"IF YOU DON'T HAVE A HOME, YOU DON'T GET SERVICES": ADDRESSING THE UNMET NEEDS OF SENIOR AND DISABLED HOMELESS

Approved and Endorsed by the SF Aging Advisory Council, September, 2021

The Aging Advisory Council, at its October 21, 2020 meeting, unanimously approved a formal proposal for the formation of a Senior and Disabled Homeless Ad Hoc Committee, consisting of Council members, Dr. Marcy Adelman (in an advisory capacity), Dr. Allen Cooper, Allegra Fortunati, and Morningstar Vancil. The goals of the Homeless Ad Hoc Committee of the Advisory Council to the Commission on Disability and Aging Services were: first, to characterize the cohort of unhoused senior and disabled individuals; second, to identify and assess the services that are specifically directed to older adults; and finally, to make recommendations for how DAS, alone and in collaborations with other agencies, can improve the circumstances of underserved, unhoused older adults. This Report came out of the diligent efforts of this Ad Hoc Committee and was approved and endorsed by the entire Council at a Special Meeting on September 27, 2021.

INTRODUCTION

According to the 2019 San Francisco Homeless Point-in-Time Count & Survey, there were 8,035 unhoused individuals on the street on a specific night, with more in alleys and parks, a 17% rise since 2017. If those in jails and hospitals had been recorded, a 30% rise would be a more accurate figure. Based on a recent survey and other reports, it is estimated that at least 15% of these people are over 60 years old, and/or have disabilities**. Nationwide, older adults are the fastest growing demographic among the homeless** and represent a particularly vulnerable population. The chances of escaping their situation on their own are highly limited. Although various agencies in San Francisco have created an extensive support system for older adults and people with disabilities, that cannot be said of programs for the city's unhoused populations. This report makes fourteen recommendations to address identified gaps in services in the hopes of creating a more comprehensive and coordinated system of support for San Francisco's unhoused older adult population.

The October 2017 Strategic Plan of the Department of Homelessness and Supportive Housing (HSH) acknowledges that Seniors and People with Disabilities are "special populations" and require extraordinary attention to address their age-related or other health conditions and to connect them to City services. At the time of this report, no follow up plan has been made and released to the public, nor has age or disability, as defined by the Department of Disability and Aging Services (DAS), as special criteria for being housed been implemented. For the most part, older adults continue not to be prioritized. After the beginning of our investigation, with COVID-19 and FEMA's support for Shelter-in-Place (SIP) Hotels for older adults and those with underlying health conditions, HSH announced that those within SIP Hotels would be prioritized for housing, as they are moved out. This, unfortunately, will not cover the majority of unhoused seniors.

With this background in mind, the work of the Homeless Ad Hoc Committee focused on services that are provided or might be provided to those in shelters, navigation centers, and SIP Hotels in what will become a post-SIP Hotel San Francisco.

One of the most active groups involved in this issue is the Coalition on Homelessness (COH). In September 2020, COH released a homeless needs assessment, funded by residual money from the Proposition C campaign. Entitled *Stop the Revolving Door: A Street Level Framework for a New System*, this study, of approximately 600 people experiencing homelessness, included homeless individuals over age 60. Questions about disability status were included later in the study resulting in a smaller number of respondents, 170 individuals, for whom we have data on their disability status. The data included demographic characteristics and a 45-minute survey on shelter histories, substance use, and mental health services. At COH's request, Andrew Hockman from UC Berkeley, a member of the original research team, generated a report for us, using the data collected from homeless individuals who were 60 years old and above.

Of the 584 unduplicated individuals interviewed for the larger survey, 109 (19%) were older adults, not all of whom answered every question. In comparing the overall cohort with the smaller group of respondents over 60 years of age, we found numerous similar results between the two populations, such as current marital status. However, several questions elicited quite different results. This report highlights those group differences to better understand the factors uniquely impacting older adults.

African Americans are considerably overrepresented (57% among 60+ respondents as opposed to 38% in the larger survey), while sexual minorities (LGBTQ) are underrepresented (6% and 24% respectively) compared to the overall homeless population. The low 6% figure might be due to problems in collecting the data with older LGBTQ individuals less willing to declare their sexual status, than those who are younger.

The median age at which older adults became homeless was 49 years of age. 51% have been homeless for more than 3 years (similar to the larger survey at 48%), while 40% have never been on a lease or owned a home for all or nearly all their adult lives, somewhat less than in the total sample of 50%. Overall, 44% of the unhoused within San Francisco came from "private housing rented from a landlord" similar to the 40% of the 60+ respondents. **However, when it came to SROs, 25% of those 60 and over reported an SRO as being their last residence before homelessness as opposed to only 9% in the full cohort.** It was relayed that some older adults do not want to move into individual housing, because of the fear they will fall, and no one will be around to help them.

When asked about stays in homeless shelters, 80% of those 60+ have been in a homeless shelter, primarily a traditional year-round one, in the past 5 years. This is a higher percentage than the 73% for the whole sample. **When asked about current or recent stays (pre-COVID), 81% of seniors stayed in traditional shelters, and 14% were in navigation centers. For the larger survey, the figures are 65% and 28%, respectively. Thus, more were in traditional shelters, and fewer were in resource richer navigation centers. Both the disparity in the SRO experience and the longer stays in shelters, as opposed to navigation centers are worthy of further investigation.**

For those living in shelters, *Stop the Revolving Door* researchers also asked about the **top service needs** of the unhoused. **Not surprisingly, case management, and specifically housing case management, were the most frequently mentioned needs among older adults, with almost one-third of the group listing each of these as their major need. Assistance obtaining regular food was listed as a need by 28% of the group. Among the disabled, housing case management topped their list, followed by mental health**

treatment, case management, anger management, and substance use treatment. For the total sample, housing case management was followed by food and then general case management.

In addition to loss of housing, the survey asked about other factors seen as contributing to homelessness, specifically substance use, mental health and, physical disability. The frequency of challenge with substance use was modestly higher in the overall group (22%) than in older adults (17%), however there were differences in the substances used with many using more than one drug. **For older unhoused, the most highly used drug was cocaine (58%), while in the entire cohort the most used substance was methamphetamine (42%). Marijuana use was common in both cohorts while opiate use was significantly less frequent among older adults.**

As stated earlier, only 170 survey participants were asked questions regarding their disability status, not the entire 584 respondents. With that caveat in mind, **in comparing mental health status with the American population at large, serious mental health disorders were more common in the homeless population. The homeless survey reported an 8.3% rate of those with a serious psychiatric disability, such as schizophrenia and bipolar disorder, compared to 3.3% in the general population. Other diagnoses, including anxiety and depression, were common and at rates similar to the general housed and unhoused populace.**

In terms of physical disabilities, older unhoused adults reported mobility issues (including arthritis, broken bones, back pain etc.) and chronic pain significantly more often and at a higher frequency than younger unhoused adults, present in 16% and 10% of the older and overall unhoused respondents, respectively.

As part of this report, the Ad Hoc Committee completed more than seventeen interviews with at least one staff member from the following organizations and city departments:

Bay Area Legal Aid (BayLegal)

Coalition on Homelessness, San Francisco (COH)

Department of Homelessness and Supportive Housing (HSH)

Department of Public Health (SFDPH), including the Shelter & Street Medical Group

Episcopal Community Services (ECS)

Homebridge (HB)

Homeless Advocacy Project (HAP)

Hospitality House (HH)

Justice in Aging (JIA)

Mayor's Office on Housing and Community Development (MOHCD)

Q Foundation (Q)

Self-Help for the Elderly (Self-Help)

Shelter Monitoring Committee (SMC)

Tipping Point Chronic Homelessness Initiative (CHI)

UCSF Center for Vulnerable Populations (CVP)

United Council of Human Services (Mother Brown's)

KEY FINDINGS FROM INTERVIEWS

From the information we obtained from these interviews, **our findings include:**

(1) In the absence of housing, there are few services. **Services within shelters/centers and SIP Hotels are scattered and uncoordinated.** There are **no universal care coordinators** who have detailed knowledge of their clients and can work across departments, particularly HSH, DAS and SFDPH, among others, and agencies to ensure a comprehensive needs assessment, regular check-ins, and high quality and effective services, including gathering of documents needed for housing eligibility. Although the Homeless Outreach Team (HOT) intervenes when called, they are understaffed and limited in their ability to intervene and follow up. HOT is also the major referral conduit to navigation centers.

(2) **Almost all access to housing, permanent supportive and scattered housing, is controlled by HSH through their housing providers** via their "coordinated entry system". Rent subsidies, such as those provided by Self-Help for the Elderly and Q Foundation, are not directed toward those in shelters/centers. The subsidies are almost exclusively preventive in nature, for those who are at risk of losing their homes. Homeless who end up in hospitals or psych wards are sometimes assessed for permanent placement in the rapidly decreasing assisted living or skilled nursing facilities or temporarily in treatment or transitional housing programs through SFDPH, but most are discharged to shelters or other temporary care facilities and often return to the streets in the short term.

    Although HSH has prioritized housing based on "vulnerability" such as mental health, medical issues, trauma, duration of homelessness, and barriers to housing like arrests, evictions, etc. in their coordinated entry system, there is no mention of age as a vulnerability. Across all organization and city department interviewees, **the actual HSH prioritization for housing is opaque,** and many feel, may only be based on the length of time a person is homeless. According to pre-COVID reports, only 9% of adult homeless individuals get permanent housing; most housing goes to families, transitional aged youth (TAY), Veterans, and Women Victims of Domestic Violence. A representative of HSH stated they were changing the "formula" to increase the weighting for age. In the face of the loss of FEMA funding, homeless within SIP Hotels, who are often elderly and with certain medical conditions, may now have a chance of being prioritized for housing. The interviewees have observed senior homeless who are suffering from **dementia, eyesight problems, urinary incontinence, constipation, serious mental illness, and being at-risk for falls. There is no mechanism in place to address these problems even within shelters.**

(3) Interviewees indicated other services that are uniquely needed within shelters/centers for seniors are **ensuring medication adherence**, benefits review and paperwork, referrals to representative payees**, IHSS caregiving for Activities of Daily Living (ADLs)**, including help showering and laundering, transportation to and from medical appointments accompanied by a **knowledgeable patient advocate or case manager**, and appropriate **low-salt, low-carbohydrate or pureed foods as needed**. (Residents of shelters/centers are not allowed to bring in outside food.)

(4) **IHSS workers have been reluctant to work within a shelter or center, without higher compensation,** because of the environment within these facilities and the lack of case management. Also, there was concern that **shelters/centers would be hesitant to allow caregivers in because of liability issues**.

(5) It was felt that there is a **need for activities to counter social isolation and foster a support network** within the facility or a case manager who can locate appropriate institutions, such as churches, senior centers and community organizations that provide programs for specific racial or ethnic groups.

(6) It was acknowledged that **seniors and the disabled homeless face greater difficulties in finding and retaining a permanent job and thus will need long term access** to a "home" within the shelters/centers all day and night, until appropriate housing is provided.

(7) **The discussions and our experience highlight that environmental factors in shelters/centers often work against the elderly**, including lack of ramps, beds that are too low (mats on the floor) or too high (in the case of bunk beds), and being placed on a top floor with no elevators.

(8) Shelters are required to adhere to 32 Standards of Care, including mandatory staff "sensitivity" training. **This training does not include anything about the aging process, ageism, recognizing dementia and mental illness, and racism/racial equity.**

SUMMARY

Older homeless represent a vulnerable and underserved population with special needs and are often hampered by medical, psychological, social, and mobility issues. Existing services do not appear to treat them as an exceptional group, and current services do not consider their unique needs. There is no identifiable mechanism to inform them of a means to becoming housed or of entering the current housing "system". While unhoused and residing in shelters and centers, there are no personnel or programs tailored to identify or assist them with their unique medical, physical, nutritional, or emotional needs. This lack of intervention undoubtedly leads to their continuing deterioration and eventually to the need for crisis intervention or even death.

SUGGESTED RECOMMENDATIONS

Subsidized and, when appropriate, supportive housing is, of course, the solution to many of the problems described above. It is imperative that seniors be recognized as a vulnerable population and

receive a higher priority for permanent housing, through increased subsidies and acquisition and construction of new senior housing units. Until adequate permanent housing becomes available, there are numerous actions and programs the City and County of San Francisco can undertake to humanely address their needs. We offer the following fourteen recommendations to improve the lives of extremely low-income older adults.

(A) Fully accountable to the Mayor, an appropriate department or individual should be designated to take the lead in coordinating services, directed toward older adults and persons with disabilities, with DAS, HSH, SFDPH, and other relevant agencies within shelters, navigation centers, and SIP Hotels, as well as on the street.

(B) Episcopal Community Services (ECS) proposed a "Healthy Aging Model of Care". (A copy of the ECS proposal is appended.) We endorse this model and know it could be adapted, along with the following recommendations, either to make systemwide changes or for a dedicated shelter or navigation center. Such a program(s) should be located within underserved communities and target those senior and disabled homeless who are particularly in need (e.g., unhoused in their 80s and 90s) or belong to a race/ethnicity especially overrepresented within the homeless population, particularly African Americans.

(C) Ensure each client goes through **a comprehensive needs assessment process** after they are accepted into the shelter or navigation center as described in the ECS proposal. This is particularly relevant to the navigation centers, so a program can be developed around their needs. This should not replace the obligation of hospitals to create a reasonable discharge plan for their patients.

(D) Due to their fixed incomes and likely difficulty in attaining financial independence, the City should greatly **increase the availability of rent subsidies for seniors and those with disabilities**, both physical and mental. These subsidies need to be reserved for those living within shelters and navigation centers, should be on-going, not short-term, and cover rent so clients will pay only 30% of their income. In addition, because the initial deposit payment is often a barrier to obtaining rental housing, the subsidies should fully cover these costs.

(E) Systemwide, **increase training requirements for shelter and center staff** on the aging process, ageism, recognizing dementia and mental illness (including addressing the stigma around mental illness), and racism/racial equity.

(F) **Research is needed to understand why seniors move out of SROs and utilize shelters over navigation centers** at a much higher rate than the general population of homeless. Results from this proposal should also be tracked, in conjunction with the UCSF Center for Vulnerable Populations so appropriate services can be directed to SRO and navigation center occupants.

(G) **Station HSH Adult Coordinated Entry System personnel at the 2 Gough Street HUB which is under DAS supervision and other places where homeless frequent**.

(H) **Allow greater access to assisted living facilities, skilled nursing facilities, and hospice for seniors and disabled homeless** through HSH, rather than SFDPH, assigning a housing case

manager to each shelter and navigation center with seniors to work with the HSH bureaucracy, advocating for sheltered older adult and disabled clients.

(I) Create a cadre of universal case managers who can work across departments and integrate the efforts of social services, medical and mental health care managers, and the housing case managers. They would act as authorized representatives and coordinate the team of other case/care managers, should be skilled in person-centered client advocacy, and be held accountable for results.

(J) Have **training sessions to instruct shelter/navigation center clients** about what universal case managers are expected to do and to whom they can complain if they are not getting adequate services. There is a need for community meetings within the shelter/center to allow clients to raise issues of concern. There should also be written documents for shelter clients explaining their rights and available services.

(K) **Develop AA, NA, and hoarder programs** within the shelter/navigation center with peer counsellors. Encourage on-site visits from Mental Health personnel.

(L) Develop a **three-meals a day program** that is nutritious and tasty and can accommodate special dietary needs (diabetic, low salt etc.) with a nearby congregate meal site.

(M) **Allow IHSS workers into the facilities** to provide care for ADLs and IADLs, to arrange transportation, to accompany clients to medical appointments, and to ensure medication compliance and follow-up on doctors' recommendations. **Provide IHSS workers with a higher level of compensation** because of these more difficult work conditions.

(N) **Provide exclusive van transportation** to SF General Hospital, Tom Waddell Clinics, and to other nearby medical and mental health clinics, similar to what is found at Southeast Health Center Clinic and Potrero Hill Health Center.

FUNDING

Potential Funding can come from Proposition C money, the Dignity Fund, DAS, SFDPH (MediCal and Whole Person Care), HSH, the General Fund, private donors through organizations including Tipping Point's Chronic Homeless Initiative as well as the Master Plan on Aging, CalAIM money and the Mental Health Services Act. Currently, there are state proposals regarding funding homelessness programs before the legislature. FEMA still remains a potential source of funding. Within the law establishing FEMA, no definition of an emergency was established. It was left to the executive branch to do so. Technically, President Biden could declare homelessness in the U.S. an emergency. There are still approximately a half a million homeless individuals living in one of the richest nations on earth. Combining the direction of these resources under the control of a single agency or individual will facilitate integration of services as well as eliminate duplication and waste.