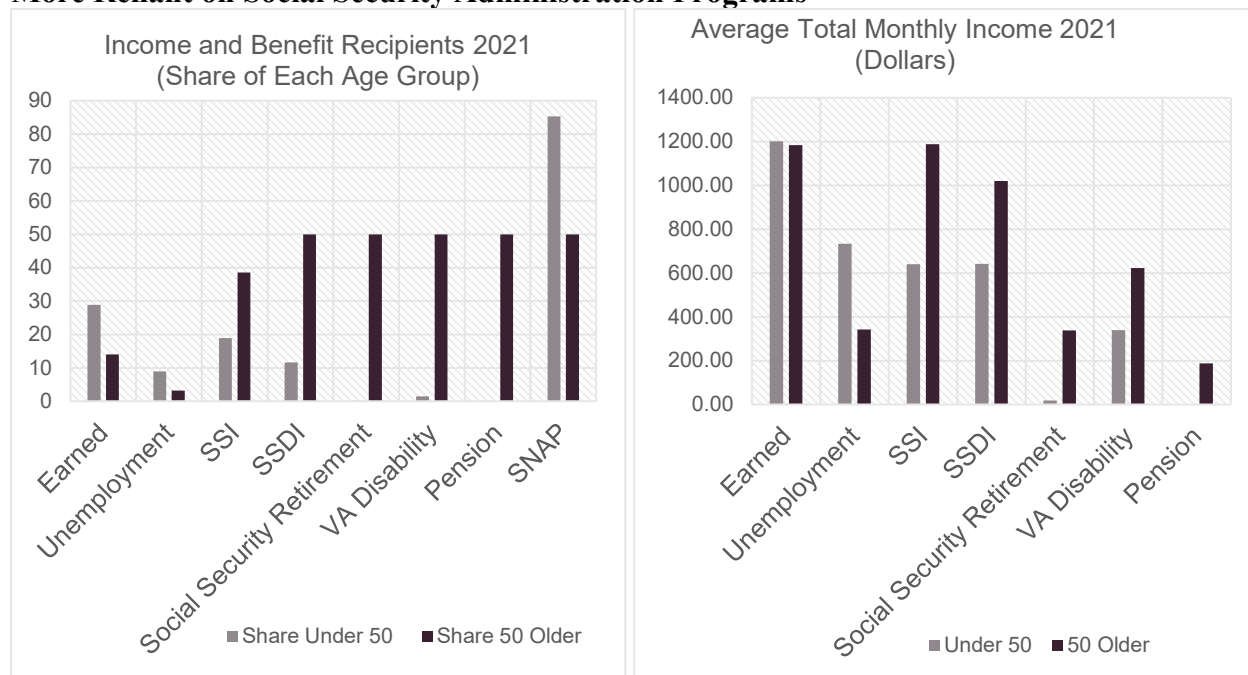
4.4. Research Question 4: What Is the Relationship of Benefits Uptake and Housing Security for Older Adults Living in Boston?

Our fourth research question relates to age-specific needs of program and benefit applicants by examining factors that make it difficult for older adults to utilize programs and benefits.

The HMIS data revealed that older adults experiencing homelessness were much less likely to receive earned income than their counterparts under age 50. However, they were much more likely to receive some form of Social Security benefit (**Figure 6**). Additionally, these benefits were larger overall than other income sources. Forty-three percent of people age 50 experiencing homelessness between 2013 and 2021 received some form of Social Security benefit as compared with 23 percent of adults under 50. A quarter of these older adults received SSI, 22 percent had SSDI, and two percent had Social Security retirement income.

Older adults experiencing homelessness had somewhat higher monthly income overall – in 2021, they received \$1,056 each month compared to \$820 received by adults under 50. These differences may have been explained in part by OASI and SSDI program income. In 2021, older unhoused adults received an average of \$548 dollars more each month from SSI, \$379 more from SSDI, and \$320 more from Social Security retirement than did adults experiencing homelessness under age 50. Older adults who received any benefits from Social Security Administration programs had an average total monthly income of \$1,290 in 2021, making them better off than older unhoused adults who did not get any OASI or SSDI benefits and had an average monthly income of \$706. (**Appendix Table 4**).

Figure 6. Older Adults Experiencing Homelessness Less Likely to Receive Earned Income; More Reliant on Social Security Administration Programs



Notes: This figure includes only adults considered homeless because they utilized Emergency Shelter services, Transitional Housing, Street Outreach, or Safe Haven services. Clients were considered homeless if they either entered or exited services in a year or if they entered prior and exited after that year. Though birthdate was masked, age was calculated based on age at entry. Rates of missing benefit information varied by income source. These figures only compare respondents who indicated whether or not they received these income or benefits.

Source: JCHS Analysis of Massachusetts HMIS data 2013-2021.

These patterns of higher reliance on SSI, SSDI and Social Security Retirement held across race and ethnic groups. However, rates varied, particularly for SSI which had the highest uptake share among Hispanic older adults experiencing homelessness at over 30 percent, down to just 18 percent of older Asian adults (Table 1).

Table 1. Participation in Social Security Administration Programs Varied by Race and Ethnicity for Older Adults Experiencing Homelessness

	SSI	SSDI	Social Security Retirement
White	24.4	24.7	2.4
Black	23.4	17.1	1.4

Asian	18.2	14.0	2.9
Hispanic	30.7	19.2	1.0
Indigenous	27.2	23.8	2.6

Notes: This figure includes only adults considered homeless because they utilized Emergency Shelter services, Transitional Housing, Street Outreach, or Safe Haven services. Clients were considered homeless if they either entered or exited services in a year or if they entered prior and exited after that year. Though birthdate was masked, age was calculated based on age at entry. Rates of missing benefit information varied by income source. These figures only compare respondents who indicated whether or not they received these income or benefits.

Source: JCHS Analysis of Massachusetts HMIS data 2013-2021.

Between 2013 and 2021, 17 percent of people 50 and older experiencing homelessness had Medicare coverage, making them ten percentage points more likely to use this health insurance program than adults under 50. While this is unsurprising, older adults were also somewhat less likely to use other public benefit options including Medicaid, which covered 65 percent of older unhoused adults compared to 68 percent of those under 50. They were about as likely to have state health insurance, which covered 28 percent of the older cohort and 29 percent of younger adults. But older adults were more likely to receive coverage from VA medical services, at 6 percent of homeless adults 50 and older compared to just 1 percent of the younger adult population.

While HMIS data gave us a baseline understanding about the use of benefits and programs and their importance to older adults, our interviewees revealed numerous barriers to older adult program participation in Social Security programs and also to older adult access to other benefits such as SNAP and housing programs. Broadly, older adults experience unique challenges related to application processes, including lack of documentation, difficulty accessing and managing application forms, challenges to communication, and a lack of trust resulting from a lifetime of systemic issues. While applicants of any age may find application processes complicated and bureaucratic, age-related experiences can compound these difficulties and become a barrier for an older applicant. In addition, benefits may not provide sufficient support for older adults' housing and service-related needs, particularly in a high-cost market.

4.4.1. Benefits may not cover costs of living.

Even when an older adult participates in public programs, the assistance these programs offer may be inadequate. The amount of public income assistance typically does not meet actual living costs, even for households with subsidy. One interviewee described older residents spending 50 to 60 percent of their income on housing. SSI and SSDI income alone will not pay for even the lowest cost options in the local housing landscape. As one participant commented, “A lot of our older clients [have only] SSI or SSDI, and 30 percent of that won’t even put you in an SRO [single room occupancy shared apartment]. It’s not even enough to get you in a room, and they usually don’t want rooms, most of them don’t want to be in an SRO for valid reasons. They’re worried about living with other people in it, causing ... them to use drugs or get their stuff stolen. But SSI and SSDI would never be able to even put somebody in a studio.”

Furthermore, those whose housing subsidy allows them to limit rent payments to 30 percent of their income may still experience economic hardships because there is little left over for other necessities, like utilities. As one interviewee explained,

We have a lot of people who are on SSI. So, you know right now it’s \$903, their rent’s a third of that. You know that the rest of that money can go so quickly, even in the best of situations.... So you know people, miss payments ... and they start to accrue arrears and we have to rely on some sort of, you know, nonprofit to support them and relieve that debt. Because, again, their income is so low payment plans are often not realistic, or they can’t be substantial enough to resolve the debt quickly at all.

Housing vouchers can also be difficult to use, as observed by one respondent: “The payment standard from Boston housing wasn’t even really covering anything [near cost] so clients with vouchers, [who] should be in the best position to be able to get into housing, couldn’t because the vouchers were only covering up to \$1,800 or \$1,900, and then suddenly landlords are asking for, like \$2,300 to \$2,400 a unit.... It’s really expensive right now.” A voucher-holder might be able to use the voucher outside of Boston where housing costs are lower, but then they might be far from service providers, social networks, and mass transit.

Interviewees also expressed concern about rigid income limits that exclude certain older households from program participation. For instance, they discussed households in which income was only very slightly over the qualification for assistance but not nearly high enough to purchase market rate housing. As one recalled, “I met [a client] that is, about \$200 over the income limits. But that \$200 won’t help them get a market rental... and then he won’t get the low-income housing because it’s like so short over...[if] you are like \$10 over, \$200 over, [you are stuck] with that.”

4.4.2. Benefits may be unrealistically time limited.

Interviewees also expressed concern that time-restricted funding programs do not align well with the needs of older adults who are no longer participating in the workforce and therefore have little expectation of rising income in the future. As an example, Rapid Rehousing is designed to offer a temporary infusion of resources that phase out once a resident's housing situation stabilizes. However, an interviewee pointed out that for older adults who have no expectations of new income sources, "you can't phase out the rental assistance. If the income doesn't go up or you don't link them to a benefit ... they've got their social security. They've got their pension. This is what they've got." When benefits expire or someone has reached a targeted point of stability (such as placement in a new home), contact with staff may also be lost. An older client who remains engaged with a caseworker in an ongoing way can address new issues when they arise before a problem disrupts their housing or health. Interviewees described the frustration of helping to stabilize clients but lacking the service structure to continue to follow them; the client becomes disconnected from services, and "That's when we find people who are not eating or people who are just not getting the services that they need [to be safe]."

4.2.3. Programs may exclude particular populations.

Even when an affordable, accessible unit becomes available, program design and exclusions create barriers for some older residents. First, rules around immigration status can restrict the use of housing programs as well as other subsidies. Explained one interviewee, "Federal benefits ... do have the so-called immigration requirement. We treat everybody the same but because of their status difference, when we respond to them, we tell them, unfortunately, you are not qualified [for certain programs]." Respondents explained the importance of the Massachusetts state-funded affordable housing system, which does not impose the same criteria and creates options for older adults excluded from federal benefits.

Older adults with a history of criminal convictions may also struggle to utilize housing programs such as vouchers. A participant illustrated this experience, explaining, "We have one gentleman right now who has an ancient, and I do mean ancient, like 35 years ago, he was he was convicted of a sex offense fairly high level ... you can't get rid of that. So, when he loses his housing,

where does he go? Everybody looks at that ... they're not looking at the individual. The fact that he hasn't offended for 35 years, he's now in pretty frail shape ... but he's, you know, again, he's blacklisted. Essentially. Where does he go?" It can be especially difficult for caseworkers to find resources to support this population. One recalls, "There's one guy, he's very cognitively limited ... [after] two plus years staying with us.... We kind of finagled some magic in the background to get him one of our units onsite with one of those vouchers.... When we look at people who stay the longest [in shelter], it tends to be sex offenders, and the sex offenders tend to be older because their sentence was so long. So, we have folks that come to us after 20-, 30-plus years of incarceration."

Life experiences can also limit older adults' access to housing-based care environments such as skilled nursing facilities. One interviewee explained the challenges of finding an appropriate home for older adults with functional deficits as well as a history of homelessness, substance use disorder, or previous convictions. They said, "We've had ... older adults who in our case manager's opinion, are nursing home eligible, but the nursing homes don't want them because they have histories of homelessness and or they have behavioral health [diagnoses].... We definitely have had people come back to shelter because they haven't been able to make it in a nursing home and that's like awful, because ... there are people like in wheelchairs with no legs. I mean not that they should not be in a nursing home, but people with severe physical disabilities ... should be in an accessible apartment." This challenge especially impacts older adults from disadvantaged groups who are more likely to become involved in the criminal justice system for systemic reasons, as explained by one interviewee: "Interplay with the criminal legal environment is also a huge barrier to people leaving shelter ... that's a whole area [that] particularly affects people of color because of the criminal justice system having been built to exacerbate structural racism."

4.2.4. Programs providing support in the home may omit younger adults in need.

Massachusetts has more services to provide home supports than many other states do, but there are still limits. First, qualifying ages vary by program, and many who are housing insecure or unhoused fall below age thresholds. An interviewee, who called for a more centralized program of supports and services for care at home, noted:

I think that it's very complicated, MassHealth, Medicare benefits, medical care. Lot of my folks use [hospital system] or some of the clinics around the city. I feel like it's very complex, and there's not enough home services. [The hospital system] has a home care program, but in order to be eligible for that you need to be more than a

senior, I forget what the age is, I think it's 65. So, in the senior world, like for home care services, you need to be 60. But for home care [in this hospital system] you need to be 65. I tried to get somebody into [another hospital system]'s home care, and their waiting list was closed. You needed to be an established patient with [them].

4.2.5. Older adults have particular challenges navigating the system of supports, services, and benefits.

In addition to gaps in services, interviewees described in great detail the challenges older clients faced in accessing services that do exist. Interviewees noted that applications for housing and benefits can be cumbersome and the paperwork overwhelming and time consuming, and securing benefits could take many repeat visits. Barriers may also be psychological, including a lack of trust in government programs and the perception, particularly among first-time applicants, that benefits are for “other” people.

Older adults experience challenges with documentation. Documentation, including birth certificates, social security cards, and identification cards, are key components of demonstrating eligibility but can create another barrier for older applicants. Older adults may not have needed to use their identification for many years. Their paperwork may be lost or expired. As one interviewee explained, “Some people have it all, and they have it all nice and neat in a folder, and some people have none of it. Some people start with it, and then they discover, and they look at the date, and it's expired.” Alternatively, the documents themselves may have deteriorated. As an interviewee described, “Sometimes we have to help them acquire [new documents] because the paper has just disintegrated. They're in their eighties. You know it's just so many little things, but it hinders [the process].” Some older adults may not even have access to requested documentation due to the disadvantaged circumstances of their birth, requiring creative and persistent administrative intervention to navigate a bureaucratic process without required materials. As one participant recalled, “We had African American consumers born in the South at home who had no birth certificate ... I think we used to get around it with baptismal certificates, but the point is ... you know, you figure out how to order these things.”

Becoming unhoused can exponentially increase this document management problem, as a person without a home will have a harder time keeping items safe and organized. One participant recalled an instance related to missing documents in which an older unhoused client possessed just

their phone: “Like, you know, you don't have paperwork. You don't have a bank account. You don't have ... all these things. And so, a lot of people get left out of the process because they just don't have, like, the adequate support to have all their information in order.”

Many older applicants need to replace documents, but this can come with costs. A participant described some of the ways they must coordinate funds for older clients to replace their documents, “We do have someone that will pay ... give them a money order made out to registry after we've set up an appointment for them to go and get a Mass ID or a new license. We sometimes can get [them] to pay for a birth certificate, or sometimes it depends on the circumstances, and how quickly they need something ... we might also, as an agency, pay for it.”

In addition to cost, it can be confusing and administratively difficult to request new documents. An interviewee told a story about helping a client obtain a new birth certificate: “So we had this gentleman. I believe he was born in Alabama. Needed his birth certificate. Didn't have it. [So we] literally called the office in Alabama, got the information needed in order to complete the application, where to send it. We got a check for it for the cost [and] sent it to Alabama.... He was an elder, older man, had a physical disability.... He lived with his friend who was just as old.... The friend brought him in. He couldn't [request the birth certificate] and his friend was just as frail and couldn't help him.”

These challenges of collecting documentation can delay or even block access to services if the application cannot be completed while a unit is available. Explained one participant, “The paperwork is like a huge burden of this process, and so someone might be eligible, but they can't find their birth certificate, or we can't order it, because it's from a, you know, a country that is hard to get in contact with.... There is a lot a lot of personal information that is requested of people for subsidized housing from marriage certificates—you have to go to the courthouse to get that, to birth certificates. ... Background checks and a lot of random information that's requested of people from their income to ... life insurance policies ... make it really complicated ... [Sometimes] you submit an application, and then, like a month later, you'll get a request for some other piece of information from this person, and then a month later, they'll ask for something else new you have to get.... And then, a month later, some of the documents [like bank statements] that you submitted have expired, and you need to get new ones.”

Finally, it can be physically taxing to obtain documentation, particularly within an abbreviated time frame and without reliable and accessible transportation. A participant described an exhausting

experience for one of their older, unhoused clients: “The client went to Social Security, and brought a shelter letter proof of residency, which used to be enough.... And then I guess Social Security was like, ‘No, this doesn’t work. You need to go to your doctor and get something from your doctor for proof of residency, because we’re going to take that from the doctor.’ So now the guy had to go to the doctor ... and then he’s going to try to go back to Social Security today, just to get a printout that says his number.... Like it’s like such a huge process, and for these clients like that’s a lot for him to do. That’s a lot for him to get done in one day.”

These numerous challenges obtaining new documents can be exacerbated by both age and income. An older adult living with low income is more likely to live with poorly managed chronic health conditions and functional mobility problems. They are also more likely to experience cognitive limitations. A caseworker mentioned this intersectionality, pointing out that, “It’s hugely frustrating to verify somebody’s identity in a lot of cases, especially for people who are low income, or, you know, have cognitive diagnoses.”

Older adults struggle with complex applications. Even with documents in hand, application processes can be complex and arduous for an older applicant. As an interviewee observed, “When you have an application process ... like for social security or SSDI ..., you have to prove things. It becomes really hard for folks, especially if they have some cognitive problems, mental health problems, trauma.” Another provided insight into the complexity of applications for subsidized housing: “Most applications for housing, you gotta have your 3-year housing history, your 5-year housing history, your 10-year housing history, [then] you get to the part of the application where it [asks for] credit references, [and] people just say, ‘Oh, I don’t even want to do this no more.’ They just give up right when they see a section like that.” These applications can be quite lengthy and taxing for older adults. Another participant noted, “A lot of [older clients] don’t have the stamina to stick with it to complete that application, so we might have to do it in two or three sessions.”

Applicants often need assistance with these complex and numerous processes, but it can be difficult for them to access program benefits managers. One interviewee summarized their concerns about the demands on applicants’ time, saying, “One of the barriers to that I’ve heard is ‘I have applied and I haven’t heard anything, and every time I try to call, no one picks up the phone or no one calls me back, or I have to wait three hours if I go [to the office].’” Without this needed assistance, older adults can struggle with both the application and recertification processes. Observed a participant,

“We've had examples where [benefits] have been shut off, and [older clients] don't understand why. And then ... it turns out there is some paperwork to fill out that they didn't understand.... And so I think, you know, if you don't have someone to help you with some of that stuff it becomes really, really challenging.”

Comprehension difficulties make applications more difficult with age. As someone explained, “Many older adults have a hard time managing information. Age-related cognitive changes, trauma-related attention differences, and loss of hearing or sight can complicate comprehension.” These sensory changes are also associated with aging. Described one interviewee, “Vision may be poor, hearing, maybe sense of touch. You can see the computer, but it's really hard for you to type.”

Transportation barriers can limit access to needed services. Transportation to and from the various offices can be complex, particularly for older adults who do not drive or own a car. Older clients must coordinate with friends, family, caseworkers or obtain assistance with public transit systems to make these trips. One interviewee noted that their agency will pay for transportation if needed: “If [older clients] come to me and say that they have an appointment, and they don't have a way to get there, if I have bus passes, I'll give them bus passes.” However, due to mobility or cognitive limitations, not all older adults will be able to utilize public transit. One provider considered this problem: “We get, like, pre-loaded T passes that we can give to our younger clients. But how does that help our older clients get around if they're on a walker or cane?” These transportation challenges might be new for some applicants and may co-occur with the health, support, or functional ability changes that precipitated their housing insecurity. As one interviewee described, “Sometimes ... the need [for transportation assistance] is new. They were able to drive. They were able ... [to] take, you know, standard public transportation. So, if they had changes in life, they've never had to think about these things.”

Access for some older adults is limited by language barriers. Language differences can make complex applications even more difficult for certain older adults to navigate. While forms are often available in Spanish, translations into other languages may be harder to locate. Yet, as one participant explained, many older clients speak other languages: “There's a lot of Mandarin, Cantonese, Portuguese, Cape Verdean Creole, Haitian Creole.” These language differences can go hand in hand with cultural backgrounds that might complicate application processes. For instance, an interviewee

explained that immigrant clients they work with who speak Haitian Creole don't typically read in that language because it was not formally taught in their schools. They said that clients "bring in all of their paperwork, and have the advocates read because they have no idea what it says." Another participant emphasized the importance of contextualizing a client's experience, admonishing the importance of supports being culturally competent: "Not everybody's situation is the same. Don't immediately judge what you see. Ask questions. There's a backstory always, especially when you see that there's, you know, loss of housing, or you know insecurity in that." Without appropriate support, clients might inadvertently lose services and supports that they need. When applicants cannot read the materials, "They may just throw them in the pile with other mail, and just forget about it. And then we find out when they lose their [benefit] and we have to try to help get it back on."

Technology barriers can present particular problems for older adults. Technology is an increasingly basic component of applications that can create barriers for older applicants, as one provider detailed: "[Older applicants say], 'This is so much harder for me. I have to remember all these passwords ... I used to just be able to go in and give them my form.'" And applicants need to be flexible and expansive in their technology use since different applications rely on different portals, platforms, devices, and systems. A participant recalled a client who (with assistance) registered online for an in-person appointment, but when the applicant arrived for the appointment, the applicant had to enter a variety of information into a kiosk at the office, and "[she was] an older lady ... [who] had no idea what to do, and [nearly left]." The participant observed that systems are put into place for the convenience of the provider, an expert in each application process, but the systems put the onus on the applicant, often a person in crisis and with limited resources, to accommodate provider conveniences.

A new technological demand might become an insurmountable barrier for an older applicant already experiencing the strain of housing insecurity along with a complex application process. Even something as simple as a communication system that relies on email could impede applicant success, given that applicants may not have access to a device or internet. One interviewee considered, "You're trying to just figure out how you're gonna maybe stay warm tonight, and you're not thinking. Oh, let me go to Boston public library and ... log into my account here." Applicants then need to set up various user accounts and messaging platforms and learn how to use them. Explained one interviewee, "Email ... might have been something that they signed up for 6–7 years ago that they no

longer can remember the password or the information to log in.” Even those who have a device, internet, and accounts might find the technology hard to use; an interviewee described older clients “not knowing how to retrieve voicemails off of phones. Not knowing how to work a government phone if you are lucky enough to get one.” Another explained the problem with relying on technology: “As much as I-pads and smartphones, and those things are available now ... there are still those that will not use those devices. So then you still have that barrier.... You still have to do in person as much as you can, because some of them just won't engage [using technology].... You know, the first day they have a frustration of ‘it's not working,’ they can put it in the drawer and close the drawer, and that's it.”

These technology issues are more prevalent for older adults, people living with few resources, and members of some marginalized communities, so impacts are focused on groups with intersecting vulnerabilities. A participant described their experience with technology barriers: “One thing I think that became clear through the pandemic was on technology, especially in our communities, you know, people of color.... We try to address ... technology, literacy, but ... if you don't have access to that, that's a huge issue.” And another participant explained that language differences also complicate technology accessibility: “Ninety-nine percent of our clients are limited English proficiency. So basically they don't have an ability to read and write and understand the language in the English. [Moving everything] online ... creates a situation for seniors ... [who struggle with the language and also have to navigate the technology].” Poverty then compounds these intersectional hardships because older adults living with limited resources might be using substandard equipment. One interviewee described a client whose phone was so crowded with spam that it was barely useful for communication purposes. They recounted the problems, saying, “He still tries to use it but it’s just really frustrating for him because he obviously doesn’t have the resources to get a different phone and is so dependent on that one and it just makes it harder, not only is he older but his first language is not English.”

And yet, even in a world of virtual applications, lacking a mailing address can be a devastating barrier in a system with extremely rigid systems and very limited resources to allocate. As one interviewee explained, “Everyone thinks ‘okay, they've got a cell phone. Everything's going to be fine.’ But if they're getting letters for interviews, and it's going through the US mail ... so that can be a barrier right there. They've done everything right up until now ... they're really close to the finish

line, and they miss ... a letter, or they miss a phone call. And now they're back at the beginning of it at the end of the line again.”

Older adult struggle with administrative burden caused by duplicative applications.

Applications for housing benefits have specific challenges, including lack of transparency about housing availability and lack of clarity about eligibility—in addition to long waiting lists since housing assistance is not an entitlement. Older applicants must improve their odds by completing applications for many housing options, including distinct applications for every subsidy program within each housing authority. One participant explained, “The applications themselves are burdensome.... If you're applying to public housing, it's one application and you have to provide all the documentation for that. If you're applying to the Section 8 program for a mobile voucher, it's another. Even though it's [the same housing authority], it's a different application, and then you have to provide all the documentation for that.” People searching for housing might apply for housing in multiple housing authorities, compounding the work.

Another interviewee noted that each application itself is onerous: “Why do they have to be 20 pages or more? Why do you need to know ... where I lived seven places before I came to where I currently live? Just ... so many questions that at the end of the day do not relate to if you're going to give me housing or not.”

Finding available housing is difficult too. “[An] easily accessible, all-inclusive database ... would be helpful for public housing. ... Consolidated Housing availability lists would be good ... they're out there [but] they're not consolidated and they're often not easy to understand.... It's not always clear what people qualify for.” One caseworker suggested that better communication could make these processes more efficient for older applicants: “Wait list transparency, I think, would be helpful for public housing.... [Housing availability lists are] not consolidated, and they're often not easy to understand.... It's not always clear what people qualify for ... [It would be helpful to have] clear information in general for people who are trying to find housing.”

Some older adults may be reluctant to accept support. Complex applications, communication challenges, and technological issues are mediated by older adults' capacity to cope with these barriers and their tolerance for public service utilization. Many older adults prioritize a sense of independence and stigmatize public assistance and subsidies. One interviewee noted, “It's culturally hard for some

elders, you know. Noted one participant, ‘I take care of me or my family should take care of me and I don’t need help. I’m okay. I’ll manage ...’ Even though you clearly can see they need help and they know they need help.” Added another that independence is “huge for older adults... just making people feel comfortable enough to say ‘hey, you know, I need a little bit of help ...’ without having the stigma behind it ... would be very helpful.” One participant considered this sense of independence while recalling a particular client, “He doesn’t want the help. He’s working. He’s in his late seventies still working every single day putting money aside. He doesn’t even want to access funds for first, to last, or security, like he feels like he needs to do it on his own. So he’s working, and he’s like, the second. I have the money, you can find me a market rate unit.”

Another interviewee offered some insight into addressing this reluctance as she recalled an older client who was chronically homeless and particularly resistant to support. “What it came down to, it was so sad. He was 74, and he told me he was like, ‘Why should I take a unit when there’s younger people that deserve it? And I’m gonna die soon, anyways ...’ He was a veteran. He worked his entire life. So we didn’t understand why he felt that way, but I think he just never had anybody that, like, cared enough to talk to him and figure it out and help him like, break it down that it was okay to do this and ask for help.” The interviewee reported that with encouragement, the client had accepted housing, “and he’s been housed since then, and he never left. He’s in the same place. He’s been a great tenant.”

Participants consistently raised the challenges of mistrust, especially for older people and those who have been systemically marginalized. Some described mistrust in terms of trauma associated with past encounters with systemic disparities. As one interviewee explained, “People who want to avoid this historical system [will] know a social worker a mile and a half away and run in the opposite direction.” Speaking of clients who had been involved in the mental health system in the past, an interviewee said that voluntarily engaging with public mental health services is “too painful for them in a in a lot of ways, and I use the word painful. It’s too stigmatized.” Another participant described the experience of trauma and the ways it can impact older adults’ willingness and ability to participate in public programs.

[Trauma] can lead to PTSD. But [cognitive issues are] another symptom of trauma ... So it’s hard to pay attention. It’s hard to understand. Things may need to be repeated time and time again. I see paranoia of government offered services and state offered services. Because, you know, maybe they had issues with their housing about three years ago ... or maybe [the Department of Children and Families] was involved when they had young kids ... so there’s mistrust of government provided service. We also have

[clients] who may have qualified for something years ago and then that program got shut down because of funding [cuts], and so they don't want to try another program because they're afraid something else will get cut.

Issues of trauma and trust impact interventions. One practitioner was deliberate in taking time to refer a new client to other programs: "If I do that too quickly, that person's not going to trust me ... it takes a while to build that trust." Aging itself can feel stigmatizing. Described one interviewee,

You are priced out of your unit, your health changed, you lost your job... Building that relationship is [listening] to the stories of...when they were a CPA ... because that makes the connection that you're seeing them as a person and not just as an old person. Because, yeah, a lot of older people, they don't want to necessarily identify as older, like they feel like the definition of older in their mind is what their great grandparents were not what they are right now.

And housing insecurity is inherently traumatic. As explained, "Everyone who's experienced homelessness has trauma.... It depends on how ... their trauma manifests. It's different for different people."

4.5. Research Question 5: How Are Programs and Services Supporting Older Adults Who Are Housing Insecure or Unhoused? How Can They Be Improved to Address Age-Related Needs in Boston and across Massachusetts?

Interviewees volunteered numerous opportunities for improving the system of supports and services for older adults with housing insecurity or experiences of homelessness. Key solutions include improving access to affordable housing, increasing opportunities to retain existing housing, expanding options for rehousing, and improving program participation by addressing administrative processes.

4.5.1. Improve access to affordable housing, rental supports, and emergency assistance.

At their most basic, housing insecurity and homelessness arise from a lack of access to housing that meets the needs of residents and is affordable to them. Affordability is a cross-cutting issue, and addressing it directly will make it much simpler to tackle other age-related challenges. Interviewees pointed to opportunities for healthcare systems to invest in affordable housing. Limited construction

subsidies, and the need for developers of affordable housing to layer multiple subsidy funding sources to make projects work, can increase development costs; one interviewee noted that their organization had constructed an entire building that offered rentals for a third of tenants' income, but when they recently expanded, they were not able to access such generous funding, and rents cost two to three times the monthly rates for the new units. In addition to ensuring that benefits actually met the area cost of living, interviewees also emphasized the need for lower-threshold subsidy programs that could support recipients across a broader range of circumstances.

In keeping with findings reported above, interviewees suggested that benefits that can be retained over time would improve housing security for older residents who are struggling economically but do not have prospects for higher income. Participants advocated for less restrictive, more graduated opportunities for qualification and for assistance that did not exclude marginalized and vulnerable groups. Many interviews mentioned the added difficulty of housing older adults who did not have citizenship or who had a history of involvement in the criminal justice system.

Finally, participants expressed that older adults benefitted greatly from various forms of payment assistance to help with missed payments or large expenses. One advocated for shallow subsidies, explaining that, "Once you're homeless, the cost of housing you goes up exponentially. Literally, that's like factor of to the third power or fourth power." Another interviewee agreed with the superior efficiency of helping older people maintain existing housing over helping them find a new home, citing clients whose housing stability may have been threatened during a period of hospitalization:

In some cases [organization name] will step in and pay the rent while that person is in the hospital, because we want to avoid losing that unit at all cost. It's cheaper for us to pay the rent for this individual for three months or so while they rehabilitate than to have that management company remove them from that apartment, and we're looking for a new apartment all over when they release. So we do a lot of trying to maintain the housing ... if we can.

Participants explained that shallow subsidies are also outreach strategies, as they create opportunities to engage new program participants. As one said, "Sometimes people get referred for help with back rent ... or utility payments. We found a large population of [participants] start utilizing our food pantry first, and then kind of spread into other parts of our organization."

Interviewees mentioned a shallow subsidy program that works well in the Commonwealth. Through a MassHealth program called Flexible Services, housing supports can partner with health

insurers to pay an expense that might otherwise threaten the older beneficiary's housing stability. By linking MassHealth to housing specialists, the funding program allows the insurer to benefit from the expertise and relationships built in the community housing system without expecting the insurer to construct an entire infrastructure of their own to do this work.

In conjunction with subsidies to address missed payments, some tenants also have to deal with the legal implications of having fallen behind on payments. Interviewees pointed to Massachusetts's Tenancy Preservation Program (TPP), designed to assist tenants who incur violations related to their mental health or disability. This state-funded program diverts cases from housing courts and helps mediate solutions for people facing evictions for reasons related to their disability or mental health challenges. Participants also pointed to a newer program designed to offer assistance even earlier, "TPP Upstream, where you could make a referral ... when there was just a lease violation before an eviction [filing occurs]. And it's been successful ... over 90 percent of the people that they work with don't become homeless."

Finally, interviewees acknowledged that sometimes relocation is necessary, especially once someone has become homeless. However, rehousing requires resources. One participant pointed to a new American Rescue Plan Act initiative MassHealth has designed to address this need. The new program will help residents pay "for the costs that people need covered when they move into housing: first and last month, and also furnishings, beds, pots and pans, filling your pantry, things like that ... we've stood up a program where, if somebody is coming out of homelessness or other situations where they didn't have [furnishings and supplies], and they're moving into an apartment they can apply ... through their health insurance... [to spend] up to \$5,500 on... the goods that they might need."

4.5.2. Increase opportunities for accessible housing.

Participants emphasized the importance of housing that meets residents' accessibility needs, and they noted that these needs can be easier to meet when housing and health systems coordinate. In some circumstances, an older resident will need to move to a more accessible home. Said one participant, "We do a lot of relocating our participants to help them get into units that work for their current lifestyle." Since access to accessible units often requires documentation of disability, another participant pointed out that an established connection with a healthcare provider can help expedite

the need determination process. “If someone loses their housing as a *direct* result of a medical exacerbation (e.g., they live on the third floor and become homeless after becoming wheelchair-bound), having thorough documentation of this by a medical provider can significantly expedite re-housing.” However, modifications are often more efficient than re-housing. As one participant explained, “Can we modify to save it? Because that's probably the fastest thing for us to do then to have you search for a new place that's going to be handicap accessible.” Small modifications to preserve an existing home are often funded by local housing organizations, as a participant noted, “When we have the funds, we'll help them with ramps.” When modifications are out of reach for a housing program, the program might help coordinate financing, “We certainly can refer them for the low interest [or] no interest loans.... Some things are way too expensive, and require too much ongoing maintenance, but we ... can assist again with those loans ... and point people in the right direction.”

Right now, the state is working with a technical assistance collaborative to examine how a person might access a home modification using MassHealth. Interviewees generally called for a regularization of the process. “We know that this person cannot walk. Sometimes the system ... puts you through so many hoops to get what you need. And in the meantime that person is suffering or having to stay in conditions that are not helpful, because we just can't get something as simple as a ramp ... everyone agrees we need the ramp. Let's just call the mobility prompt company, get the measurements, and order it.”

4.5.3. **Increase touchpoints to staff and services where people live.**

Housing-based services and personal care and assistance programs can improve housing stability for older residents. However, misaligned program requirements can leave out some people who need support. A centralized and coordinated set of services—or even a centralized portal for applying for these benefits—could help address some of these access issues.

Residents aged 60 or older who meet clinical and financial requirements receive personal care and assistance support through the Frail Elder Waiver (FEW). Unlike most states, Massachusetts does not maintain a wait list for home care provided through Home and Community-Based Support Medicaid waiver services. However, older adults need stable housing to receive in-home assistance. As one participant explained, “We can link people with services. Unfortunately, many of those services require that you have a home, right? If you need help bathing or eating, you're not getting

that in a shelter. You're not getting that in your car.” One interviewee addressed this problem by bringing a home health aide into the various housing units managed by their organization. “We recently partnered with a home health aide company that is actually pretty good at working with the population. And so [they support] a number of our folks that are living in permanent housing, mostly at [the organization’s housing] center, but now also in the community.” There are also people experiencing homelessness who need these supports but are not quite old enough to qualify for the public programs. While there are many programs and resources, age of eligibility may vary. One respondent described these challenges working with a client she characterized as “an at-risk senior”:

“I can't get her into home care because she's only 62, so she's going to have to go to adult primary care, and I am going to have to take her. She's too young [to receive support from an Aging Services Access Point], because you have to be 65 for that and she's homebound. And so I don't know what's going to happen. I'm going to get her to that appointment, and I'm just going to throw my hands up and say, ‘We have to do something, this is this is a very ill woman.’ ”

The state is exploring a medical respite program to provide both shelter and assistance to people who experienced a health crisis while unhoused. An interviewee explained:

Medicalizing shelter doesn't seem like the right response. But we are missing this middle. We have [some medical respite programs] but those are really short term, and they wind up sending people back to the shelter [or] street. So what we're standing up is based on more on a California model where they let people stay up to 6 months.... It would be for people coming from the hospital who have a primary medical issue that they need to recuperate from. But while you're there, the hope is that you can engage that person, and you have better odds of finding them an appropriate place to go.

Many interviews emphasized the value of residents’ access to staff within their housing communities or buildings. Explained one interviewee, “Immediacy is really important. I think that when people [have] questions, issues, whatever tough moments, I think if you have someone who's on site, you can frequently fix it in the moment before something accelerates and becomes a big problem.” Emphasizing the value of regular contact, one participant noted, “We know [the residents] through familiarity, too, and being in the building every day, whereas a case manager may see them twice a year.” And another added a comment about the value of regular contact with staff: “Some of the maintenance guys are great ... we get a lot of information from them.... I’d like to see a new sort of mandatory training for anybody that's going to work in any building that is subsidized ... at least with the older adults, over 60.”

Interviewees called for more formal, housing-based supports as well. As one pointed out, “I really like the supportive housing piece. There's a huge lack of supply of that. I don't even know that many agencies are providing this type of service. HUD has to fund this.” One cited the value of property-based service coordination and noted that, over time, small amounts of assistance translated into much greater stability: “There are many people that live here that could easily, at this point, from years of living with the supportive environment, that could handle living in regular senior housing with a subsidy. They would need a subsidy, but they don't need the case management support that they did when they first came in... I mean that we have people that have lived here 25 years, and they're not going anywhere so very little, turnover.” Another noted, “I do think that there's merit for some folks [to live in a] building with robust services, including some level of I'm nursing support. So ... if somebody needs starts to need a higher level of care, they don't have to go somewhere else [because] that's already built in.”

Another interviewee pointed out that supported housing residents tend to become engaged participants in various types of community building and preventative care programming. “They want to participate in health and wellness, [a] seasonal meal, or social activity, anybody that's on the lease is welcome to attend. There's no qualification other than living there legally.”

4.5.4. Increase older adults' program participation.

Opportunities identified by participants to improve program uptake by older adults include coordinated application processes, presumptive eligibility, reducing recertification requirements, the Program of All-Inclusive Care for the Elderly (PACE), and connecting and coordinating the network of service providers.

Coordinated application processes can improve benefits access. Long, complex, and repetitive applications that demand extremely long—in which applicants have to “tell their story over and over”—and indefinite waiting periods for benefit approvals deter older adults from making applications for public support. One organization reduces the demand on the older applicants by dispatching volunteers to some of this administrative work. “We would have them fill up one application completely ... and then the volunteers would complete the other 15 or 20 applications with that information ... and then we would mail it out for them.” Many of the applications also require follow-up with additional information provided later in the process. To address the need to

collect additional information later in the process, one organization tries to serve an intermediary role between benefit programs and older adults, which can be particularly important for people without permanent addresses or access to email or other technology.

Some shelters have attempted to bring enrollment specialists onsite. Explained one participant, “Three of our five shelters ... have, you know, regular staffing hours with nurses and things like that ... [to create a] one-stop shop model where the services come in, or the opportunity or the benefits enrollment specialist, whatever they are, come on site.” Another shelter benefited from a state worker who visited the shelters:

There used to be a lady, she came into [the shelter] on Wednesdays to bring checks and to sign an affidavit for clients, so that they can go and get their ID, because, unfortunately, clients who are in shelter don't always have proof of residency. So this just bypasses that whole process. She no longer comes to the shelter, but ... she created a program on Wednesdays for homeless clients to go in and to get IDs first, because the RMV is very backed up. I believe my appointments were looking at like six weeks at one point.

However, these organizations are using marginal solutions for a bigger issue. At a high level, numerous and complex application systems are out of step with the emergent nature of housing insecurity, particularly when experienced by vulnerable older people. As one interviewee described, “The current process big picture tends to forget the individual. It looks at all the problem[s], and this person wants to stay in the community. This person needs help, right? They need help, and we want to give it with respect and dignity ... I think we tend to forget if we were there, how would we feel about this?” This interviewee argued for a single portal for benefit application: “My North star ... is that of one portal. Let's just have one portal that can simplify the efficiency of the communication, and really is understandable to the individual as well as the person helping [them].”

The Commonwealth has explored a different approach. It has organized surges, or single-day events in which the housing authority for a participating community sets aside some units for elderly and disabled residents, representatives from multiple programs and services are assembled, and then prescreened applicants experiencing chronic homelessness are invited to attend. On the day of the event, applicants are brought from the shelters in buses, and

They were checked in. They were given an ambassador volunteer. They were given maps of okay, here's your stop one. Here's your stop two. Here's your stop three. We had ... DTA [Department of Transitional Assistance] and SNAP there. Social Security Administration was there to prove income and identification. We had MassHealth eligibility counselors to fix any eligibility issues. We had food. We had, I think, some

clothing. We had games because it was an all-day event. Everybody had different rooms, so we had a PACE room where you could go learn about PACE and see if that was a match to you. We had Senior Care Options, which is a MassHealth program ... so that basically we would route people to where they were eligible for things and have them sign up or learn about the services.... If they signed up ... [we could complete the process on the spot] ... You have to be nursing facility level of care for PACE, so they actually had their assessment done there that day... We brought nurses, state nurses there, who read and reviewed approved those screenings.... So that's a three-month process we were doing in a day. They then went to the Boston Housing Authority room, where they ran criminal records checks, and, you know, signed them up for housing, and by the end of the day, if they made it through, which is a long day, if they made it through, and said yes to these things, they had an apartment and services connected, and then we met like three days later, and case conferenced each one of those people to say, okay ... How are we going to make this work?... We did that three or four times.... The first time we invited, I think, 60 people and 20 people showed up, the last time we invited 120, and we had like 60 people show up, so I mean, we are solving homelessness one person at a time.

Presumptive eligibility can reduce wait times. The wait times for services are untenable for many applicants experiencing acute need. One participant considered the typical wait for an application for disability-related income supplements: “From my experience with the SSI, SSDI, it feels like they at least deny first. And they kind of force an appeal. I could be a little jaded on that, but that that often looks like what happens with those.” Another considered the limitations imposed by these wait periods: “Our options become very limited, and they're driven by sometimes mostly administrative right. If we could do it the other way around, I could move [the client] somewhere, and you give me three months to finish the paperwork. Then then that would allow that person to be safe in in a setting.”

An interviewee discussed the importance of connecting applicants to services while they wait for applications to be reviewed. “When you apply for Social Security here in Massachusetts, you're also able [to] apply for what they call EADC [Emergency Aid to the Elderly, Disabled and Children], which is a state funded program kind of like welfare where SNAP benefits come from that gives people access to ... a small amount of money while they wait for their claim to be decided on.” Presumptive eligibility, which is a feature of MassHealth, was raised as a solution by one participant:

With MassHealth, there's something called presumptive eligibility where you ... get approved for MassHealth, and then you have a certain period of time to ... get your documentation together. I know, with Social Security ... that's a really big barrier getting people back onto their SSI or their check got lost, or they miss the

recertification, and then with SSDI, the difficulty in being approved as somebody with a disability. But that's very onerous, and it's like you have to really jump through a ton of hoops, and have, you know, a hearing and an appeal hearing for people that, in our caseworkers' point of view, it's obvious that they have a disability, or more than one disability ... you know they will get there, but it takes so long, like 90 days ... or 120 days. And then there's a review, and I think anything to streamline that application process, or consider something like presumptive eligibility with follow up documentation [would be helpful].

Reducing recertification requirements can improve benefits continuity. Some benefits need regular recertification, which can endanger benefits older clients have already secured if they fail to complete forms or lack needed documentation. One interviewee suggested that more recertification materials come to applicants “pre-filled” so they need to submit documentation only if circumstances have changed in a meaningful way. Another described a workflow designed to allow people experiencing homelessness to recertify their Medicaid less frequently, saying, “We're about to launch a program ... called continuous eligibility for people experiencing homelessness, which means once they get on Medicaid, rather than having to do the paperwork every 12 months, they would do their paperwork every 24 months.” The state plans to use data collected by a HUD mandate through the Homelessness Management Information System (HMIS) to identify people eligible for this lower level of scrutiny.

Eligibility for Medicaid services was continuous during the pandemic, and a participant described this experience: “It’s been great for the last few years, we did not have to recertify for MassHealth. Now they're starting up again. So people are going to lose it, they're going to fall off. They may lose their health care.” This interviewee went on to emphasize the significantly unlikely situation that an unstably housed beneficiary would suddenly have too much income to qualify for support. “This [group] is very low income, and I don't know what's going to change from this February to next February. Great, if they hit the lottery, they lose their MassHealth and they get money.”

The Program of All-Inclusive Care for the Elderly (PACE) can reduce administrative burden. PACE was designed to increase efficiency by allowing a provider to manage client resources directly, reducing documentation requirements and wait times. As a provider explained, “We [PACE] actually become their insurance ... and there is no middle man between the clinicians and what we

recommend, whether that be equipment, so oftentimes their patients actually will get more than somebody who's on standard MassHealth, because we can say, oh, they need a hospital bed, because we've made all these assessments, and that's the end of the story, and, like we don't have to fill out ... 20 pages of forms and talk to all these people to make that happen. So we really do ... everything. We kind of keep patients comfortable and aging in place in our homes.” In contrast, another interviewee described the added complexity when services are distributed between different providers:

A CNA [certified nursing assistant] ... comes. They get meals on wheels. They might even go to health center where there's a different nurse. Okay, none of these people that I just mentioned, none of them know anything about each other. They don't communicate. There are different organizations to make that happen.... What's really amazing ... [about PACE is that] it's that very multi-disciplinary, interdisciplinary team approach.... It's a really fragile population. So the only way to make this happen is you really have to have a lot of hands in the pot, right? But [with PACE] it's one pot, and it's the same pot.

Connecting the provider services network could increase efficiency. Most older adults are not served by a program like PACE that manages a wide variety of resources for each individual client. It can be especially difficult to collaborate between the housing and health systems, and service providers may try to do more within their organization. Yet this could result in parallel but less efficient service systems. As an interviewee explained,

I worry about doing too much in shelter because they're trying to solve everything. I also worry that shelter and homeless providers take on a lot because the Medicaid and MassHealth world is so complicated.... [The shelter will hire their] own psychiatrist rather than try and link up with each psychiatrist for each person from each plan, and I'm not always sure that that's the best or right answer. I prefer to see more linkages ... I worry about the disconnect between the homeless provider world and the health care world, particularly as [clients] are getting older.

One strategy for improving coordination involved having housing case management services paid for by Medicaid for people who had chronically experienced homelessness. An interviewee said, “A big piece of our case management department is funded through MassHealth to ... [work] with people who are high utilizers of the emergency room ... We'll get notified when folks on our panels go to the ER ... We have weekly meetings, so we collaborate pretty closely with the emergency room here, and we have ... monthly meetings with the ER leadership as well.”

While these connections are difficult to forge, study participants described great outcomes when the health and housing systems were efficiently linked. One housing provider recalled partnerships with hospitals through their accountable care organizations (ACO):

We are working directly with the hospital, the doctor, the navigator, the program administrator. And so, we're able to get things a little faster in terms of like, we need a letter to verify [that a client's] disability requires this type of ramp or this type of ... bed. ... So what I found really helpful about the ACO programs is that you can navigate very easily right in that person's world [since] we're all working from the same information that's in the system. We can all access the information at the same time. So it's very easy for us to have here planning meetings and to be able to provide services for those individuals.

Another participant described coordination between housing and health systems related specifically to planning hospital discharges of vulnerable older adults. They said, “I lead the work stream related to discharge planning from hospitals. I'm getting them to work with healthcare plans and shelters to prevent inappropriate discharges to shelter of people who are housing unstable or experiencing homelessness.”

Yet participants were frustrated by the limitations of these efforts, particularly without a coordinated electronic medical record (EMR). One explained this challenge from the clinical side: “You know [clients have] complex medical problems ... [and] these patients are oftentimes going through several health care systems, and while I have access to some, I don't have access to many.” And another linked this to the challenge of maintaining documentation in an ongoing way, imagining a single location which could store identification and program participation information. They envisioned a system in which current documentation of program involvement as well as identification could be uploaded and kept safe, resulting in “some type of centralized data point for them, where, like, whatever they may need, whether it's medical housing, financial, follow-up, anything like that, you can find all the information right there.”

Long-term relationships between clients and providers can increase housing security. As noted earlier, some continuity and access to the “bigger picture” of an older client’s needs can be lost when they are rehoused or no longer eligible for a certain program—yet problems can still arise that destabilize housing once again. Interviewees pointed to the value of ongoing relationships that allow interventions to be continuous and incremental. An interviewee in a position to follow clients long-term described a client “that's falling a lot, and I'm like.... ‘Let's talk to [your primary care doctor

because you are] falling a lot. Is there any reason why you're doing that?' I'm asking them a question. I'm building a relationship, saying, 'Look, I care! You know I'm seeing some things, so how can I help you?' And getting them to take services ... if I do notice that there's a decline." Housing-based services can fill some of these gaps. A service provider can build a relationship with residents who do not actively need support, and they can passively monitor residents for emerging needs before a crisis.

Early prevention can be effective. In general, participants were proponents of early interventions for older adults to prevent housing crises and of service continuity to facilitate these preventative measures. As one put it, "Get to know us before you need us." Yet, many older adults are unaware of resources and may be disconnected from services until a crisis happens. "If you don't specifically have a caseworker, someone who can help you with all that stuff ... you might not even know what benefits you're entitled to," explained one participant. It can be difficult to proactively connect clients to services, which can result in a backlog of need. As one noted, "I think a gap is, there's not enough ways to help before those crises happen. How do you get into people's homes and help them without people asking for it?" As a result, older adults who are unconnected to service systems may present asking for assistance with a specific unmet need when they are actually experiencing many compounding challenges. As a participant described, "[We get a referral to find someone new housing], but ... we see someone who's been in a home struggling to pay their rent so they're not eating well. Or we see that this person has a transportation issue and they're not getting to their medical appointments. Or there are repairs that need to be done.... So, we often uncover a number of those things just because ... that person was brought to our attention has having a need to relocate."

An important component of proactive intervention is access to professional services including physical health and mental healthcare. One participant described the feedback between inaccessible services and the need for supports: "When your life is totally in upheaval it's certainly not good for your mental health. You may lose all of your belongings because you can't pay for a storage. in which case, then, you move into your new place, and you've got next to nothing. So I think the ever keeping people housed. I think you know a lot goes back to better mental health behavioral health services."

5. Discussion

Our first task was to use our observations of housing and aging service systems in Boston to explore the ways older adults might be specifically vulnerable to housing insecurity and homelessness. Our work confirmed that the causes of housing insecurity and homelessness are complex and multifaceted, but that there are articulatable ways in which the risks of becoming homeless or the vulnerability to the conditions of being homeless are particularly acute for older adults compared to their younger counterparts. In **Figure 7**, we consider the micro or individual-level factors identified in the literature that contribute to housing insecurity and the macro-level policy areas related to these conditions. From this study, we add an age-related vector that describes, from our findings, the ways in which circumstances related to aging can interact with each condition and make it more acute. This suggests that resource allocation and program design, from application to management, should take older adult experiences into account.

This age-specific vector of hardships reflects that some experiences become more common with age. Since older adults are less likely to work, they are more vulnerable to inflation and a misalignment between public programs and actual local living costs. This increases their exposure to poverty and housing cost burdens compared to those in working-age households who have more opportunity to adjust their household income to new market conditions. Age also increases the risk of cognitive and physical disability, conditions that are associated with housing insecurity. Both cognitive and physical disability can destabilize an older adult who had been living independently by creating new needs that must be addressed for them to continue to live safely in the community. For instance, loss of mobility can make a previously good-fit home unsafe and untenable without modification. Advanced age is also associated with change over time, increasing risks that an older adult has fallen out of step with technology and systems that have become integral to independent living and benefit utilization.

Other age-related experiences make older adults more vulnerable to conditions related to housing insecurity. For instance, as chronic conditions compound and become more acute, a person grows dependent on certain regimens and resources, and even a temporary disruption of electricity or refrigeration can create critical problems in managing insulin or charging a powered mobility scooter. Frailty that accompanies age can make an older adult a target of violence, or it can make them feel more vulnerable to crime, creating additional concern for those who need to sleep in a place

that has not been designed for habitation. Frailty can also make it more difficult for older people to access shelter services, especially when this access demands waiting in long lines and contending with inclement weather.

Finally, age-related circumstances can make it harder for an older adult to manage transitions and rebalance resources by applying for public program assistance. Isolation and lack of social capital can reduce options for older adults to manage change. Past experiences of systemic inequity, public program inefficiencies, or harsh institutional treatment can create trauma and mistrust of public systems that make older adults more cautious and less willing to engage with systems. Trauma, mistrust, and cognitive decline can make systems feel overwhelming and create additional barriers to navigating bureaucratic public systems. Age-related physical and sensory disabilities further complicate these application processes by making the tools more difficult to use. In fact, for every risk factor for homelessness documented in the literature, our findings surfaced older adult specific experiences that could increase vulnerability to that experience.

Figure 7. There Is an Age-Related Vector of Risk to Housing Security

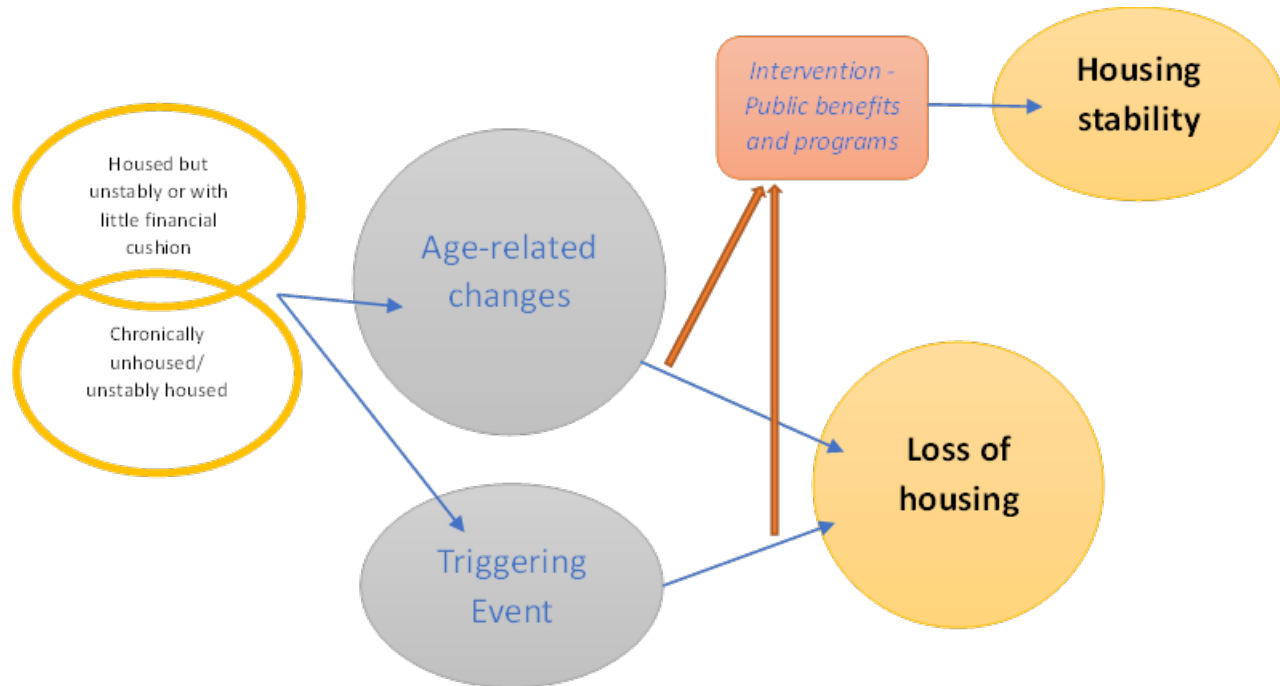
Micro/Individual	Older Adult Specific	Macro/Policy
Poverty	<ul style="list-style-type: none"> Income sources and public benefits may not adjust with inflation Cost of living increases with age-related changes in health and ability Age-related vulnerability increases reliance on multiple public programs 	<ul style="list-style-type: none"> Public programs and benefit systems
Housing cost burdens	<ul style="list-style-type: none"> Higher rates of housing cost burden Fixed incomes make it difficult to absorb cost increases 	<ul style="list-style-type: none"> Affordable housing Income disparities
Cognitive disability	<ul style="list-style-type: none"> Age-related cognitive decline Loosely connected or missing informal supports Associated difficulties managing complex applications and benefit systems 	<ul style="list-style-type: none"> Long-term care services and supports (LTSS)
Physical disability and chronic health issues	<ul style="list-style-type: none"> Age-related changes in health and functional ability Unmanaged chronic conditions worsen with age Need for physically accessible housing Sensory changes that make complex applications difficult 	<ul style="list-style-type: none"> Healthcare LTSS Housing accessibility Public transportation
Mental health and substance use disorders	<ul style="list-style-type: none"> Unmanaged chronic conditions worsen with age Loss of natural supports over time 	<ul style="list-style-type: none"> Healthcare Mental health care
Social isolation	<ul style="list-style-type: none"> Widowhood Access to technology and tech literacy Mobility challenges 	<ul style="list-style-type: none"> Physical infrastructure that promotes connectivity

		<ul style="list-style-type: none"> • Social and educational resources
Discrimination	<ul style="list-style-type: none"> • Compounded disparities over time such as income, education, and housing • Learned mistrust • Trauma compounding over time 	<ul style="list-style-type: none"> • Structural inequities, particularly related to race/ethnicity
Violence	<ul style="list-style-type: none"> • Increased physical and social vulnerabilities • Age-related cognitive changes • Trauma compounding over time 	<ul style="list-style-type: none"> • Legal system • Housing and shelter system
Immigration	<ul style="list-style-type: none"> • Generational cultural preferences • Age-related changes increase reliance on public programs and services 	<ul style="list-style-type: none"> • Public programs and benefit systems
Institutional involvement	<ul style="list-style-type: none"> • Learned mistrust of public programs • Disconnection from social infrastructure • Rules excluding participation in public programs 	<ul style="list-style-type: none"> • Carceral system • Inpatient mental health and substance use treatment facilities • Nursing home

5.1. Public Programs and Benefits Can Increase Housing Security for Older Adults

We find that public benefits and programs can moderate age-related risks to improve housing stability for older adults. In **Figure 8**, we propose a model for this relationship. This model shows age-related experiences destabilizing housing as well as the effect of service and support interventions. These age-related experiences can occur gradually, such as arthritis that slowly over time makes climbing stairs more difficult. Age-related experiences can also be a sudden “triggering event.” For instance, an older adult who relies on a spouse for assistance may lose housing stability if that spouse dies. Public programs are well positioned to provide support for older adults to manage both gradual age-related changes and triggering events, either by bolstering the household’s economic situation or layering services to meet the older adult’s emergent needs.

Figure 8. Public Programs and Benefits Are Related to Housing Stability



5.2. There Are Opportunities to Increase Older Adults’ Uptake of Public Programs and Support and Improve Equity

Finally, this research identified opportunities to connect older adults to the public programs and services that can increase their housing stability. We believe that older adults would benefit from trauma-informed processes related to benefits applications and management. Housing insecurity and homelessness can be traumatic experiences. Further, the conditions precipitating housing insecurity or loss, ranging from loss of key supports to discrimination, violence, and poverty, may also be traumatic. Intersectional concerns arise as disadvantaged groups are disproportionately exposed to trauma that can compound barriers to benefits and program use. Trauma-informed practice begins with an awareness of the prevalence and symptoms of trauma. Processes are then designed to be sensitive to trauma, to maximize empowerment, and to minimize exposure to additional triggers (Mersky, Topitzes, and Britz 2019). For instance, a trauma-informed practice might ensure housing security and stability before engaging in detailed documentation and application processes.

Trust and responsiveness are key components of a trauma-informed approach. Our findings suggest that many older applicants benefit from high-touch services and long-term relationships with culturally competent service providers. They respond especially well to low barrier-to-entry services that do not demand complex applications and do not maintain long waiting lists for access. Low-barrier services can create a platform on which to build key relationships and create a foundation of

trust, which can translate into the uptake of additional supports and services. Trauma-informed processes also streamline experiences for the older applicant rather than placing high demand on the applicant to accommodate the convenience of program administration. Finally, trauma-informed public services would carefully approach the intersectional disadvantage of groups as they age and design processes that are inclusive for specific groups. Applicants will particularly struggle when they experience age-related challenges that compound circumstances such as lifelong systemic experiences of discrimination, not being a native English speaker, or having a legal status that excludes them from public program resources. A person-centered, trauma-informed approach to public services and benefits creates opportunities to improve access to public programs for older adults and to minimize the housing disruptions precipitated by life-course related changes.

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Appendix

Appendix Figure 1. Pathways into Housing Insecurity and Homelessness

Micro/Individual	Macro/Policy	Literature
Poverty and income inequality	<ul style="list-style-type: none"> Public programs and benefit systems 	(Byrne, Henwood, and Orlando 2021; McDonald, Dergal, and Cleghorn 2007)
Housing cost burdens	<ul style="list-style-type: none"> Housing markets Subsidized housing Income disparities 	(Donaldson and Yentel 2019; Shinn et al. 1998)
Cognitive disability	<ul style="list-style-type: none"> Long-term care services and supports (LTSS) Mental health and behavioral supports 	(Backer and Howard 2007; Stone, Dowling, and Cameron 2019)
Physical disability and chronic health issues	<ul style="list-style-type: none"> Healthcare LTSS Housing accessibility Public transportation 	(Barile, Pruitt, and Parker 2018; Beer et al. 2019; Guillén, Panadero, and Vázquez 2021)
Mental health and substance use disorders	<ul style="list-style-type: none"> Healthcare Mental health care 	(Piat et al. 2015; Crane et al. 2005; Barile, Pruitt, and Parker 2018; Nilsson et al. 2018)
Impoverished social networks; Isolation	<ul style="list-style-type: none"> Physical infrastructure that promotes connectivity Social and educational resources 	(Cummings et al. 2022; McDonald, Dergal, and Cleghorn 2007)
Discrimination	<ul style="list-style-type: none"> Structural inequities, particularly related to race/ethnicity 	(Fraser et al. 2019; Otiniano Verissimo et al. 2023; Paul et al. 2020)
Violence	<ul style="list-style-type: none"> Legal system Housing and shelter system 	(Baker et al. 2010; Piat et al. 2014)
Immigration	<ul style="list-style-type: none"> Public programs and benefit systems 	(McDonald, Dergal, and Cleghorn 2007; Teixeira and Halliday 2010)
Institutional involvement	<ul style="list-style-type: none"> Transitions from foster care Carceral system Inpatient mental health and substance use treatment facilities Nursing home 	(Montgomery et al. 2016; T. Byrne, Roncarati, and Miller 2021; Piat et al. 2015; Metraux and Culhane 2006)

Appendix Table 1. Trends over Time of Individuals Receiving Homelessness Services in Boston and Across Massachusetts

	Boston			Rest of Massachusetts			Total
	Adult Recipients Under Age 50	Adult Recipients Over Age 50		Adult Recipients Age 50 and Under	Adult Recipients Age 50 and Over		All Adults in Massachusetts
	Number	Number	Share of all Boston	Number	Number	Share Rest MA	
2013	3,194	552	15	17,260	8,538	33	29,544
2014	3,416	582	15	20,939	9,327	31	34,264
2015	3,262	586	15	22,259	8,682	28	34,789
2016	2,885	575	17	21,930	8,473	28	33,863
2017	2,935	666	18	17,722	8,148	31	29,471
2018	3,427	922	21	16,529	7,853	32	28,731
2019	3,343	942	22	15,598	7,498	32	27,381
2020	3,171	992	24	11,529	5,533	32	21,225
2021	3,420	1,230	26	10,384	4,721	31	19,755

Notes: This figure includes only adults considered homeless because they utilized Emergency Shelter services, Transitional Housing, Street Outreach, or Safe Haven services. Clients were considered homeless if they either entered or exited services in a year or if they entered prior and exited after that year. Though birthdate was masked, age was calculated based on age at entry. The ‘rest of Massachusetts’ totals exclude Boston.

Source: JCHS Analysis of Massachusetts HMIS data 2012-2022.

Appendix Table 2. 2022 Frequency of Homelessness in Three-Year Period, 2013-2021

	Rest of Massachusetts			Boston			Total Massachusetts with Boston	
	Recipients Under Age 50	Recipients Age 50 and Over		Recipients Under Age 50	Recipients Age 50 and Over			
	Number	Number	Share of Rest of Massachusetts 50 Over	Number	Number	Share of Boston 50 Over	Number	Share 50 and Older
First Time Homeless	33,087	18,234	36	5,647	1,312	19	16,068	34
Second Time	9,368	4,934	34	1,391	355	20	16,068	33
Third Time	3,737	2,414	39	472	150	24	16,068	38
Four or More Times	7,687	6,337	45	894	458	34	16,068	44

Notes: This figure includes only adults considered homeless because they utilized Emergency Shelter services, Transitional Housing, Street Outreach, or Safe Haven services. Clients were considered homeless if they either entered or exited services in a year or if they entered prior and exited after that year. Though birthdate was masked, age was calculated based on age at entry. The ‘rest of Massachusetts’ totals exclude Boston.

Source: JCHS Analysis of Massachusetts HMIS data 2012-2022.

Appendix Table 3. Demographics of People Experiencing Homelessness in Massachusetts in 2021

	Rest of Massachusetts			Boston		
	Recipients Under Age 50	Recipients Age 50 and Over		Recipients Under Age 50	Recipients Age 50 and Over	
	Number	Number	Share of rest of Massachusetts over 50	Number	Number	Share of all Boston over 50
Total Number	10,384	4,721	31	3420	1230	26
Age (mean)	33	59	-	31	59	-
Race/Ethnicity						
White Only	3818	2655	41	707	471	40
Black Only	2245	793	26	1333	414	24
Asian Only	85	36	30	38	22	37
American Indian, Alaskan Native, Native Hawaiian Islands, Pacific Only	142	61	30	52	41	44
Hispanic	3530	737	17	1,120	210	16
Gender						
Female	5490	1476	21	1949	339	15
Male	4790	3220	40	1428	877	38
Transgender, No Single Gender, Questioning Gender	93	31	25	24	less than 20	-
Veteran Status						
Veteran	303	609	67	61	174	74

Notes: This figure includes only adults considered homeless because they utilized Emergency Shelter services, Transitional Housing, Street Outreach, or Safe Haven services. Clients were considered homeless if they either entered or exited services in a year or if they entered prior and exited after that year. Though birthdate was masked, age was calculated based on age at entry. The ‘rest of Massachusetts’ totals exclude Boston.

Source: JCHS Analysis of Massachusetts HMIS data 2012-2022.

Appendix Table 4. Benefits Program Income and Participation in 2021

	Recipients Under Age 50		Recipients Age 50 and Over	
Total Monthly Income, Any Source	\$820		\$1056	
	Average Dollar Income	Number of Recipients	Average Dollar Income	Number of Recipients
Earned Income	1202	1838	1184	515
Unemployment	734	563	343	115
SSI	640	1187	1188	1402
SSDI	642	729	1020	1086
Social Security Retirement	18	386	338	121
VA Disability Benefits	340	90	623	152
SNAP	-	5506	-	2686

Notes: This figure includes only adults considered homeless because they utilized Emergency Shelter services, Transitional Housing, Street Outreach, or Safe Haven services. Clients were considered homeless if they either entered or exited services in a year or if they entered prior and exited after that year. Though birthdate was masked, age was calculated based on age at entry.

Source: JCHS Analysis of Massachusetts HMIS data 2012-2022.



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