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Short Report

Examining the health status of homeless adults entering permanent supportive housing

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ABSTRACT

Background Permanent supportive housing (PSH) has been recognized as an effective intervention and the national policy for addressing chronic homelessness in the United States. Due to an aging cohort of homeless adults and prioritizing those who are most vulnerable for housing, the health status of those entering PSH is likely worse than those previously reported in the literature.

Methods This report examined the self-reported health and health conditions of a sample of 421 homeless adults entering PSH between 2014 and 2016. The average age of our sample was 54 years old.

Results Overall, 90% reported two or more chronic conditions (either physical or mental), 68% reported at least two chronic physical health conditions and 56% indicated at least two chronic mental health conditions. Describing their health status, 57% reported fair, poor or very poor health.

Conclusions These findings suggest that access to housing will not easily remedy the well-documented premature mortality among chronically homeless adults.

Keywords aging, health disparities, homelessness, premature mortality, vulnerability indexing

Introduction

Permanent supportive housing (PSH) has been recognized as an effective intervention and the national policy for addressing chronic homelessness in the United States, contributing to a 21% reduction in chronic homelessness between 2010 and 2015.[1] Adults entering PSH are likely to have a high disease burden,[2] because homelessness is associated with a high incidence of acute and chronic health problems and premature mortality.[3,4] These health disparities are likely exacerbated by age. Approximately half of all chronically homeless individuals in the United States are aged 50 or older, compared to 1990 when nearly 90% of the population was younger than 50 years old.[5–7] In addition, because PSH is a relatively scarce resource, there is a growing practice known as vulnerability indexing wherein homeless individuals with higher risk of mortality due to medical conditions receive priority for placement in PSH.[8] Taken together, the health status of those entering PSH is likely worse than previously reported in the literature.

In this brief report we examine the self-reported health and health conditions of a sample of 421 homeless adults entering PSH between 2014 and 2016 and consider how the health status of this sample differs from population norms and previously published reports on homeless adults. This study was conducted in Los Angeles County, which has been described as the homeless capital of the United States and where vulnerability indexing has been standard practice

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since 2014. The study was part of a larger project funded by the National Institute on Drug Abuse to examine the health risk behavior and social networks of individuals as they transition from homelessness to PSH.[9]

Methods

Interviews were conducted with 421 homeless participants either prior to or within 5 days of moving into PSH. The average time between baseline interview and move-in was 23.1 days (SD = 28.3; range: −5 to 171; median: 14). Respondents entered PSH administered or coordinated by 26 collaborating housing and social services agencies from August 2014 to January 2016. Clients were referred to the study by agency staff members or approached by study staff members during leasing events. People were eligible for participation if they were at least 39 years old, currently homeless, spoke English or Spanish, moving into PSH within 20 mile of downtown Los Angeles, and had no minor children. The minimum age of 39 (thereby turning 40 during the course of the study) was chosen to reduce variability owing to differing developmental stages within the life course.

Participants in this study represent 66.9% of individuals aged 39 or older who were entered into the Los Angeles County Homeless Management Information System (HMIS) in the same zip codes and PSH types (without dependent children) during the same time period based on data provided by the Los Angeles Homeless Services Authority (LAHSA). In fact, the mean age of people placed in PSH during the same time as our study was 47.7 (SD = 13.0) years old with 74.3% of those placed being over the age of 39. While age, race and ethnicity were similar across HMIS and study data, our sample was 27.8% female, whereas HMIS had a higher proportion (33.4%) of women.[10]

Structured interviews were conducted by trained study interviewers who asked about self-reported health;[11] health conditions were assessed with an item adapted from the National Health Interview Survey.[12]

Results

As shown in Table 1, participants had an average age of 54, most identified as male (72%), and a majority identified as black (56%), followed by white (24%) and Latino or Hispanic (9%). Most had completed high school (77%), nearly one-third were military veterans (30%), and the average monthly income was nearly $600. Participants' most common place of stay during the prior 3 months was emergency shelters (42%), followed by transitional living facilities (21%) and outside (17%). More than three quarters had experienced literal homelessness during the 3 months prior to their interview (77%), and the mean lifetime duration of literal homelessness was 6 years (SD = 6.9).

Table 1 Demographic characteristics and health status, homeless adults entering permanent supportive housing (*N* = 421)

	% (n) or M *(SD)*
Age	54.4 (7.5)
Gender	
Male	71.5 (301)
Female	27.8 (117)
Transwoman or transfemale	0.7 (3)
Race and ethnicity	
Black	56.0 (235)
White	23.8 (100)
Latino or Hispanic	8.8 (37)
Multiracial	4.8 (20)
Other	6.7 (28)
Completed high school	77.0 (324)
Monthly income	596.1 (473.7)
Military veteran	30.4 (128)
Most common place of stay (prior 3 months)	
Shelter	41.8 (176)
Transitional living	20.9 (88)
Outside	17.1 (72)
Vehicle	7.1 (30)
Other location	13.1 (55)
Years of literal homelessness (lifetime)	6.0 (6.9)
Any literal homelessness (prior 3 months)	76.7 (323)
Chronic mental health condition	
Schizophrenia	27.8 (117)
Bipolar	30.6 (129)
Post-traumatic stress disorder	28.7 (121)
Anxiety	45.8 (193)
Depression	53.7 (226)
Chronic physical health condition	
Hypertension	51.8 (218)
Heart failure	7.8 (33)
Diabetes	24.0 (101)
Respiratory disease (e.g. COPD, asthma)	29.0 (122)
Cancer	11.2 (47)
Other	71.5 (301)
Two or more chronic physical health conditions	68.2 (287)
Two or more chronic mental health conditions	56.3 (237)
Two or more chronic conditions (physical or mental)	89.6 (377)
Fair or poor self-rated health	57.4 (241)

COPD, chronic obstructive pulmonary disease.

The most commonly reported chronic mental health condition was depression (54%), followed by anxiety (46%), bipolar disorder (31%), post-traumatic stress disorder (29%) and schizophrenia (28%). More than half of participants (52%) reported being diagnosed with hypertension, 29% with a chronic respiratory disease, 24% with diabetes, 11% with cancer and 8% with heart failure; 72% reported some other chronic physical health condition, such as arthritis, anemia, hepatitis C or HIV/AIDS. Overall, 90% reported two or more chronic conditions (either physical or mental), 68% reported at least two chronic physical health conditions, and 56% indicated at least two chronic mental health conditions. Describing their health status, 57% reported fair, poor or very poor health.

Discussion

Main findings of this study

The self-reported health and health conditions of our sample of homeless adults aged 39 and older who were moving into PSH appear worse than previously suggested by the literature on homelessness. For example, compared to the current sample, Weinstein *et al.*[2] in one of the few studies to report on chronic health conditions of PSH residents reported lower rates of diabetes (12.9 versus 24.0%, respectively), hypertension (40.9 versus 51.8%), and fair or poor self-rated health (46.6 versus 56.3%), although the authors used independent medical verification of health status and the average age in the sample was slightly younger (49, range: 20–75 years versus 54, range: 39–82 years). Our sample was more comparable to what Brown *et al.*[5] found in an older (aged 50 or older) population-based sample of homeless adults, which had similar rates of respiratory disease (29 versus 26.3%, respectively), heart failure (7.8 versus 7.1%), and fair or poor self-rated health (56.3 versus 55.7%). These high rates of chronic health conditions are not surprising given that access to PSH was prioritized based on vulnerability indexing of an aging cohort of chronically homeless adults, but they suggest that access to housing will not easily remedy the well-documented premature mortality among chronically homeless adults.[8]

What is already known on this topic

A high disease burden and health disparities among adults who have experienced homelessness has been well documented[1–9] and was found to be the case in this study. As compared to our sample, Los Angeles County residents within the same age range (39–82 years) had lower rates of diabetes (15.3 versus 24.0%, respectively), heart failure (2.0 versus 7.8%) hypertension (36.5 versus 51.8%), respiratory disease (9.7 versus 29.0%), and fair or poor self-rated health (29.3 versus 57.4%).[13]

Limitations of this study

This brief report relies on self-reported health status of study participants that was not verified through medical records or exam, and restricting our sample to those aged 39 and older may skew our characterization of adults entering PSH. The study also focuses solely on a US city and it is not clear whether people who experience homelessness in other cities or countries have the same age distribution or health disparities. In addition, vulnerability indexing has only been reported on in the literature in the United States.[14]

What this study adds

The results of this study underscore the need to provide health care coordination and comprehensive health services as part of PSH. The results also suggest that the physical characteristics of the PSH units could be considered as they may need to be modified to accommodate the health-related limitations of PSH residents as they age.[15] PSH programs would also likely benefit from an increased focus on chronic disease self-management in addition to housing retention services, yet there are no agreed-upon standards of care for PSH programs. Any effort to establish such standards should consider the role of PSH staff members in addressing end-of-life care in addition to ongoing medical concerns.[8]

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