AGING AND HOMELESSNESS IN NEW YORK CITY

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Table of Contents

List of Figures iii

Part I – A Hidden Population 1

A. Contextual Background 1

B. Introductory Background 2
   1. Definition 2
   2. Federal Action 3
   3. Estimates 3
   4. Older Persons Experiencing Homelessness 5
   5. Age Status 6
   6. Descriptive Findings about the Homeless Population in General 8
   7. Risk Factors Associated with Homelessness 12

Part II – Aging and Homelessness in New York City 15

A. The Shelter System 20

B. What We Know About Older Homeless New Yorkers 22

C. Factors Linked to Homelessness in New York City 26

Part III – City and Community Support for the Homeless Population 28

A. All Age-Inclusive Organizations Providing Broad Range of Services 28
   1. The Coalition for the Homeless 28
   2. Project Renewal 29
   3. Care for the Homeless 30
   4. Susan’s Place 31
   5. Partnership for the Homeless 32
   6. The West Side Federation for Senior and Supportive Housing 33

B. Organizations Exclusively Supporting Older/Elderly Homeless Persons 34
   1. The Encore 49 West Residence 34
   2. Casa Mutua 35
   3. DOROT’s Homelessness Prevention Program 37
   4. Valley Lodge Shelter 38
   5. The Women’s Mental Health Center Shelter 40
   6. The George Daly House 41
Part IV – Needs, Problems and Recommendations for Policy and Program Action  43

A. Service Needs  43

B. Problems Encountered in Providing Services for the Homeless  45
   1. At the City Level  45
   2. At the Individual Level  46
   3. At the Contractual Level  47

C. Recommendations for Policy and Program Action  48

References  50

Appendices

Appendix A: The McKinney-Vento Homeless Assistance Act  A-1
Appendix B: HOPE 2011 and HOPE 2012: The New York Street Survey  B-1
Appendix C: The Advantage Program Overview  C-1
Appendix D: NY Court: Singles Don’t Have to Prove Homelessness  D-1
## List of Figures

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Figure 1</td>
<td>Total Number of Unique Individuals Receiving Homeless Services in New York City</td>
<td>15</td>
</tr>
<tr>
<td>Figure 2</td>
<td>Children Ages 0-17 Receiving Homeless Services in New York City</td>
<td>16</td>
</tr>
<tr>
<td>Figure 3</td>
<td>Households Receiving Homeless Services in New York City</td>
<td>17</td>
</tr>
<tr>
<td>Figure 4</td>
<td>Repeat Families with Children as a Percent of Eligible Families with Children</td>
<td>18</td>
</tr>
<tr>
<td>Figure 5</td>
<td>Breakdown of New York City Homeless Population (By Month)</td>
<td>19</td>
</tr>
</tbody>
</table>
Part I - A Hidden Population

A. Contextual Background

The growing incidence of populations experiencing homelessness is a social and political problem of enormous significance. Due to its elusiveness and transitory nature, only estimates of the number affected can be provided to determine its actual magnitude.

The core objective of this exploratory study is to shed some light on a particular subgroup of the population who experience homelessness – older adults in New York City – to gain some understanding of who they are, what factors precipitated the loss of their abode, what services are available to them, the structural challenges and individual impediments they confront in accessing services, and eventual regaining of housing. This topic is loaded with complexities, including the definitional issues of what constitutes “homelessness” and “older” age status, as well as the absence of an accurate tracking system to render an estimate of their numbers and of their changing demographics, which is partly due to the transitory situation of this population (National Alliance to End Homelessness, 2010).

The methodology for inquiry is pursued along two lines:

1. Drawing on secondary sources through a review of the nationwide and New York City literature on homelessness
2. Information obtained through meetings with resource professionals and experts on the subject of homelessness in New York City who offered tremendous help and guidance in pursuing this study.

The author is most grateful to the following individuals for their participation:

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B. Introductory Background

Before embarking on an exploration of homelessness in New York City, some background information is in order, including a brief overview of homelessness across the country as reported in the literature.

1. Definition

There has been a change in the definition as to who is to be counted as homeless. Prior to the current crisis, which began in 1980 with the onset of a dramatic increase in homelessness, the definition of “homelessness” was much broader, including persons residing in substandard housing such as SRO hotels, cheap boarding houses, and skid row flop houses. At the present time, homelessness in the United States is addressed by the Department of Housing and Urban Development (HUD), which promulgates best practices and definitions which are highly influential. HUD has defined homelessness as pertinent to an individual who:

- lacks a fixed, regular, and adequate night time residence, or
- has a primary night time residence that is:
  - a supervised publicly or privately operated shelter designed to provide temporary living accommodations, including welfare hotels, congregate shelters, and transitional housing for the mentally ill;
  - an institution that provides a temporary residence for individuals intended to be institutionalized, or;
  - a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for a human being.

(McKinney Act, 2002(1)).¹

A chronically homeless person is defined by HUD as an “unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more or has had at least four episodes of homelessness in the past three years (U.S. Department of Housing and Urban Development, 2011, p.3).”

¹ For an updated and more detailed definition of homeless individuals, please see Appendix A.
In practice, some studies limit their methodology to counting people who are either (a) in shelters or; (b) easy to locate on the street. Advocates maintain that the latter count does not represent an accurate representation of all the unsheltered homeless. A more comprehensive definition, they argue, should include people living in subways and parks (Markey, 2010), those without homes who are lodged in separate quarters where they are treated for drug abuse, mental illness, alcoholism, HIV, and those living in traditional housing who have a presence in soup kitchens.

2. Federal Action

The first federal task force on homelessness was established in 1983; however, it had a relatively narrow mandate of providing information to localities on how to obtain surplus federal property. In 1987, a more comprehensive programmatic and policy action led into law the 1987 Urgent Relief for the Homeless Act, later renamed the Steward B. McKinney Homeless Assistance Act.

In 2000, President Clinton renamed the legislation the McKinney Vento Homeless Assistance Act to acknowledge the leadership of deceased Representative Bruce Vento, chief Democratic sponsor of the original bipartisan Act (See Appendix A). In 2008, the U.S. Congress appropriated $25 million to this Act, representing the most comprehensive multifaceted bill to have had far reaching effects. In fact, it is the only federal legislation centrally focused on the problem of homelessness in the country (Gonyea, Mills-Dick & Bachman, 2010).

In May 2009, President Obama signed the Homeless Emergency Assistance and Rapid Transition to House Act (HEARTH) into public law, reauthorizing HUD’s Assistance Program, following the allocation of $1.5 billion for the Homeless Prevention Fund, which addresses the prevention of homelessness, rapid rehousing, consolidation of housing programs, and new homeless categories.

3. Estimates

Every year or so, HUD prepares a report to Congress, titled the Annual Homeless Assessment Report [AHAR] which attempts to portray the demographics of the homeless population nationwide. More frequently, quarterly reports are also published by the Homeless Pulse Project to monitor trends in homelessness and those affecting social policy and funding. Two basic methods are employed:
• Point in Time (PIT) counting and data collected via a computerized Homeless Management Information System (HMIS).

• The US Conference of Mayors Status Report, which is focused on providing survey information for 27 cities.

According to the 2010 Annual Homeless Assessment Report (AHAR) to Congress, the number of people using emergency shelters (78%), transitional housing (16.8%), and both facilities (4.5%) over the one federal fiscal year period from October 1, 2009 to September 30, 2010 was estimated at more than 1.59 million. This marked a 2.2% increase from the corresponding number reported in 2009 (US Department of Housing and Urban Development, 2011).

Noteworthy of attention is that since 2007, there has been a 17% decrease in the estimated number of people using homeless shelters in major cities (from 1.12 million to 1.02 million), and a corresponding 57% increase of homeless shelter use in suburban and rural areas – from 367,000 to 576,000 (US Department of Housing and Urban Development, 2011).

The number of people experiencing homelessness on a single January night in the 2010 Point in Time (PIT) count was estimated to be 649,917, marking an increase over the 643,067 reported in 2009.\(^2\)

Almost two-thirds of the 2010 PIT population were individuals rather than members of a family household; their numbers have increased from 404,957 reported in 2009 to 407,966 in 2010 (US Department of Housing and Urban Development, 2011, p. 1). In the subpopulation of sheltered people reported in the latest PIT count, 26.2% suffered from serious mental illness; 34.7% had substance abuse problems; 3.9% of the adults were HIV positive; 12.3% were domestic survivors, and; 1.1% were unaccompanied youth.

\(^2\) In order to qualify for funding from the HUD, the NYC Department of Homeless Services began its street surveys in 2005. The Homeless Outreach Population Estimate (HOPE) count has been criticized for undercounting the true number of unsheltered people in the city, due to its methodology and strict procedures for counting people, and has been described as a useless tool for accurately measuring the size of the street people and their true needs (Markey, 2010). It should be noted that the NYC Department of Homeless Services website describes the HOPE methodology as follows. “New York City’s methodology for counting the homeless is considered the gold standard by the U.S. Department of Housing and Urban Development. The City’s streets, parks, and subway stations are divided into approximately 7,000 HOPE Areas, each about the size of a few square blocks. In the months before HOPE DHS uses information from outreach providers and past HOPE results to divide the City into high density areas, where we expect to find unsheltered individuals, and low density areas, where we may not. On HOPE night, teams of volunteers survey a sample of the areas, collectively walking over a thousand miles through New York City’s streets, parks, and subway stations.” (New York City Department of Homeless Services, 2012a).
The National Alliance to End Homelessness (2009) estimated the baseline number of the homeless over the course of a year to be 2.5 million, with a lower bound of 1.6 million and an upper bound of 3.5 million. Between 2008 and 2009, the number of homeless increased by approximately 20,000 – the largest percentage increase was the number of family households (3,200 additional households or a 4% increase) and the number of persons in families (6,000 individuals or a 3% increase) (National Alliance to End Homelessness, 2011). Earlier estimates placed the number of people in the country that experienced an episode of homelessness and were dependent on homeless assistance at 2 to 3 million people (Caton, Hasin, Shrout, Opler, Hirshfield, Dominguez & Felix, 2000).

Typically, homelessness has been perceived as a transitory event or one-time occurrence. This is no longer the case. Two interesting trends during the past years are noteworthy. The first is an increase in the proportion of individuals who experience homelessness repeatedly and for longer periods of time. It is estimated that approximately 10% to 20% of the homeless of all ages are “chronically homeless” (Caton, et al., 2000). The second trend is the increasing number of “first time homeless,” which includes families, children, military veterans, and recent victims of domestic violence (Karash, 2010).

The chronically homeless often cycle between emergency shelters, hospitals, jail, and treatment centers. Research suggests that on any given night, chronically homeless persons can account for up to 50% of those seeing emergency shelters. Yet even those who experience homelessness for the first time in later life can quickly enter the ranks of the chronically homeless population due to the long waiting lists for publicly subsidized housing in most cities (Gonyea, Mills-Dick & Bachman, 2010). Data from providers of homeless assistance services suggests that approximately 10% are found to be chronically homeless, indicated by the extended periods of time that assistance was being provided (Caton et al., 2000).

4. Older Persons Experiencing Homelessness

The reporting and sightings of homelessness we read about or see do not usually include images or stories of older people experiencing homelessness. Yet, there is troubling evidence of a growing number of Americans in older age groups who are either homeless or “at risk” of losing their homes. This population continues to be largely invisible or forgotten in larger society, neglected by an absence of public focus and statistical acknowledgement. In relation to the overall homeless population, the older age group comprises a small fraction; in absolute
numbers, their size is increasing at a fast rate (US Department of Health and Human Services, 2003). This trend was confirmed in the latest 2010 Annual Homeless Assessment Report to Congress which estimated that 14.9% of all sheltered people were 51-61 years old and that 2.8% were 62 years and older (US Department of Housing and Urban Development, 2011).

While a fair amount is known about the poverty levels of the older population, as well as about national homelessness in general, relatively little is known about older people who have lost their homes. The absence of a focus on this group may, in part, be due to their own behavior – choosing to remain invisible by avoiding shelters and soup kitchens. It may also reflect societal discomfort in acknowledging that an aging family member is suffering from mental illness, addiction or poverty, and/or living in an unsafe or unhealthy environment (Gonyea, Mills-Dick & Bachman, 2010). To some degree, lack of attention may also reflect a societal perception that the nation’s older population is, by and large, faring quite well in comparison to younger age groups.

Federally mandated systems of targeted benefits and entitlements for the older population may also contribute to the perception that the issue of homelessness experienced by older individuals is of limited concern to policy makers. Much of the public’s attention on the crises of housing insecurity over the past few decades has focused on families with young children, one of the fastest growing homeless groups in the country, as well as on the increasing number of runaway or “thrown away” adolescents and young adults (Gonyea, Mills-Dick & Bachman, 2010).

5. Age Status

If homelessness has been an elusive concept, so is the definition of age status or consensus of what constitutes an older person in the homeless community. The definition of aged status in the literature on homelessness has varied from study to study, using ages 40, 45, 50, 55, 60, 65 as markers of aging. Taking into account their low life expectancy, some consensus has been reached in recent years delineating age 50 years and over as a benchmark for aged status in the homeless count. This runs counter to the Census designation of the older population as age 65 years and older, which some researchers still use (Sermons & Henry, 2010). In rare instances, a distinction is made between the homeless “older adults” (50-64 years) and the “elderly homeless” (65 years and older).
Using ages 50 years and older as a benchmark to designate the older/elderly homeless has been justified on the following basis:

- Individuals between ages 50-65 years are a vulnerable age group – not yet old enough to qualify for Medicare or social security, they are the most likely to fall through the cracks of government safety nets;
- The accelerated effect of aging due to poor nutrition and harsh living conditions, which can magnify any acute or chronic ailment and/or impaired cognitive functioning they may have, can cause individuals age 50 years and older to appear 20 years older than their actual cohorts living in housing (National Alliance to End Homelessness, 2010);
- A low life expectancy placed at a 42-52 year age range among those who have been homeless for long periods of time, with only a rare number reaching 62 years of age. Their premature death most often results from acute and chronic medical conditions rather than from mental illness and substance abuse (National Coalition for the Homeless, 2009a).

Though general consensus has been reached regarding age status, reports on the homeless population have often neglected to open a specific entry that would designate and numerically account for the presence of this especially vulnerable older age group. Recently, some specification of age has been reported in HUD’s 2008 Annual Homeless Assessment Report to Congress (AHAR), which states that:

- 16.8% of the shelter population were above age 51;
- 2.8% were above age 62, and;
- 30% among all those who stayed in emergency shelters for more than 180 days were over age 50. (National Coalition for the Homeless, 2009f)

Their subsequent 2009 Annual Report states that over 250,000 older adults were sheltered in emergency or transitional housing programs throughout the country during 2008 (Coalition for the Homeless, 2009f; Gonyea, Mills-Dick, &Bachman, 2010). According to Sermons and Henry (2010), among the older homeless population in cities, there was a larger number of homeless persons in the 50 to 64 age bracket, than in the 65 years and older age bracket.
6. Descriptive Findings About the Homeless Population in General

The following pages detail information found in the literature pertaining to some of the characteristic traits and behavioral patterns of homeless persons, as reported by Dietz (2009), Hecht and Coyle (2001), the Coalition for the Homeless (2009); Caton et al. (2000), Medicine.jrank.org (2011), Partnership for the Homeless (2011), and the National Coalition for the Homeless (2009c,d).

- Impact of Homelessness on Older Persons: Observations have been made that the effect of homelessness manifests itself in a disproportionate acceleration of frailty, health complications, and inability to undertake common activities when compared to persons of their same chronological age. Homeless older adults are also at a higher risk of memory loss, dementia, and decreasing physical wellness.

- Substance Abuse: Estimates of substance abuse in the homeless population vary widely because of sampling and operationalization of variables. In the late 1990s, rates of substance abuse ranged as high as 20-25% for adult homeless men. However, most research on the homeless population has been focused on a much younger population to the neglect of the older age groups. There is a need to systematically study the experience of the older homeless persons, particularly since this cohort was initially exposed to psychoactive drugs during the Vietnam War, and may, at this point in life, have continued to abuse/misuse drugs and alcohol. Research based on a sample of homeless people shows the following:
  - Homeless men use more substances than women
  - Non-Hispanic Caucasiains are more likely than other ethnic groups to misuse alcohol, rank second highest in tobacco, hallucinogens, non-medical prescription for drugs, and rank third highest in use of marijuana
  - Among those ages 55 years and older, non-Hispanic Caucasiains indicate the highest rates of alcohol abuse, while African Americans rank the highest in illicit drug abuse
  - Older homeless individuals are more likely than younger ones to report that they have an alcohol problem, but are less likely to report drug use
Older adults with serious substance abuse or misuse problems may have difficulty maintaining a home and are the most likely to report that substance abuse contributed to their homelessness.

- **Greater Risk of Victimization and Injury:** While childhood victimization suffered by homeless individuals did not show to be linked to reports of alcohol abuse, child neglect and childhood sexual assault did have an effect on drug abuse. Victims of sexual abuse were at much greater risk than others to have a drug problem. The older/elderly homeless are perceived to be an easy target for robbery and are vulnerable both on the street and in shelters. Victimization and financial abuse is rampant, particularly in the case of men suffering from mental illness and impaired judgment. There are indications that the relative protection that women, in general, often have from most crimes is not transferred to older homeless women, who are more likely than their male counterparts to be victims of sexual assault, and equally likely as older homeless men to be victims of theft and assault. In one study that researched the predictor of victimization among older people, the findings indicated that they remained the same for men and women, with the exception of sexual assault which victimized significantly more women. (Dietz & Wright, 2005).

- **Health Issues:** Homelessness and health are intimately interwoven. Poor health is both a cause and result of homelessness. A 2008 report from the National Health Care for the Homeless Council estimated that 70% of their clients do not have health insurance. A serious injury or illness forces the uninsured to make a choice between paying hospital bills or paying rent. Homeless persons are three to six times more likely to become ill than housed persons because of the lack of proper nutrition, personal hygiene, and basic first aid. Homelessness tends to magnify the effects of aging, including increased physical frailty, chronic illness, impaired cognitive functioning, loneliness and isolation, mental illness associated with

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3 In 263 cities and 46 states, Puerto Rico, and Washington, D.C., there have been 880 acts of violence committed against homeless persons by housed individuals, resulting in 244 deaths among homeless people and 636 victims of non-lethal violence. The attackers can either be individuals who harbor great resentment against the homeless, mission offenders cleaning the world of a particular evil, scapegoat offenders acting out resentments against the world, or “thrill seekers” taking advantage of a vulnerable group (National Coalition for the Homeless, 2009e).
memory loss effects, which in turn, affects the ability to secure housing, given that acquiring housing often involves multiple appointments and self-initiated persistence. Cognitive impairment can lead to impaired judgments resulting in: failure to pay mortgage or rent; unsanitary living conditions that conflict with neighbors or property management; eventual eviction.

- **Diseases Common among Homeless People:** Heart disease, cancer, liver disease, kidney disease, skin infections, HIV/AIDS, pneumonia, and tuberculosis are common among people living in the streets or spending most of their time outdoors. They are at high risk of developing frost bite and hypothermia, suffering from dehydration, or having exposure to infectious diseases or infestations – all of which can lead to or compromise an already weak immune system and exacerbate existing chronic health problems, especially during winter or rainy periods. It is not the case that many homeless deaths are specifically attributed to exposure-related causes. However, the risk of death from other causes is increased eightfold in homeless people who experienced any of these conditions. This is particularly the case since many homeless people do not receive medical care. Some homeless persons utilize hospital emergency rooms as their primary source of health care – a most ineffective choice given the lack of continuity of care.

  Older homeless persons are particularly vulnerable to multiple medical problems and to chronic illnesses that go untreated. The barriers to seeking health care can be any one of the following:

  - Lack of knowledge as to where to get treatment;
  - Lack of access to transportation and identification documents;
  - Psychological barriers such as embarrassment, nervousness about filling out forms and answering questions poorly, or self-consciousness about appearance and hygiene when living in the streets;
  - Expenses involved in seeking care.

- **Noted Differences by Age:** A comparison of older and younger homeless people showed the following. The older age group was found to be:

  - More likely to have been married before their shelter life;
  - More likely to be veterans;
Twice as likely as younger individuals to report economic resources, entitlements, VA income;

Less likely to receive public assistance income, unemployment compensation;

More likely to indicate that drug/alcohol abuse, injury/illness are major forces leading them to end up homeless.

By contrast, the younger age group was more likely to have been recently released from prison and to have longer durations of homelessness. Of note, older age and arrest history were shown to be the strongest predictors of longer duration homelessness.

**Noted Differences by Gender:** Older men, as compared to older women, were found to be younger and single and to report histories of alcohol abuse. In comparison, a higher percentage of women reported histories of mental health problems, had less income sources (mostly from Social Security). Older women received food stamps or general public assistance. Older men reported job loss twice as often as women as the precipitating factor that led to becoming homeless, whereas women were three times more likely than men to indicate eviction as being the leading factor. Men tended to have a longer duration of homelessness than women, suggesting that women’s pathways may be more crises-driven and more quickly solved.

**Personal Traits:** Older homeless individuals generally distrust crowds, shelters, and clinics, often prompted by fears that seeking or utilizing services and/or applying for shelter leads to institutional placement in long term care facilities. Distrust of shelters can often be traced to difficulties in climbing stairs or waiting in long lines to get a bed, among other factors. Homeless persons who remain in shelters or on the street for long periods of time rarely survive beyond 62 years of age. In many cases, this premature death can be traced to acute and chronic medical conditions aggravated by homeless life, rather than from mental illness or substance abuse.
7. **Risk Factors Associated with Homelessness**

Multifaceted factors at both the individual level and systemic level have been identified as “risk factors” directly linked to homelessness. Both levels interact and accumulate over time.

- At the biographical and individual level, the following were cited:
  - isolation
  - lack of family support
  - loss of primary caregiver
  - relationship breakdown
  - social exclusion
  - domestic violence
  - health problems
  - lack of health insurance
  - disability
  - inability to function and manage one’s life effectively
  - prison release
  - severe substance abuse

- At the systemic level, the precipitating forces widely linked to homelessness are:
  - poverty
  - unemployment
  - lack of access to affordable housing
  - increased wealth disparity
  - income inequality causing distortions in the housing market that push rent burdens higher and often result in failure to pay rent, closely followed by eviction

A weak housing policy on site often allows condominium conversion and community gentrification in neighborhoods traditionally known to have entitlement buildings and low rental housing. This can push low income people out into the street. Market rate housing is simply not a viable option, especially for older people who depend on modest entitlements, while at the same time publicly subsidized housing options have become scarce. Even when affordable housing is available, persistent poverty makes the accumulation of funds (first month, last month rent, evicted

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4 Refer to Section 6 on page 8 for sources.
security deposit) for a new rental an insurmountable obstacle. The rise in joblessness and loss of many high-skilled and semi-skilled jobs has given rise to high unemployment rates, home foreclosures, and personal bankruptcies.

A study conducted in California has noted differences between age and gender in explaining causes of homelessness. While the majority of both young and older age groups mention loss of job and insufficient access to affordable housing as root causes, the older group was more likely to indicate that drug or alcohol abuse and/or injury or illness as being linked to loss of housing. Younger groups were more likely to cite domestic violence and release from prison as explanatory reasons. Older men reported job loss as the precipitating factor twice as often as women. Women were nearly three times more likely to report that they had been evicted than the men in their age group. This may suggest that the two types of structural causes of homelessness (loss of jobs and lack of affordable housing) may affect people differently according to gender (Hecht & Coyle, 2001).

8. Projected Growth of the Older/Elderly Population

Despite the absence of nationwide statistics that provide an accurate account of older homelessness, projections have been made based on empirically-based trends and current estimates on the demographics of future homelessness among the population ages 65 years and over. The following pages present the basic premises on which the projections are made by researchers at the Homelessness Research Institute and published by the National Alliance to End Homelessness.  

Two primary forces are foreseen as major contributors to the projected growth: the growing older population and the economic vulnerability among the older persons.

The rapidly increasing growth of Americans over age 65 has been well documented. Suffice it to state that their numbers have risen from 3.1 million in 1900 (representing 4.1% of the nationwide population) to 40.0 million in 2010 (U.S. Department of Health & Human Services, 2012). Earlier projected growth for New York City’s population 65 years and older was forecast to rise 44.2%, from 938,000 in 2000 to 1.35 million in 2030 (New York City Department of City Planning, 2006).

The poverty rate for older Americans began declining from over 25% in the late 1960s – due in large part to increases in government programs and entitlements – to a 9% to 10% poverty level since the mid-1990s. In 2010, 9.0% of people over age 65 reported annual incomes below the poverty threshold. An indicator of even greater economic vulnerability is the deep poverty experienced by this age group. In 2010, 2.5% of those 65 years and older reported incomes valued at only half of the poverty threshold (DeNavas-Walt, Proctor, & Smith, 2011).

The basis for the projection of elderly homelessness by the year 2050 takes into account HUD’s 2008 estimated number of 43,450 sheltered homeless people over age 62, together with the anticipated growth in the elderly homeless population as the demographic aging process continues its course.

Built into the forecast are four assumptions:

- that no proactive and significant interventions, policies, or actions are initiated to end homelessness nationwide;
- that the elderly population will increase as projected by the U.S. Census Bureau through 2050, reaching 86.7 million;
- that the rate of deep poverty in the elderly population will remain constant at 2% through 2050 as it has remained since 1975, and;
- that the 2008 ratio of one sheltered elderly homeless person to every 22 elderly persons in deep poverty remains constant through 2050.

If these assumptions hold true, homelessness is projected to increase by 33% – from 44,172 in 2010 to 58,772 in 2020 – and will more than double between 2010 and 2050, when more than 95,000 people aged 65 years and older are projected to be homeless (National Alliance to End Homelessness, 2010). The problem associated with elder homelessness will continue to grow as the baby boomer generation ages. Some may “age” into older homelessness or unexpectedly become homeless for the first time during later life. Either way, the needs of older/elderly homeless persons require special attention.

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6 The economic vulnerability facing the country is a critical component of this prediction. The lingering effects of recession and downturn of the economy has pushed more and more Americans into a precarious position. In March 2012, the official unemployment stood at 8.3%; 40% of the families estimated to be facing eviction due to foreclosures were renters; those born between 1955 and 1964 are finding themselves in poverty at midlife (National Alliance to End Homelessness, 2009).
Part II – Aging and Homelessness in New York City

Though New York City launched its five year plan to end homelessness in 2004, by the beginning of 2011 the homeless population in the City had risen to an all-time high not witnessed since the 1930 depression (Coalition for the Homeless, 2011). For fiscal year 2010, 113,553 unique (meaning not double-counted) individuals slept in the City’s emergency shelters, slightly higher than the 110,122 reported for 2011 (see Figure 1). Respectively 42,888 and 40,238 among these were under 18 years of age (see Figure 2). Classified in terms of households, the numbers served during FY 2010-2011 totaled 24,776 and 23,255 respectively (Figure 3).

Figure 1. Total Number of Unique Individuals Receiving Homeless Services in New York City

Source: New York City Department of Homeless Services, Critical Activities Report: Total DHS Services – Fiscal Years 2002 to present. Numbers shown are “total number of unique individuals receiving services (unduplicated).”
Figure 2. Children Ages 0-17 Receiving Homeless Services in New York City

Source: New York City Department of Homeless Services, Critical Activities Report: Family Services – Fiscal Years 2002 to 2009 and Families with Children Services – Fiscal Years 2011 to present. Numbers shown are calculated by summing “number of unique individuals receiving services (total unduplicated)” for the “0 to 5,” “6 to 13” and “14 to 17” age brackets.
New York City-based numbers of the homeless had been creeping up since FY 2008 due to a rise in the number of families entering homeless shelters. Though the City was moving homeless families out of shelters and into apartments, the number of families becoming homeless increased (National Alliance to End Homelessness, 2009). Part of this can be traced to the intake of “repeat” families with children. As a percent of eligible families with children sleeping in the City’s homeless shelters, 40% were “repeat” families in FY 2010. That percentage increased to 49% in the following year. (See Figure 4.) A breakdown of the composition of the City’s homeless population from July 2001 to 2011 indicates the high numbers of homeless children
throughout the decade, particularly in 2003-2004 and 2008-2009, a slight rise of adults in families in 2008-2009, and an even trend for single adults (Figure 5).

Figure 4. Repeat Families with Children as a Percent of Eligible Families with Children

Source: New York City Department of Homeless Services, Critical Activities Report: Family Services – Fiscal Years 2002 to 2009 and Families with Children Services – Fiscal Years 2011 to present. Numbers shown are calculated using “Repeat families with children” and “For eligible families with children, number of families found eligible.”
In addition to the yearly information on the homeless, the Department of Homeless Services (DHS) publishes a daily Shelter Census Count, which classifies the homeless into a family status typology. The count taken on December 12, 2011 identified the following number of sheltered persons by family status category:

- **Total Number Sheltered**: 39,787, among whom 42% were children
  - **Total Single Adults**: 8,567, among whom 28% were women;
  - **Total number of Individuals in Families with Children**: 28,321; 57% were children;
  - **Total number of individuals classified as Adult Families**: 2,899.
A once yearly Snapshot Street Survey is conducted, referred to as the DHS Homeless Outreach Population Estimate (HOPE). The survey conducted in late January 2011 reported 2,648 unsheltered persons living in the streets of New York City, the majority in midtown Manhattan. This number marked a 15% decline in the number of homeless people sleeping on the street when compared to the previous year’s Street Survey, which identified 3,111 street people (Appendix B).

The 2012 Survey took place on January 30. The annual 2012 survey of homelessness in New York City has found a 23 percent increase in the number of people living on the streets. The DHS counted an estimated 3,262 homeless people living on the streets on January 30, 2012, as compared to 2,648 counted in 2011.

A. The Shelter System

Providing a formal shelter system to homeless New Yorkers was only put in place in the 1980’s. In 1979, a New York City lawyer, Robert Hayes, brought the Callahan vs. Carey class action suit against New York City and New York State, claiming the State’s constitutional “right to shelter.” This action was settled by a consent decree in 1981, in which agreement was reached that both the City and the State were mandated to provide board and shelter to all homeless men who met the need standard for welfare or who were homeless. By 1983, the same right was granted to homeless women. With the dramatic surge of homeless families in the mid 1980’s, the McCain litigation brought forth by the Legal Aid Society eventually led to the City’s recognition in 2008 that homeless families also have a “right to decent and habitable shelter,” as well as assistance to obtain permanent housing (Community Service Society, 2010). This led to the expansion of the shelter system to include a new substratum of large numbers of impoverished and runaway children, teenagers, young adults, street children, and street youth.

The New York City Department of Homeless Services (DHS) was created in 1993 and given the responsibility, among other functions, of operating shelters for the homeless. It carries out this function primarily through contractual arrangements with not-for-profit organizations, as well as with hotels and landlords, establishing separate shelters for single adults, childless couples, families with children, and adult families. Until recently, all persons in the shelter system who met program requirements were eligible for ADVANTAGE rent subsidies; these have now been cancelled. (Appendix C).
A number of smaller providers, such as faith based organizations, also provide shelters for single adults, expectant mothers, and young people. These have no direct relationship with the DHS.

In 2012, there were 9 City-run and 217 privately run shelters. The Department identified 63 adult facilities; 16 shelters for adult families; and 147 shelters for families with children. “Family” shelters include pregnant women; single mothers with children under age 18; intact couples with children; one parent with a child under age 18. Shelters for “Adult Families” do not include children.

The large majority of shelters for homeless veterans and “safe haven” shelters were once included as part of the DHS daily adult shelter census count. They were converted into different service models in early 2007 and since then excluded at various stages from the DHS adult shelter census reports (Coalition for the Homeless, 2011) but this information is on their website. Currently, under the New York City Veterans Administration, 452 homeless veterans are housed in transitional quarters awaiting access to permanent homes. No solid count of unsheltered veterans was available; a ballpark estimate reported around 300.

Older adults in shelters may be particularly vulnerable. Residents may be assaulted and robbed by other residents. Three common reasons why homeless individuals refuse to reside in shelters include refusing to give up any portion of their very limited income from entitlements; resistance to shelter rules, such as curfews; and objecting to “being treated like children” (Horn, 2011, p.35).

The shelter population includes: women and children; ex-convicts; substance abusers and persons with mentally illness. The male population ranges from highly functional to persons who are violently schizophrenic. Some receive public assistance, particularly those who are severely mentally ill or disabled. There are some who work wage jobs; others are out of work. Work histories range from jobs as laborers to messengers to those holding managerial positions. Some even have PhD's (Benjamin, 2011).

In November 2011, the Mayor’s Office, together with the participation of the Commissioner of the Department of Homeless Services, announced a shift in policy which basically would require single adults, being accepted into a homeless shelter, to prove (and, if

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7 Information obtained from Department of Homeless Services.
8 All information on Veterans in New York City was obtained from Ms. Karen Fuller, Homeless Program Director, NY Harbor Department of Veterans Affairs.
possible, document), that they had no other housing option. According to the Commissioner, nearly 1,700 single adults seek shelter every month. The decision was challenged by the Legal Aid Society on the basis that this new policy violates the 1981 consent decree that established the “right to shelter” in New York City (Gardiner, 2011). In February 2012, the Manhattan State Supreme Court ruled the City could not go forward with this policy. The City is appealing.\(^9\) (See Appendix D).

According to the experience of a former shelter system’s staff member, some “clients” may have had other options, but burnt those bridges. Presumably, they became too difficult to live with, due to domestic violence, psychological outbursts, thievery, alcoholism and drug addiction, sex offender status, etc. A sizable number have been put out by spouses, mothers, girlfriends and other relatives (Benjamin, 2011).

B. What We Know About Older Homeless New Yorkers

Older persons who are homeless in New York City are, in many ways, facing the same need as their younger counterparts. What makes their situation different is their physical frailty, health problems related to aging, higher risk of memory loss, dementia, declining physical wellness, and vulnerability to predators. To exacerbate these disadvantages is the high levels of poverty prevalent among older adults. According to the U.S. Census Bureau’s 2006-2010 American Community Survey, the percentage of people 65 years and older living below the poverty level in New York State was 11.5%. In New York City it was 18.2%.

There is a movement to keep older adults in their homes rather than placing them in nursing facilities, but what becomes of those people who do not have a home (Horn, 2011)? When older people lose their housing, they have very few options and are forced to navigate a confusing and often unsafe network of services designed for a more physically-able population. This is particularly true in situations where the staff of the City’s shelter system or Drop-in Centers is not prepared to effectively respond to this population’s unique geriatric needs.

Though the DHS recognizes special social categories among homeless persons—such as chronically homeless, disabled, and veterans—most of its reporting system has not singled out the older and elderly homeless persons as a distinct social and vulnerable group. Given the scarce

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\(^9\) According to the Commissioner of the Department of Homeless Services, approximately 1,700 single adults seek shelter each month. The number of single adults in the Shelter System increased by more than 24% between 2009 and 2011. (Gardiner, 2011).
attention given to this population, it is difficult to provide a comprehensive profile of older homeless New Yorkers. What follows is an attempt to detail some of the limited quantitative and qualitative research findings that have focused on this older homeless population.

- **Scarcity of Quantitative Data:** As mentioned earlier, there are more homeless people in the City than existed years ago; an increasing number among them are older/elderly adults, as well as a growing proportion who are “at risk” of losing their homes (Partnership for the Homeless, 2011; Horn, 2011). Yet discussions on homelessness have largely ignored older age groups “at risk” of losing their housing. They have not directed attention to the presence of older/elderly persons who are homeless in the City. In the Department of Homeless Services Daily Shelter Census Count older/elderly persons remain invisible because of the absence of age-specific information on the daily numbers reported on those sheltered based on the different typological classification.

Two data sources single out the presence of older homeless New Yorkers. The first is the DHS “Critical Activities Report” prepared for each fiscal year which enumerates the total number of clients receiving services from the Department, classified by age groups. (Appendix E). Below are the figures reported for clients ages 45 years and older receiving services during the 2010 and 2011 fiscal years:

- **FY 2010:** ages 45 to 64 years = 16,875; ages 65 years and older = 1,170 clients
- **FY 2011:** ages 45 to 64 years = 17,722; ages 65 years and older = 1,304

The second source of information available is the number of older veterans housed in the Veterans Administration Transitional Housing Program in New York City who are awaiting access to permanent housing. Of the total number of 452 beds in the VA’s six facilities, veterans ages 55 years and older numbered 212, representing 47% of all the veterans in the Transitional Housing Program. It is also estimated that around one-half of the unsheltered veterans are in that age range as well.

Academic research studies centered on older homeless New Yorkers have noted the creeping increase in the age of the sheltered population.
Single adults in the shelter system were on the average five years older in 2002 when compared to 1998;

Those over age 40 made up 53% of all the sheltered population in 2002, compared to less than 30% in 1988;

By 2005, 13% of the residents in the Single Adult Shelters were 55 years and older. (Shinn, Gootlieb, Wett, Bahl, Cohen, & Ellis, 2007).

**Limited Qualitative Information:** Scholarly research focused on qualitative/descriptive information regarding homeless New Yorkers is limited. The studies cited below detail some of the findings reported in the literature, with a reminder that they are based on select samples of homeless persons and cannot be generalized to apply to all homeless New Yorkers.

A study of the chronically or not chronically unsheltered population in Manhattan revealed the following: the chronically unsheltered were older, more likely to be veterans; have a more extensive history of homelessness; higher rates of self-reported mental/psychiatric illnesses and substance abuse. They also had higher incidences of peripheral vascular disease, chronic liver problems, diabetes and repeated trauma. Few had access to entitlements and income; and slightly less than one half had health insurance. They had spent most of the previous winter outdoors in subway areas, emergency shelters, and drop-in centers. (Levitt, Culhane, De Genova, O’Quinn, & Bainbridge, 2009).

Counter to the typical stereotype, some studies of sheltered populations reported the following:

- Over half the sample had lived relatively conventional lives, involving periods of employment and residential stability before becoming homeless at age 59. Multiple events shifted people who were unsupported by family and society away from this life. The slide into homelessness often appeared to be slow with lives looking less conventional as time went on (Shinn et al., 2007)
- Previous living arrangements of newly sheltered persons showed that over 55% came directly from housing situations, including owned or rented
units; from supportive housing and from staying with family or friends. Two percent sought shelter or transitional housing after spending the previous night in a unit that they owned (Karash, 2010).

- Two studies noted the presence in shelters of highly educated professional people, some with postgraduate education:
  - One shelter housed professionals; a formerly employed architect; a White House advisor (under President Nixon) for the EPA; and a former mathematician in the Quantum Science Corporation in New York (Horn, 2011)
  - Comparisons made between homeless adults and low-income housed persons, both groups aged 55 years and older, showed high educational levels attained by homeless individuals, including college and postgraduate studies. Three quarters in the homeless group had completed high school and 43% attained some higher educational level. Reported work histories in this group included teachers, engineers, army officers, and a number occupying positions in the business world. (Shinn et al., 2007).

- But there were troublesome findings as well. Compared to homeless families, homeless single adults showed to have a much higher rate of mental illness, addiction disorders, and other severe health problems (Coalition for the Homeless, updated 2010). A study on psychiatric disorders among older homeless New Yorkers reported that:
  - 9% of older men and 42% of older women displayed psychotic symptoms
  - Close to one-third in each gender group exhibited symptoms of clinical depression
  - Levels of cognitive impairment ranged from 10 to 25%; however, in only 5% of the cases was this severe, which is roughly comparable to the general population (medicine.jrank.org, 2011).
C. **Factors Linked to Homelessness in New York City**

As is true in settings outside of New York City, it is typically the confluence of multiple factors or serious events that lead to homelessness, rather than any one cause. With this in mind, the following pages present a listing of some of the root causes identified in the literature and through interviews that have contributed to homelessness in New York City.

- **Lack of Affordable Housing:** This is most frequently cited as the major immediate cause of the City’s homelessness. Advocacy groups blame the City’s administration for allowing the real estate sector to dictate housing policy, predictably resulting in pro-landlord policies, and for lack of oversight as evidenced by weak rent regulations, high rent increases, poor code enforcement, and rampant cooperative and condominium conversions (Metropolitan Council on Housing, n.d.). Lack of affordable housing is also linked to doubled-up or severely overcrowded housing and domestic violence (Coalition for the Homeless, 2010).

- **Unemployment/Lack of Job Opportunities/Long Term Joblessness:** There is a growing number of adults over age 55 who are unemployed. Skilled and middle class workers and those with higher educational levels find themselves without a job and homeless for the first time. Those between the ages of 50 to 64 years are the most vulnerable, too young to be eligible for entitlements and at times confronting age discrimination in hiring practices. There is also a population of aging boomers above age 65 who need to keep working yet cannot find jobs (Mohn, 2006; Gonyea et al., 2010). With age, the ability to find work is disrupted, leading to inability to pay rent or to find an affordable place to live. As income stagnates and housing costs rise, adverse events may lead older adults to become homeless for the first time in their later years.

- **Low Income and High Poverty Levels:** Levels of poverty at older ages was over 18 percent in New York City according to the U.S. Census Bureau’s 2006-2010 American Community Survey. The median household income for renters in the Bronx and Brooklyn is barely $30,000 to $35,000 respectively. According to the Community Service Society (2010), two thirds of poor New Yorkers and over one-third of near-poor households spend at least half of their incomes on rent, placing
millions of low income New Yorkers “at risk” of housing hardships and displacement.

- **Relationship Problems:** These have been mentioned more frequently as an antecedent to homelessness, eventually leading to housing displacement. Such problems occur at many levels and often reflect domestic abuse (particularly in the case of women) and cases where a resident relative has burnt bridges with his/her family due to unacceptable behavior that is longer tolerated in the family home. It is also the case that a person living in a conflicting relationship with spouse or significant other can be evicted if his/her name is not on the lease.

- **Disruptive Experiences in Childhood:** These have shown to be robust predictors of homelessness among a sample of younger New Yorkers and scored relatively high among homeless adults leading unconventional lives (Shinn, et al., 2007).

- **De-Institutionalization:** There are contradictory views on whether the closing of hospitals has played a role in New York City’s homelessness. Historically, it has been perceived as a contributory factor, particularly in the case of older mentally ill adults who find difficulties in maintaining a home. More recently, this perception has been challenged. Based on findings that the majority of the homeless do not suffer from severe mental illness, it is argued that de-institutionalization does not, in and by itself, exert a direct effect on creating homelessness. Rather, the disproportionate numbers of the mentally ill who are homeless can also be traced on systemic factors, such as the unavailability of appropriate housing, lack of treatment, and inadequate entitlements for this population (medicine.jrank.org, 2011).
Part III – City and Community Support for the Homeless Population

The 1980’s witnessed the nationwide creation of a number of city services, non-profit organizations, advocacy groups, and faith-based organizations focused on the homeless population. In New York City, the Department for Homeless Services (DHS) entered into contractual relationships with a number of local non-profit organizations to provide support to homeless persons. Among these are:

- Organizations that defined their mission as exclusively providing services and support to the older/elderly homeless population. This has been achieved by setting up shelters, transitional housing, subsidized permanent homes, and service-enriched affordable housing.
- In addition, there are large-scale organizations with a broad range of services open to all age groups. While these are not specifically targeted to the overall homeless population in general, older homeless people can derive benefits from them in the form of direct services.

The rest of this discussion presents a select representative number of these two types of organizations for the purpose of singling out the various benefits each one offers to support the older homeless New Yorkers, beginning with the latter.

A. All Age-Inclusive Organizations Providing Broad Range of Services

1. The Coalition for the Homeless

The Coalition is an advocacy and research organization dedicated to the principle that affordable housing, sufficient food, and a chance to work for a living wage are fundamental. Though all age-inclusive in its coverage, its programs and activities meet the needs of older age groups as well. The Coalition achieves its goals through:

- The Advocacy Department which raises social consciousness concerning homelessness;
- Lobbies at both State and City Hall levels to implement more just and practical policies to address the systemic causes of homelessness, and;
- Calls for special attention to be given to housing physically and mentally disabled individuals.
The Coalition functions as a research and information center as well, and provides 11 direct service programs, which include:

- Crises intervention
- Eviction prevention
- Client advocacy
- Food programs
- Job training
- Coalition housing
- Permanent housing on scattered sites
- Youth programs
- Rental assistance
- After-school and summer camp programs for children
- Mobile soup kitchens on streets

Of all the homeless persons who participated in its direct service programs over the past year, 16.9% were between the ages of 51 and 65 years, and included 60% African Americans, 19% Latino/Hispanics and 12% Caucasians (among those who identified their ethnicity).

The presence of older age groups is particularly noted in the crises intervention programs. A definite increase in the homeless population is noted by the Coalition, indicated by larger numbers attending the Crisis Intervention Center, as well as utilizing other programs. The composition of its clients has also changed, whereby more are surfacing from among the working poor or those who have lost their jobs later in life.

2. Project Renewal

Since 1967, the primary mission of Project Renewal has been to end homelessness in New York City by empowering women and men to move from the streets and shelters toward health, and into homes and jobs. Its focus is women and men suffering from mental illness and

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10 The Crisis Intervention Center deals with referrals to shelters, shelter-related problems, family related problems, and difficulties in qualifying for eligibility to be accepted in shelters.

11 During 2010, the Coalition for the Homeless distributed 350,000 meals to people living on the streets, provided life-saving services to more than 8,500 families, reached hundreds of homeless children with their specially designed youth programs, and fought the City in court when it cut off rental subsidies to 12,000 formerly homeless families. The Coalition also undertakes eviction prevention services, psychiatric counseling, legal aid to victims of domestic violence, and addiction treatment.
drug addiction who have been homeless for years and cycle in and out of emergency rooms, jails, and the streets. The organization serves 13,314 homeless and low income New Yorkers yearly with a portfolio that includes 35 comprehensive programs designed to break this cycle.

Among others, its comprehensive programs include:

- Supportive transitional and permanent housing with access to services;
- Emergency assistance;
- Integrated health care, treatments for addiction, mental health, dental services and HIV support;
- Parole support and treatment for men and women leaving prisons;
- Psychiatric outreach;
- Job training and placement;
- Oversight of 62 shelters accommodating 600 beds.

The age range of its clients ranges from 18 to 79 years of age. Among its older clients, 1,965 are 50 to 64 years old and 155 are 65 years and older.

The profile of its clients includes mostly males, some veterans, and approximately 50% African Americans. Life expectancy is low, and few reach their elder years. Not all clients want to be housed and clients have high levels of mental illness (mostly bipolar, schizophrenia) or substance abuse. Some are considered to be dangerous and violent. The current profile includes 50 recently released inmates who are mentally ill, some having been in prison anywhere from three to 25 years.

3. **Care for the Homeless**

The primary mission of this organization is to provide a wide array of high quality services to homeless children, women, and men and to help improve the policies and programs that address the housing, health care, and emergency needs of all homeless. Of equal concern to this organization is ensuring that families and individuals who are “at risk” of becoming homeless receive health care, emergency, transitional housing, and other benefits in order to prevent future homelessness.

The direct services provided by Care for the Homeless are centered on making health care more accessible to the homeless population by offering a full range of medical and social services for homeless individuals and families without regard to their ability to pay. In addition to providing health education and outreach, its services are delivered by sending teams of...
doctors, nurses, and social workers to 37 designated service sites across the City. These sites include licensed medical clinics, soup kitchens, drop-in-centers, shelters and outreach posts and are located in Brooklyn, Queens, Manhattan, and the Bronx.

Though the total number of older homeless people benefitting from this organization is unknown, Care for the Homeless provides direct services to this population by way of:

- Sending medical teams to two organizations that exclusively serve the “older age” homeless persons: The Valley Lodge and the George Daly shelters (discussed below);
- Providing shelter, safety and support for mentally ill and medically frail homeless women at Susan’s Place, their transitional 200-bed residence located in the Bronx.

In its experience, this organization has found that the health problems among older homeless people are not much different than those of older persons who are housed, and include high levels of diabetes, hypertension, and coronary problems. What it sees as much more prevalent among homeless older adults are the impact of heat and/or cold, peripheral vascular diseases, and trauma due to violence and falls.

Care for the Homeless notes that the presence of older homeless persons has increased in absolute numbers in recent years, with intact families and single mothers continuing to represent the largest group in numerical terms. Additionally, the composition of the homeless population has changed – it is no longer dominated by drug/alcohol addicts, but now includes many more victims of the economic downturn.

4. Susan’s Place

This transitional residence, originally set up with 180 beds and an on-site medical and dental clinic, is an extension of the Care for the Homeless organization. Its mission is to help the increasing number of homeless people who desperately need health care and shelter services. Specifically, Susan’s Place is dedicated to serving medically frail and mentally ill homeless women, providing them with healthy meals, clean clothing, recreational activities, and a broad range of primary health care and social support services. An important component of their program is to help their clients achieve maximum self-sufficiency through providing needed services, guidance, and support. The ultimate objective is to place their clients in permanent housing and have them remain there.

In 2010, Susan’s Place expanded to a 200 bed shelter in response to an urgent request from the City for help in accommodating the growing number of elderly homeless women.
struggling with medical frailties and mental illness. To ensure that this particular group receive the special care they require, Care for the Homeless created a new position, Medical Case Manager, to ensure that the health/medical needs of these clients are appropriately attended to.

Residents have the opportunity to participate in a wide range of activities, including in-house education groups, recreational activities, and support groups such as Alcoholic Anonymous, Narcotic Anonymous, etc. A library and computer lab is available for clients to use for educational/recreational purposes and to communicate with one another.

The staff includes social workers, case managers, housing specialists, after-care specialists, substance abuse counselors, and a recreational therapist. Their licensed medical and dental clinic has a primary care provider, a social worker, a psychiatrist, a registered nurse, a medical assistant and a part-time dentist and podiatrist.

5. Partnership for the Homeless

This organization exemplifies the potential for a large-scale, all-age inclusive organization to incorporate within its broad portfolio a special program component to serve the “near homeless/already homeless older adult.”

The primary objective of this component is not only to salvage homeless persons from the street or shelter, but to provide a long term residential permanency for them with appropriate supportive services. Of equal importance is ensuring the integration of older adults into a community setting in order to prevent their social isolation.

As part of its recent strategic focus on systemic issues, the organization’s goal is to create structures needed to foster and maintain housing stability for older adults and to provide support for them to live healthy, independent lives. Based on an adaptation of the Naturally Occurring Retirement Community (NORC) program, which emphasizes the need to strengthen the connections older adults have to their communities before confronting a crises, Partnership for the Homeless envisions a plan that mixes public and private entities which provide community-based and in-home services and activities. These entities would work with local leaders and community residents, including older adults. Within this context, the active role of Partnership will be to strengthen and reinforce the interaction of all these different entities into a cohesive body of services and support, in addition to providing additional services as they are needed.

Clients served by Partnership for the Homeless have historically been 70% male, mostly Caucasian, with increasing numbers of undocumented immigrants, mostly from South America.
Three in every four were previously married; 10 to 15% are currently married but lost contact with their spouse. The most serious health problems in the group are cardiovascular and mental illness, in addition to the typical problems associated with aging.

6. **The West Side Federation for Senior and Supportive Housing**

This organization is community-based and focused on the need to provide safe, affordable housing with supportive services for low income people in general. More specifically, the Federation develops, manages, and provides social supportive services in housing for the older adults, homeless persons, and those suffering from mental illness. Among its current executive staff are those who spearheaded the first private shelter for older adults in 1990 to accommodate 92 women and men, most of whom had mental and physical issues. Currently, the Federation operates 24 buildings servicing 1,700 persons; one building is reserved exclusively for grandparents raising their grandchildren.

Sixty five percent among its clients had experienced homelessness, and one in two were actually homeless at the time of entry. Many clients were street people. Others were referred by hospitals, churches, and synagogues. Information specifying the number of clients who were homeless before their intake and now reside in the Federation’s 24 buildings was not available. It is conceivable that there will be some overlap among the three groups of clients being serviced: elderly, mentally ill, and homeless. The Federation’s specific attention to the homeless elderly population is evidenced in its sponsorship of the Valley Lodge Transitional Shelter for the elderly homeless persons and the Fleming House, an adult home for 47 mentally ill homeless elderly individuals.

Though different eligibility criteria are applied for residence in each of its buildings, overall, elderly homeless and mentally ill applicants need to be 50 years and older, free of crime convictions, preferably sober, and have access to income sources /entitlements to be able to guarantee the required partial payment of rental costs that represent 30% of their total income. Undocumented applicants confront great difficulties in meeting this requirement. A social profile of the total client population identifies foreign points of origin, including Czechoslovakia, the Dominican Republic, and Jamaica. The majority are Caucasian, some are African American, and few are of Latin American descent. Among recent arrivals, there are many who come from a middle class background. As a whole, the composition is a mix of clients including those who had worked in the past despite their mental illness, but with advancing age their mental condition
got worse and they could no longer cope with a job; street people; those referred to by shelters; and undocumented people. In general, many mentally ill clients previously lived with their families who may have been in denial of their relative’s mental health, ashamed of them, hid them from their neighbors, and did not seek treatment. Some residents maintain contact with family members while others do not, either because their families cannot cope with a mentally ill member, or because the family members feel guilty for not taking care of them.

Women clients are no longer “bag ladies” but many are mentally ill. They may have previously lived with their family in tight ethnic communities but found themselves alone with no support when parents died. Some are very educated while others are street people referred to by relatives or by the shelter system. The men are mostly loners, mentally ill, or former sexual deviants. The undocumented persons live in fear of being deported, cannot apply for entitlements, and their lack of income prevents them from being housed. For most of the group, the major factors associated with becoming homeless included untreated mental health; unaffordable rents; eviction, and financial abuse by family members.

B. Organizations Exclusively Supporting Older/Elderly Homeless Persons

1. The Encore 49 West Residence

The West Residence opened its doors in 1988 to welcome older/elderly men and women who had become homeless or were living in transitional situations or in shelters. It currently houses 88 residents between the ages of 62 to 95, comprising 49 men and 39 women. Most have had a long history of being homeless. The organization’s intent is for clients to remain permanently at the West Residence and not become transients – this is explained at the outset to applicants, though they are free to leave if they so desire. However, only three people have left over the past three years.

The primary goal of the organization is to develop an individualized program for each client to empower them to reach their full potential by acquiring the skills necessary to live functionally and independently within the residence and larger society. Reaching this objective enables residents to avoid premature, unnecessary and costly institutional placement. With this goal in mind, clients are exposed to a comprehensive range of services, including: education and management of ADL skills; medical and or psychiatric care to prevent recurrence of
homelessness or hospitalization; individual counseling, referrals, crisis intervention/prevention; financial assistance, money management; and linkages with hospitals when necessary.

With a staff that includes doctors, nurses, psychiatrists, social workers, nurses’ aides, and a podiatrist, residents are provided with social, medical, and psychiatric services on site. These include medical and psychiatric assessments, diagnoses and psychopharmacology, and medication management. In addition, a multitude of recreational group activities are organized, such as arts and crafts, exercises for stress management, bingo, movies, trips, parties and holiday celebrations.

Fifty percent of the 88 residents have mental health problems – mostly schizophrenia and clinical depression. Ninety percent cannot live on their own because of their health/disability problems and need for medication compliance. Non-ambulatory clients are sent to nursing homes. Most clients live permanently at the Residence, but are free to search and find housing with their Section 8 vouchers. The majority of residents come from a low income background, some are veterans, are men previously living on the street, or are referred from the Shelter system, from Fountain House or by Outreach programs. Seventy percent are African Americans; some come from South America and Cuba. The majority of those who are mentally ill (45) have never worked; those who were employed held low service jobs. None of the residents have degrees or professions; four served in the military. More recently, the intake has seen “first time homeless” people who have confronted economic hardships and possess a greater ability to take care of themselves. Visits from family members are rare, as schizophrenia burns people out. Sometimes friends come to visit.

Factors leading to their homelessness include: alcohol addiction among men; chronic schizophrenia among women; deinstitutionalization; and lack of affordable housing.

2. Casa Mutua

A permanent supportive residence for formerly homeless people houses 54 mentally ill, single adults (31 men and 23 women) who came from shelters, the streets or were referred by DHS. The majority of residents are in their 50’s and 60’s; their oldest member is 75 years old. To be eligible, all applicants must have some form of mental illness. The specific criterion for acceptance is a psychiatric diagnosis.

Casa Mutua acts as a landlord and social service provider. Each resident gets his or her own voucher and becomes a tenant. Eighty percent of the residents are on SSI; the remaining
residents receive Public Assistance benefits. As tenants, residents are charged one-third of their total income towards rent. At times, the organization has to take over payment responsibilities when tenants fail to pay regularly. Residents are free to move out and to come and go as they want. The only reason for eviction is nonpayment of rent. To ultimately be provided with housing, residents have to be assessed as high functioning and competent.

The organization’s goal is to help residents gain independence and to stabilize them in permanent housing. This is done by providing comprehensive social, psychiatric, and legal counseling, in addition to other supportive services. Psychiatrists are contracted to come twice weekly and nurses attend to physical health problems. Only a few residents self medicate and are compliant with medication; the majority do not take their medicines, and close to one third do not see a psychiatrist at all or do so offsite. The staff regularly advises residents to visit the doctors on site or helps them connect with doctors on the outside. A recreational specialist is on staff to organize a variety of activities and parties for special occasions, but few residents are interested in participating.

Most residents come from a blue collar, low income background. Some have been employed; others are HIV/AIDS survivors or were addicted to opium. Residents represent an ethnic mix of African Americans, Caucasians, and Hispanics in addition to five Caribbean and two Asians.

A number of behavioral problems were reported. Some tenants fight or threaten others (mostly women), especially those released from prison. Others suffer psychological breakdowns from drugs. Many do not leave their rooms, become depressed, and resent paying 30 percent of their income for rent. They find residence life boring and prefer to live in shelters where there is more activity and company. Most don’t eat well, neglect to take care of themselves or participate in recreational activities. Their health problems include diabetes, obesity, and high blood pressure, yet they do not observe medication compliance. They spend their money very quickly and then have to borrow. Those in contact with their family visit them, rather than have their family come to the residence.
3. DOROT’s Homelessness Prevention Program

This Program provides older homeless persons with safe temporary housing while assisting them to find an affordable permanent residence in a relatively short time period. The first choice may not always be the ideal setting, in which case DOROT’s Relocation Program is charged with the task of continuing to look for better and more appropriate housing. This can take some time. Through its After Care Program, DOROT provides continuous support to clients after they have been resettled. It also counsels older people who are “at risk” of losing their homes, to help them avoid becoming homeless.

The eligibility criterion for acceptance into this program is: 60 years of age and older; ambulatory; free of alcohol and drug dependency; free of psychiatric disorders; and committed to seeking permanent housing. To that end, they must have access to sufficient and stable income (whether it be private or through entitlements) to afford the partial rental requirement once housing is secured. Those who cannot meet these criteria are referred to other agencies.

At any given time, the program has capacity to house 14 older homeless people. Once they are accepted into the in-house program, a regular assessment of each client is made to determine their needs, the particular problems they face, and the type of financial management assistance and counseling each requires. Aside from free meals and assistance provided to gain access to their benefits and entitlements, residents are also offered training in life skills. Thanks to DOROT’s Cash Relief Program, together with corporate and individual donations, the 14 in-house clients are provided with any additional assistance needed while they are in residence, including medical care, clothing, etc.

DOROT’s After Care Program addresses the needs of those clients who have “graduated” to permanent housing, providing them with continuous assistance and support to stabilize their life and prevent the recurrence of becoming homeless. At the time of discharge, comprehensive information is gathered as groundwork for the particular assistance and services “graduates” might need. The Discharge Sheet includes information regarding the types of contacts to be maintained, recommendations for future services needed, and specifics regarding their social, medical, health, and economic profile at the time they move out of the in-house program. Once housing is secured, graduates are handed a “Wish List” to indicate their most pressing needs to prepare for moving into their new home, such as household items, furniture, linens, food provisions, etc. To the extent possible, DOROT’s Cash Relief Program and donor contributions
try to meet those needs. The current number of active graduates who are now in permanent homes totals 150; many among them have become volunteers offering their services back to the Program.

Contrary to past years, when the majority of clients were illiterate men with little knowledge of English language, two thirds of the current clientele are women. The majority are retired. Only two of the 14 current residents are looking for work. Most are no longer in contact with their families; others do not want to be dependent on family members. Still others were emotionally and physically abused. Over the past three to five years, the background of arrivals has included middle income, white collar professionals, and persons previously employed in middle level managerial positions. Now that income is required as a condition for acceptance into the program, the shifting profile seen in recent clients makes it easier to meet this financial obligation.

Many clients are often depressed, suffer from high levels of anxiety, and encounter many family problems, such as quarrels with adult children and sons-in-law. Men suffer from depression, and are particularly embarrassed to admit they are homeless or unable to provide child support. For the group as a whole, the primary factors leading to the loss of their home were domestic violence, eviction, or inability to pay rent.

4. Valley Lodge Shelter

Valley Lodge is a 92-bed transitional shelter dedicated to serving older men and women who are homeless. Admission is open to medically and mentally frail people over age 52 who are ambulatory and free from communicable diseases. Currently, 41 residents are over age 65. The primary mission of the shelter is to secure an appropriate, affordable permanent house for each client. At the outset, long and short term goals are discussed with each resident individually, which serves as the basis for a case management contractual agreement designed to attain an independent living plan and to secure permanent housing. All residents must make a firm commitment to pursue these goals. Support structures and assistance for goal setting and achievement are provided by the shelter. On the part of residents, meeting their commitment requires participating in money management training, willingness to apply for benefits and entitlements, and readiness to enter into medical, psychiatric, and addiction treatment when deemed necessary.

The services provided include:
• 24 hour staffing and security
• full meal program
• assistance with daily living
• escort services to appointments
• on-site medical and psychiatric/health services, medication supervision, money management, intensive case management, referral to on-site and community medical, psychiatric and addiction services
• active recreational program
• referral to permanent housing

Many residents have mental health problems, including schizophrenia, paranoia, bipolar disorder, dementia, and clinical depression. Three psychiatrists are on staff three times per week, in addition to an on-site medical team. Some residents work part time or have a 20 hour/week work program. A few women attend training programs to become home health aides. Most residents have a blue collar background. Male residents include many with a prison history, drug/alcohol addiction and excessive smoking. A major problem, particularly among the men, is that they don’t want to take advantage of the on-site services provided (particularly the medical services). In the past, women residents were seriously mentally ill, but recently this has been less of a problem. Recent arrivals, particularly the women, have a middle class background and either come with, or immediately obtain, their SSI entitlements. All residents are pressured to save 50% of their income, given that all support services, including medical care, are free. The only items that residents pay for are escort services and co-payments for outside medical care.

The current group of residents represent a mix of nationalities and ethnicities with countries of origin that include Africa, Guyana, the Philippines, Russia, the Dominican Republic, Liberia, Haiti, and Jamaica. Some residents are undocumented. The ethnic mix includes 50 residents of African descent, 28 Hispanics, and 14 Caucasians.

Valley Lodge places between 60 and 70 clients into permanent housing each year, with a low rate of return to the shelter system. In some cases, financial assistance is given to “graduates” who have already moved into housing to enable them to remain in their apartments. Placements include independent apartments, supportive SROs, congregate housing, and skilled nursing facilities. Major forces leading to homelessness include financial troubles, mental illness, substance abuse, job loss, death of parent, and eviction.
5. The Women’s Mental Health Shelter

Located at the Park Avenue Armory, this shelter provides a temporary home to mentally ill women over the age of 45 who are all in need of permanent housing. The overreaching goals of the Shelter are twofold. The first is to provide a short term, safe, and supportive environment to address the immediate needs of individuals with mental illness. The second is to place these women into permanent housing.

The Shelter houses 100 women in ages ranging from 45 to 81 years, with the highest concentration in the 50 to 60 year old age group. There are no restrictions imposed upon their documented status in the country. Clients are sent from Assessment Centers operated by the Department of Homeless Services, where applicants are examined for medical and psychological problems, history of substance abuse, and types of services needed. A few clients are referred from Outreach Programs, hospitals, etc. At any one time, many of the 100 women living in the shelter have had long histories of homelessness and chronic psychiatric problems, including schizophrenia, bipolar disorder, clinical depression, and anxiety disorders, as well as age-related health problems. Very few have substance abuse issues. Family visits are not allowed. Ideally the average length of stay at the Shelter is nine months; however, in reality it often stretches into 18 months to two years. Clients are free to leave the Shelter during the day but must return by 10 p.m.; otherwise, they lose their bed. Not all clients partake in the three meals and snacks served daily.

With a staff of experienced psychiatrists, nurse practitioners, two social workers, two graduate student interns, a clinical director, peer advocates, program aides, and housing specialists, the Shelter assists clients through structured social work services, medical interventions, case management, planning, and housing placement. Recreational activities are also organized for them. An important program component provided by the Housing team supports “ready to move out” clients in all the preparations required to qualify for supportive housing, whether in congregate or scattered buildings. Qualifying for housing depends in large part on having all the necessary documents required and regular access to income sources/entitlements to cover the 30% rental costs. Clients without income sources can obtain public assistance, disability allowance, etc. The problem lies with transients who often cannot meet the required documents, or more pointedly with undocumented persons – many of whom
are ready to leave the shelter but, given their inability to gain access to entitlements, are unable to meet the financial requirements to become eligible.

Most of the clients come from economically disadvantaged backgrounds, many with less than an 8th grade education. A few hold college degrees and have travelled around the world. Many became homeless after living with their family. Others could no longer afford to pay the rent, while still others were previously in abusive relationships. Few residents hold jobs. Those employed work in the health care field or as receptionists. As long as they take their medication, a number of clients can hold steady jobs. Relationships with family members range from being actively involved with family to completely cut off from family. In the latter case, these are mostly clients who are severely psychotic. The composition of the group is mixed: 60% are African American and Caribbean, 30% are of Hispanics/Latino descent, and the remaining 10% are Caucasians, some from Germany, Poland, and Russia.

6. The George Daly House

As a private non-profit center, this organization was contracted by the City’s Department of Homeless Services to become part of its shelter system. Its primary mission is to provide supportive programs, services, and guidance to homeless people to enable them to achieve maximum independence and self-sufficiency. The ultimate goal is to place its residents into permanent/supportive housing in the larger community.

This 88 bed shelter currently houses 57 men and 31 women ranging in age from 45 to 82 years old. Most have been transferred from DHS and Drop-in Centers, or switched from other places. The first floor of the facility has 14 beds and houses clients with varying degrees of mobility, using walkers, wheel chairs, and canes. The second and fourth floors are for men and the third floor is for women. The criteria for acceptance are age 45 and older, with a manageable mental illness, and access to an income source whether private or through entitlements. Acceptance also requires a screening for medical and mobility issues and to obtain a socio-psychological profile. Sex offenders are not admitted.

Clients are free to leave the shelter during the day on the condition that they observe the 10:00 p.m. curfew to safeguard their bed. Some do have overnight passes or legitimate reasons for coming in late and in those cases, their beds are held. Clients without an approved overnight or late pass that fail to observe the 10:00 p.m. curfew may lose their bed at their official shelter.
In that event, clients would sign a curfew violators log and wait for an available bed at their official shelter or can be transported to another shelter that has vacancy.

The George Daly House provides a variety of services. The staff includes a social service director, a program director, program aides, four case workers (two of whom are bilingual), a housing specialist, a full time head cook, and two part-time cooks. The onsite benefits provided include:

- regular visits from Care for the Homeless medical teams
- availability of a psychiatrist once per week
- health education
- intensive case management
- money management
- a podiatrist twice per month

The staff regularly informs clients of the entitlements and public assistance they should apply for. Case management staff, together with the housing specialist, prepares clients to become eligible for transfer to permanent and supportive housing. This preparation involves assistance in collecting all the documents required for eligibility and discussing with clients the kinds of questions and issues that will be raised during their interviews with the assessment teams. These play an important role in determining whether or not a client meets the necessary requirements to gain access to housing.
Part IV – Needs, Problems, and Recommendations for Policy and Program Action

This section includes a brief overview of three broad topics.

1. The first outlines some of the primary service needs of older/elderly homeless people.
2. The second cites some of the problems encountered by agencies and social work professionals in their efforts to service and assist older homeless persons.
3. The third topic concludes with a number of recommended policy and program actions at both the State and New York City levels that might be considered as initial steps aimed at minimizing and preventing future episodes of homelessness, as well as methods to ease the suffering of those on the street.

The majority of the needs, problems, and recommendations identified below represent positions taken and views expressed by the professionals interviewed.

A. Service Needs

- More health care services designed specifically for the older homeless population are clearly needed, since the one and only federally funded Health Care for the Homeless Program does not meet the needs of the majority of homeless Americans.\(^\text{12}\)

- Older Americans who become homeless in their later years are a vulnerable population who require more preventive action. Universal access to affordable, high quality, and comprehensive health care would help protect sheltered and street homeless persons against illnesses, help make it possible for those who remain ill to recover, ease the suffering of those living on the street, and ultimately help reduce homelessness as well.

- Mental health issues among older adults are of concern because they are often associated with homelessness. When linked to memory loss, mental illness can affect the ability to secure or acquire housing, which often involves multiple appointments

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\(^{12}\) Health Care for the Homeless (HCH), the only federally funded program for homeless individuals, is designed to specifically provide health care to homeless persons. HCH provides primary health care, substance abuse services, emergency care, outreach, and assistance in qualifying for housing. Many HCH projects also provide dental care, mental health treatment, supportive housing, and other services. These programs are estimated to serve more than 740,000 homeless people yearly, according to the National Coalition for the Homeless (2009a).
and self-initiated persistence. Significant memory problems, cognitive impairment, and dementia make it difficult to follow up on procedures necessary to secure housing.

- Attention needs to be directed at chronically homeless adults who are aging on the street. They are the most likely to experience multiple health problems, chronic illnesses, and mental health issues that go untreated. Exposure to harsh weather and unsanitary conditions can then lead to hypothermia and frostbite, and can exacerbate existing health problems.

- Substance abuse disorders in the older population need to be assessed, particularly alcohol abuse, since these are likely to aggravate pre-existing medical problems or lead to alcohol-related diseases.

- Expansion of intensive case management services is needed for homeless people – whether living in shelters or on the street. Such services are integral to facilitate the transition of homeless people into permanent housing and to ensure that they remain there. In addition, this service enables older people to connect to services such as primary health care, financial management, referrals, and other resources.

- Case management is also needed for cases where homeless people confront obstacles in accessing resources and benefits such as SS, SSI, Medicaid, Disability entitlements, and others. Older homeless persons may not always know that they are eligible for certain benefits and may not know where to go and how to deal with the bureaucracy. Due to health limitations, they may have difficulties completing necessary paperwork. They may also need assistance in overcoming barriers in the utilization of social services at both the structural and individual level.

- More drop-in social centers are greatly needed for older homeless persons and those who are marginally housed in order to reduce the numbers of those on the street and to prevent isolation, a major contributory factor to homelessness. The notion of age-segregated drop-in social centers, coupled with outreach programs and organized activities, has shown in the past to be useful for the older age groups, as exemplified by the now defunct St. Peter’s Place. St. Peter’s Place was the City’s only drop-in center exclusively for homeless people ages 55 years and older. Its closure affected hundreds of people, most in their 60’s and 70’s, and has often been mentioned as a model to replicate.
• Rental subsidy needs to be restored and should be specifically targeted to assist those in the older homeless population who are the most vulnerable and needy.

• There is clear need to focus attention on the 50 to 65 year age group who are vulnerable, have serious health problems, and are unemployed. They are not eligible for benefits such as Medicare and may not have access to affordable health insurance. Development of health care resources for this age group is essential.

• A center or location needs to be provided where older persons who are experiencing homelessness can access multiple services under one roof. A multidisciplinary team representing different specializations can be brought together on this site to provide comprehensive assessments and services.

• In cases where there is a long waiting list for subsidized housing, it is essential to set up sufficient transitional housing programs to quickly move older/elderly people out of shelters and off the street.

• More research is needed on different subjects pertaining to the older homeless population including an assessment of the root factors leading to their homelessness; their perceived condition and situation as homeless people living in shelters and on the street; the frequency and duration of homeless episodes; their health status and functionality; their expectations; and the experience of those who have gained access to permanent housing.

B. Problems Encountered In Providing Services For The Homeless

1. At the City Level

• Historically, the older/elderly homeless population has been largely overlooked. As a consequence, debates on homelessness have largely ignored the growing number of older homeless New Yorkers and those who are “at risk” of losing their home. Rather, the focus of attention has been on homeless youth and children.

• Difficulties exist in identifying the size of the older homeless population because of the scarcity of age-specific information in most of the data reporting system on the homeless.

• There are insufficient programs and services in place specifically designed to aid vulnerable older people in the City. These are not always equipped to respond to the
health conditions associated with aging, frailty, poor mobility, loss of vision and hearing, and chronic pain.

- The shelter system can present a difficult environment for older/elderly people, particularly when it is designed for a more physically-able population and lacks handicap accessibility. The enforcement of strict hours, the rule that clients leave the shelter during the day, and the expectation that they be engaged in actively seeking or maintaining employment is often unrealistic for those who have serious chronic problems. Not all shelters are staffed with people well prepared to effectively meet geriatric needs.

- A “housing policy” that is not favorable to providing access to affordable housing for those who have lost their home is an obstacle for the elderly homeless. No subsidy is available to stabilize housed people who are at risk of losing their homes and few, if any, programs are geared to provide a safety net for the older population “at risk.”

- Community resistance to the establishment of shelters is seen in a number of communities that have protested against plans to set up shelters that would bring hundreds of homeless men and women to the neighborhood. Examples of resident protests include: a) East New Yorkers opposing plans for a 200-bed men’s shelter located next to a day care center and a 164-bed women’s shelter slated for the area; b) Brooklyn residents against a proposal to build a 200-bed homeless shelter in Greenpoint; c) a lawsuit filed by the Chelsea Business and Property Owners Association against a plan to build a shelter for 328 drug-addicted and mentally ill homeless men.

- Paucity of research on the needs of older homeless people – pertaining to service delivery, support services, and outreach programs to evaluate their effectiveness and identify whether services/programs need to be restructured or better models of delivery need to be devised.

- Drastic cuts in federal and state funding since 2008 have affected services for the homeless.

2. At the Individual Level

- Older homeless persons face greater challenges in seeing and utilizing much needed services than their younger counterparts. This is not only due to their frailty, health
constraints, mobility, and difficulties in accessing benefits, but also due to their own self-perception. Some older people hold onto the desire to be completely self-reliant, and may feel that accepting services equates to admitting that they are old and no longer independent or self-sufficient.

- Older people may be more difficult to work with because of distrust towards service providers. They may fear the system overall, fear being put in a home, or fear losing their independence. A prevailing perception is that seeking help from a social service agency will lead to institutionalization. Some older people vigorously avoid the shelter system because they fear the aggressiveness of younger clients and staff.

- It should also be mentioned that some older clients have found difficulties in obtaining the documentation required to be eligible to receive permanent housing. This is particularly true in cases where clients were born in some Southern states during the 1920 to 1950 time period, decades during which birth certificates were not always issued in cases of homebirth. In a number of cases, it was necessary to return to the birthplace and obtain verification of a client’s identity, through baptismal registries, school records, and even personal testimonies.

3. At the Contractual Level

- Cuts in federal funding, occurring simultaneously with a high rise in operating costs, has unfortunately pressured some non-profit organizations that partner with DHS to curtail their staff.

- The criteria set by DHS for evaluating performance levels stipulates that shelters partnering with the agency have a yearly quota to place a certain number of clients in permanent housing; otherwise their funding is cut.

- At times, there are difficulties in meeting this quota because of a large constellation of issues that have to be resolved before a client becomes eligible to gain access to permanent housing. Among others, these include appropriate diagnosis of their physical health, psychiatric evaluation of their mental health condition, their psychological readiness, compliance to observing their medicine intake, etc.
C. Recommendations for Policy and Program Action

Recommendations for policy and program action include the following:

- Shift policy and programs related to homelessness in the direction of addressing the structural roots of the problem – namely, the shortage of affordable housing and rising poverty levels – rather than confining policy/program actions solely to the provision of services.

- Incorporate into all policy and programmatic action both the “visible” sheltered population and the unsheltered living on the street, as the universe of concern and attention.

- Given the wide recognition of the root causes of homelessness, modify the housing policy by restricting the rampant destruction or conversion of low income dwellings, single room occupancies, and entitlement buildings into cooperatives and condominium buildings.

- Place more energy and allocate more funding toward increasing the supply of subsidized affordable housing and permanent supportive housing. This can be done in New York City by turning vacant housing into affordable apartments.

- Prioritize the housing and service needs of the most vulnerable people—unsheltered persons living on the street, individuals who are chronically homeless, disabled, and those with serious health problems.

- Provide a safety net to reduce homelessness among older people by actions that safeguard housing stability for those marginally housed, and create stable housing situations for those already homeless. This involves enforcing rental regulations\(^\text{13}\) providing financial assistance for people to remain in their homes permanently, and preventing older people from being evicted. Services currently available do not adequately meet these housing needs.

- Develop a typology that classifies older homeless persons according to age, gender, medical/health problems, duration of homeless episodes, functionality, history of

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\(^{13}\) The Senior Citizen Rent Increase Exemption [SCRIE] program was devised to offer eligible tenants an exemption from rent increases. Under this program, the owner of the building receives a credit against their real estate taxes from the City of New York. Applicants are expected to meet ALL of the eligibility requirements. Whether or not homeless senior citizens or those “at risk” of losing their home have taken advantage of this program is not known.
drug/alcohol abuse, and mainstream service utilization. By taking account of their different characteristics, programs, interventions, supportive services and agency practices can be better planned and more effectively targeted.

- Initiate proactive measures to prevent “at risk” people from ending up homeless. A recommended way to address this problem is to mobilize the Adult Protection Services Agency to assume a greater role in reducing/preventing homelessness by setting up a special unit to reach out, provide assistance, and protect older people “at risk” before they lose their homes.

- Restore Federal Housing Aid to homeless families in New York City, which was cancelled in 2006. Under earlier administrations, this aid was reported to be successful and cost effective in “graduating” homeless families from shelters to stable homes. According to the Coalition for the Homeless (2011), during the period when New York City used Federal Housing resources (FY 1990-2005), an average of 5,916 homeless families resided each night in municipal shelters, as opposed to 9,058 families from the time (FY 2006-2010) when the City cancelled Federal Housing Aid to Families.

- Develop group programs for older people by establishing a drop-in center exclusively for older age groups. This can lessen feelings of isolation which can contribute to homelessness. These centers can also be utilized through programs and discussions to address older people’s hesitancy, fears, and anxieties, all of which prevent them from utilizing available services or from taking steps to seek help.

- Expand programs targeted to older homeless individuals that work seriously towards reintegrating this group into the community.

- Ensure that official reports and statistics pertaining to homelessness in New York City include age-specific information on both the sheltered and unsheltered homeless population in order to numerically highlight the presence of older New Yorkers among this population.

- Encourage research studies centered on the older homeless population to better understand their background, needs, characteristic traits, and living circumstances.
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McKinney Act, 42 United States Code, Section 11302 2002(1)


APPENDIX A:
THE MC KINNEY-VENTO HOMELESS ASSISTANCE ACT
The McKinney-Vento Homeless Assistance Act
As amended by S. 896 The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009

SEC. 103. [42 USC 11302]. GENERAL DEFINITION OF HOMELESS INDIVIDUAL.

(a) IN GENERAL.—For purposes of this Act, the term “homeless”, “homeless individual”, and “homeless person” means—

(1) an individual or family who lacks a fixed, regular, and adequate nighttime residence;

(2) an individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;

(3) an individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including hotels and motels paid for by Federal, State, or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing);

(4) an individual who resided in a shelter or place not meant for human habitation and who is exiting an institution where he or she temporarily resided;

(5) an individual or family who—

(A) will imminently lose their housing, including housing they own, rent, or live in without paying rent, are sharing with others, and rooms in hotels or motels not paid for by Federal, State, or local government programs for low-income individuals or by charitable organizations, as evidenced by—

(i) a court order resulting from an eviction action that notifies the individual or family that they must leave within 14 days;

(ii) the individual or family having a primary nighttime residence that is a room in a hotel or motel and where they lack the resources necessary to reside there for more than 14 days; or

(iii) credible evidence indicating that the owner or renter of the housing will not allow the individual or family to stay for more than 14 days, and any oral statement from an individual or family seeking homeless assistance that is found to be credible shall be considered credible evidence for purposes of this clause;

(B) has no subsequent residence identified; and

(C) lacks the resources or support networks needed to obtain other permanent housing; and
The McKinney-Vento Homeless Assistance Act
As amended by S. 896 The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009

(6) unaccompanied youth and homeless families with children and youth defined as homeless under other Federal statutes who--

   (A) have experienced a long term period without living independently in permanent housing,

   (B) have experienced persistent instability as measured by frequent moves over such period, and

   (C) can be expected to continue in such status for an extended period of time because of chronic disabilities, chronic physical health or mental health conditions, substance addiction, histories of domestic violence or childhood abuse, the presence of a child or youth with a disability, or multiple barriers to employment.

(b) DOMESTIC VIOLENCE AND OTHER DANGEROUS OR LIFE-THREATENING CONDITIONS.—Notwithstanding any other provision of this section, the Secretary shall consider to be homeless any individual or family who is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions in the individual's or family's current housing situation, including where the health and safety of children are jeopardized, and who have no other residence and lack the resources or support networks to obtain other permanent housing.

(c) INCOME ELIGIBILITY.—

   (1) IN GENERAL.—A homeless individual shall be eligible for assistance under any program provided by this Act, only if the individual complies with the income eligibility requirements otherwise applicable to such program.

   (2) EXCEPTION.—Notwithstanding paragraph (1), a homeless individual shall be eligible for assistance under title I of the Workforce Investment Act of 1998.

(d) EXCLUSION.—For purposes of this Act, the term “homeless” or “homeless individual” does not include any individual imprisoned or otherwise detained pursuant to an Act of the Congress or a State law.

(e) PERSONS EXPERIENCING HOMELESSNESS.—Any references in this Act to homeless individuals (including homeless persons) or homeless groups (including homeless persons) shall be considered to include, and to refer to, individuals experiencing homelessness or groups experiencing homelessness, respectively.

Source: Retrieved from
APPENDIX B:
HOPE 2011 AND HOPE 2012:
THE NEW YORK STREET SURVEY
Key Findings

- Total estimate of 2,648 unsheltered individuals in 2011.
- A 15 percent decline since 2010 in unsheltered individuals and a 40 percent decline since 2005, the first year the survey was administered Citywide.
- 1,747 fewer New Yorkers on the street since 2005.
- Decoys were used throughout the HOPE 2011 survey as a quality control measure to ensure validity.

Unsheltered Population Decreased by 15% from HOPE 2010

DHS Releases Results from HOPE 2012

On the night of Monday, January 30, more than 2,900 volunteers fanned out across the five boroughs to conduct the annual Homeless Outreach Population Estimates (HOPE). The Department of Homeless Services (DHS) announced a total of 3,262 individuals living unsheltered throughout the City - 614 more individuals than the previous year, but 1,138 (26 percent) fewer than in 2005.

Each year, HOPE allows the City to effectively project service needs and allocate resources accordingly. Required by the U.S. Department of Housing and Urban Development (HUD), street surveys similar to HOPE are conducted in municipalities across the country and are a requisite for receiving funding under the McKinney-Vento Homeless Assistance Act. While most cities conduct their surveys bi-annually, New York holds itself to a higher standard and conducts the HOPE survey annually. With the independent audit of decays as a quality control measure, New York City’s HOPE survey embodies the Bloomberg Administration’s innovative yet data-backed approach to government.

Working with non-profit providers, DHS employs a comprehensive, round-the-clock outreach program, through which teams engage the street homeless population 24 hours per day, seven days a week. Citywide, bringing services directly to those in need. Through the creation of low-threshold housing, offering alternatives to traditional shelter, known as Safe Havens and stabilization beds, many individuals who had previously resided on the streets for years have accepted housing options and moved indoors.

To assist those on the street, more supportive housing will become available this year to Medicaid users through State funding, enabling many Safe Haven and stabilization bed residents to move on to permanent housing and receive the wrap-around social services they need. Additionally, Homeless Services and the Department of Housing Preservation and Development are working together to develop additional permanent housing alternatives. Together, these options offer significant housing investments in the street homeless population to move more individuals toward permanency, quickly.

"The end result of having our street homeless individuals in a home of their own remains our ultimate goal. Our outreach teams remain committed to assisting the street homeless population, and remind all to call 311 if they see an individual in need," said DHS Commissioner Seth Diamond. "We would like to sincerely thank all the volunteers who took part in HOPE 2012!"
APPENDIX C:
THE ADVANTAGE PROGRAM OVERVIEW
Advantage

DUE TO THE STATE'S WITHDRAWAL OF STATE AND FEDERAL FUNDING FOR THE ADVANTAGE PROGRAM, DHS WILL NO LONGER BE SINGING NEW ADVANTAGE LEASES AS OF APRIL 1.

PROGRAM OVERVIEW

What is the Advantage program?

Advantage is a rental subsidy that helps clients transition from temporary, emergency shelter to self-sufficiency as quickly as possible, instilling responsibility through its firm linkage to employment. Effective August 1, 2010, this new program has been revised from our previous Advantage subsidy to promote employment and foster self-sufficiency, so that households can return to independent living.

Advantages:

- Helps pay for one or two years of rent support to eligible households
- Requires participants to work and contribute:
  - 30 percent of their gross monthly income toward rent in the first year
  - 40 percent of their gross monthly income in the second year, if they qualify

Who is eligible for the program?

Households in shelter who:

- Have an adult in the household that must be working at least 20 hours a week, earning at minimum wage or above, and engaged in HRA-approved activities for a total of 35 hours weekly
- If there are other adults in your household, those adults must be:
  - Working and/or participating in HRA-approved activities for a minimum of 30 hours weekly and be in compliance with all HRA public assistance requirements, OR
  - In receipt of SSI (or be coded by HRA as “SSI Pending”), SSDI or other federal disability benefits, OR
  - Certified by HRA as "Needing At Home" to care for a disabled family member who is in receipt of federal disability benefits
- Have an Active or Single Issue Public Assistance case
- Have been determined eligible and residing in shelter for at least 60 days
- Remain compliant with all Public Assistance requirements
- All household members must be free of sanctions for 30 days before certification
- Have a total household income that does not exceed 200% of the federal poverty level

Although we require households who can work to do so, we also recognize that

some may be unable to work due to disability. Households may also qualify if:

- All adult members of the household are in receipt of SSI, SSDI or other federal disability benefits, or certified by HRA as “Needed at Home” to care for a disabled family member who is in receipt of federal disability benefits.

How long does the program last?

Clients will receive one year of rental assistance. A second year renewal is available if clients meet the following renewal criteria:

- An adult in the household with demonstrated work, with an increase of employment to 35 hours per week at minimum wage or above - having been out of work for no more than two months since the start of the subsidy;
- Remain compliant with Public Assistance requirements, if applicable;
- If the household is not on Public Assistance, and employment hours were less than 35 during the year, the household must show participation in other work-related activities approved by HRA for up to a total of 35 hours weekly throughout the year;
- If there is another adult in the household, that adult, at the time of renewal, must be:
  - Working at least 20 hours weekly at minimum wage or above, OR
  - In receipt of SSI, SSDI or other federal disability benefits, OR
  - Certified by HRA as “Needed at Home” to care for a disabled family member who is in receipt of federal disability benefits;
- Continue to have an income that is less than 200 percent of the federal poverty level.

What is the amount of rental assistance available?

The amount of rental assistance given to a particular household depends on its income and household size. DHS will not contribute to rent amounts above the maximums listed below. Rents above the allowed maximum amount are prohibited under the Advantage program. Landlords are prohibited from charging extra for heat and hot water. In addition, side deals are strictly prohibited. Advantage participants should not pay any fees to landlords or brokers above what is legally agreed upon in the lease. Any such requests should be immediately reported to DHS by dialing 311, or calling the Preventon Helpline at (212) 607-6200.

Example of Year 1 Client Contribution and Rental Subsidy

<table>
<thead>
<tr>
<th>Household Size*</th>
<th>1 or 2 people</th>
<th>3 or 4 people</th>
<th>5 or 6 people</th>
<th>7 or 8 people</th>
<th>9 or 10 people</th>
<th>11, 12 or 13 people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Household Income</td>
<td>$1,000</td>
<td>$1,000</td>
<td>$1,000</td>
<td>$1,000</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>30% of Income (Client Contribution)</td>
<td>$300</td>
<td>$300</td>
<td>$300</td>
<td>$300</td>
<td>$300</td>
<td>$300</td>
</tr>
<tr>
<td>Maximum Rent</td>
<td>$962</td>
<td>$1,070</td>
<td>$1,316</td>
<td>$1,481</td>
<td>$1,703</td>
<td>$1,925</td>
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<tr>
<td>Subsidy Amount</td>
<td>$662</td>
<td>$770</td>
<td>$1,016</td>
<td>$1,181</td>
<td>$1,403</td>
<td>$1,625</td>
</tr>
</tbody>
</table>
### Example of Year 2 Client Contribution and Rental Subsidy

<table>
<thead>
<tr>
<th>Household Size*</th>
<th>1 or 2 people</th>
<th>3 or 4 people</th>
<th>5 or 6 people</th>
<th>7 or 8 people</th>
<th>9 or 10 people</th>
<th>11, 12 or 13 people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Contribution</td>
<td>Household Income</td>
<td>$1,200</td>
<td>$1,200</td>
<td>$1,200</td>
<td>$1,200</td>
<td>$1,200</td>
</tr>
<tr>
<td>Toward Rent Income (Client Contribution)</td>
<td>$480</td>
<td>$480</td>
<td>$480</td>
<td>$480</td>
<td>$480</td>
<td>$480</td>
</tr>
<tr>
<td>Rental Subsidy</td>
<td>Maximum Rent</td>
<td>$962</td>
<td>$1,070</td>
<td>$1,216</td>
<td>$1,481</td>
<td>$1,703</td>
</tr>
<tr>
<td>Rental Subsidy</td>
<td>$482</td>
<td>$590</td>
<td>$893</td>
<td>$1,001</td>
<td>$1,223</td>
<td>$1,445</td>
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</tbody>
</table>

*Eligible household size is determined by HRA*

### What assistance is available once clients exit shelter?

Once a family or individual exits shelter, they can receive aftercare services through Homebase. Aftercare is there to help households transition back to homes in the community and it is important for clients to ask for help when they need it.

**Aftercare services include:** Tenant conflict resolution, good neighbor education, payment resolution, help accessing transitional benefits, assistance with upgrading or finding employment, assistance accessing services from other City agencies and community-based groups.

For all questions concerning Aftercare services, clients may dial 311 to find the nearest Homebase location, or call the DHS Prevention Helpline at (212) 607-6200.

### For more information about the new Advantage:

- **Clients in shelter:** Please see your caseworker or housing specialist
- **Shelter Staff:** Please contact your Program Administrator or Program Analyst
- **Prevention and Aftercare:** Please call the Prevention Helpline at (212) 607-6200
- **Members of the Community and Elected Officials:** Please contact DHS' Office of Communications and External Affairs at (212) 361-7900 or (212) 361-7973
- **Landlords/Brokers:** Please call the DHS Office of Re-housing at (212) 607-5310
APPENDIX D:
NY COURT: SINGLES DON’T HAVE TO PROVE HOMELESSNESS
NEW YORK — The city cannot go forward with a new policy requiring single people to prove they have no other options before they enter homeless shelters, a court ruled Tuesday.

The decision in Manhattan state Supreme Court was in response to how the city introduced the proposal, which would have required people to show they're truly homeless, with documents if possible.

City Council Speaker Christine Quinn, who opposed the policy, hailed the ruling as "a tremendous victory" and commended the court for its action.

The city plans to appeal.

The council voted in December to sue Mayor Michael Bloomberg's administration over how the policy was communicated to lawmakers and the public. The city delayed enacting it pending the court review.

The mayor's administration made the policy change in November, with only a week's notice before the council held a hearing lasting several hours. Department of Homeless Services Commissioner Seth Diamond participated.

Quinn said neither the council nor the public was adequately consulted about a move she called "cruel and punitive." The policy would put thousands more people on the street because it required "people who could least shoulder it" to provide proof they have nowhere else to stay, Quinn said.

Bloomberg, an independent, responded Tuesday that the same standards should apply to everyone seeking shelter.

Otherwise, the mayor said, judges should explain to city residents "why they think that you should just have a right to walk in and say, `Whether or not I need services, give it to me.'"

Diamond said in a statement that the ruling by Judge Judith Gische pertains only to procedure, not to the legality of the policy.
The judge’s ruling "focused only on the administrative process used to communicate the eligibility procedure for single adults entering the city’s shelter system,” Diamond said. The decision does not "make any determinations about its legality other than ruling on the method used to issue it."


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<table>
<thead>
<tr>
<th>CRITICAL ACTIVITIES REPORT</th>
<th>TOTAL DHS SERVICES - FISCAL YEAR 2011</th>
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<tbody>
<tr>
<td></td>
<td>Total</td>
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<tr>
<td>Basic Demographic - Adult and Family Services</td>
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<td>Year-to-Year Comparison</td>
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<tr>
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</tr>
<tr>
<td>%Change vs. Jul 2010</td>
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</tr>
<tr>
<td>%Change vs. Jul 2010</td>
<td>0.4%</td>
</tr>
</tbody>
</table>
Ravazzin Center on Aging

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