CALIFORNIA COMMISSION on Aging

Supporting Older Adult Homelessness in California

Report | August 2024

Background

Older Adult Homelessness

The California Statewide Study of People Experiencing Homelessness by UCSF found that in the past decades, the proportion of adults experiencing homelessness who are 50 and older has risen faster than other groups.[1] The median age of homeless adults in California is currently 47. The study predicts that the proportion of people age 65 and older experiencing homelessness in the United States will triple between 2017 and 2030.

Mental Health & Homelessness

Among older adults who have experienced homelessness, a large proportion have experienced mental health struggles in their lives. Eighty-one percent suffered from at least one severe mental health symptom in their lifetime, particularly depression and anxiety symptoms. Twenty-two percent have experienced hallucinations at some point in their lives. Twenty-three percent have been diagnosed with PTSD and 28% have attempted suicide at some point in their lifetime.

Across the board, mental health symptoms were more common in those who experienced early onset homelessness (i.e. experienced their first episode of homelessness before the age of 50).

Cognitive Impairment

Cognitive deficits are both a risk factor for and perpetuator of homelessness.

Studies on older homeless adults have found that 25-35% of individuals meet the criteria for cognitive impairment[2] (compared to 4-7% of the general homeless population[3]) and declined in memory/reasoning abilities, inhibitory control, and verbal memory. An estimated 30-40% of older homeless adults report ADL or IADL (instrumental activities of daily living) limitations[2]. A study on 25 older homeless adults in Oakland, California reported similar outcomes as almost half of the individuals met requirements for mild to major neurocognitive disorders.[4]

The causes of cognitive impairment are hard to identify and can be related to many overlapping conditions, including substance use disorders or different developmental and neurological conditions[5]. Many cognitive deficits are associated with the increased risk of severe head injury (24%) experienced by the homeless.[5]

In many cases, specific cognitive impairments are difficult to identify as cognitive impairment may be a symptom of many overlapping mental health and substance abuse disorders, such as AIDS-related dementia, prolonged depression, medication side effects, post concussive-disorder, or self-medication with psychoactive substances.[5]

The evidence shows that cognitive impairments are a risk factor for homelessness as they are predictive of poorer socio-occupational outcomes (e.g. psychosocial skill acquisition and social problem solving), which impact the ability to live independently and maintain housing.

Impact of Homelessness on Health

Overall, older adults experiencing homelessness suffer from significant detriments and display health equivalent to the health of those in the general population who are 20 years older:[1]

Mental health conditions are exacerbated by the chronic stress, violence, and poor sleep associated with homelessness. Sixty-three percent of older adults experiencing homelessness reported at least one mental health symptom in the last 30 days, particularly depression and anxiety symptoms. Thirty-six percent reported difficulty remembering, concentrating, or understanding, and 13% reported hallucinations. Adults who experienced early onset homelessness were more

[1] https://homelessness.ucsf.edu/sites/default/files/2024-05/Older%20Adult%20Homelessness%20Report%2005.2024.pdf
[2] https://www.va.gov/HOMELESS/nchav/docs/Schinka_EarlyCognitiveDeclineAndDementiaInHomelessVeterans_January2019_508.pdf
[3] https://doi.org/10.1177/070674370905400210
[4] https://doi.org/10.3389/fneur.2022.905779
[5] https://nhchc.org/wp-content/uploads/2019/08/hh-0303.pdf

likely to report these symptoms compared to those who experienced late onset homelessness.

Among those with mental health symptoms, only 26% reported receiving mental health counseling or medication in the last 30 days.

Sixty-one percent of older adults experienced any kind of discrimination at least once a week. Among those who experienced discrimination, 25% cited their mental health status or cognitive disability as a reason for being discriminated against.

Cognitive impairments and homelessness perpetuate each other as individuals often have difficulty complying with regular treatment programs and directions[5]. Cognitive deficits can lead to irregular social behaviors that are interpreted as noncompliant by treatment staff, resulting in many patients being banned from providers. Many adults then develop additional cognitive deficits during episodes of homelessness.[6] This leads to a dual premature-accelerated pathway of cognitive aging in homeless adults.[6]

Dementias

In the general population, minor cognitive decline in the 60s or mid-50s is not unusual. In healthy adults, however, these changes should not lead to ADL or IADL limitations. The risk for developing dementia and Alzheimer's disease increases with age: the risk increases from 3% in adults aged 65-74 to 32% in adults age 85 or older.[2] Symptoms of dementia and Alzheimer's disease include cognitive impairments that progressively worsen and eventually lead to severe ADL limitations, requiring 24-hour-care.

A study recently conducted in Ontario, Canada has found a dementia rate of 68 per 1,000 in homeless adults compared to 62 per 1,000 low-income adults and 51 per 1,000 adults in the general population.[7] Prevalence ratios between homeless adults and the comparison groups were highest within the age ranges of 55-64 and 65-74. This implies that the risk for onset of dementia is significantly earlier in the homeless population and aligns with the evidence that older homeless adults report health levels similar to those 20 years older in the general population.

Proposition 1

Proposition 1 changes the way money is invested into behavioral health services. The original Mental Health Services Act (MHSA), approved in 2004, imposed a 1% tax on individuals earning more than $1 million per year. Ninety-five percent of MHSA revenue was allocated to counties for local mental health programs while the remaining 5% were used by the state. Counties were required to invest 76% of their funds in Community Services and Supports (CSS—including Full-Service Partnerships (FSPs) and housing services), 19% in Prevention and Early Intervention, and 5% in Innovation.

The recently passed Proposition 1 and Behavioral Health Services Act (BHSA) focus on increasing funding for housing services. Only 90% of BHSA (formerly called MHSA) funds will now be allocated to county services. Of that amount, counties must invest 35% in FSPs, 30% in Housing, and 35% in Behavioral Services and Supports. Of the money spent on housing, 50% must be spent on programs for those suffering from chronic homelessness, and up to 25% may be spent on capital development. All programs are targeted towards those suffering from mental illness, serious emotional disturbance, or substance abuse disorder.

Current Programs

Full-Service Partnerships (FSPs)

FSPs provide full high-intensity outpatient mental health treatment for clients with mental illness.[8] FSPs utilize a "whatever it takes" approach, with lower client to caseworker ratios than other CSS programs. Other CSS programs generally provide low to moderate intensity outpatient mental health services for those with mental illness. FSPs aim to decrease avoidable emergency room utilization, psychiatric hospitalization, jail/incarceration, and eviction/homelessness.[8]

Barring some variations, most FSPs provide a comprehensive collection of mental health services,

[6] 10.1192/bjo.2020.3
[7] https://doi.org/10.1016/S2468-2667(24)00022-7
[8] https://dhs.saccounty.gov/BHS/Documents/Reports--Workplans/MHSA-Reports-and-Workplans/RT-2022-23-MHSA-Annual-Update--Sacramento-County.pdf

including assessments, planning, social rehabilitation, intensive case management, co-occurring substance abuse services, and psychiatric medication support. Some FSPs offer 24/7 board, care, and crisis response services. FSPs are designed to be culturally competent, recovery-oriented, client-driven, and trauma-informed.[8]

Permanent Supportive Housing Programs (PSH)

Permanent Supportive Housing (PSH) programs are used by many counties to specialize in providing supportive, subsidized housing linked to other intensive behavioral health services.[9] Currently, PSH programs are generally a blend of FSPs and other CSS components.[8] Eligibility is typically restricted to individuals suffering from severe, persistent, or significant mental illness who are at risk of homelessness. PSH programs have demonstrated efficacy at treating long-term patients with complex behavioral needs.

Enriched Residential Care Programs

Similar to PSH programs, some counties also offer Enriched Residential Care (ERC)[10] programs (also known as Augmented Board & Care[11]) for adults suffering from severe mental illness. These programs generally provide additional therapeutic and support services in adult residential facilities (ARFs) or residential care facilities for the elderly (RCFEs).[10] These facilities are non-medical, 24-hour-staffed residences that provide room and board, medication oversight, supervision, and ADL assistance[10]. ERC facilities typically offer increased support compared to other residential facilities, but do not offer the same level of permanence and medical, intensive case management as PSH programs.[11]

Augmented Residential Care Facilities (SB 1082)

SB 1082 aims to add a licensure process for Augmented Residential Care Facilities (ARCFs).[12] ARCFs shall be similar to ARFs and RCFEs, but provide additional staffing, supervision and services beyond what a typical ARF or RCFE may offer. ARCFs shall be held to a more consistent standard and create tailored individual supports plans for clients to help those with complex behavioral needs.

[9] https://doi.org/10.1111/1475-6773.13553
[10] https://file.lacounty.gov/SDSInter/dmh/1159007_MHSAAnnualUpdateFY23-24Adopted4-9-24.pdf
[11] https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/bhs/documents/NOC/MHSA/COSD%20MHSA%20FY%2022-23%20Annual%20Update%20Final.pdf
[12] https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB1082

Recommendations

With the increase in funding allocated to housing programs and FSPs by the Behavioral Health Services Act, there may also be an opportunity for FSP and PSH programs to expand their eligibility to better serve older adults—the older homeless population already experiences a disproportionate amount of mental health symptoms and will make up an even larger portion of homeless adults in the next decades.

Expanding FSP & PSH Programs

According to the California Statewide Study of People Experiencing Homelessness by UCSF, 23% of older adults stated that their mental health or substance use was a barrier in obtaining housing.[1] Navigating complex applications or administrative requirements proved to be challenging while managing mental health symptoms.

For many cases, primary care and a return to housing would provide adequate mental health support.[1] Others experience complex behavioral and functional needs. Evidence shows these clients would be a better fit for PSH programs as they integrate intensive case management.[1] Adults with complex behavioral needs include people with functional impairments in addition to at least one of the following: recent hallucinations, a recent psychiatric hospitalization, regular illicit drug use, or heavy episodic alcohol use. The researchers estimate that 22% of older adults fit these criteria. Forty-three percent of older adults experience one of the four behavioral needs alone.[1]

Given that cognitive impairments are highly prevalent in older homeless individuals,[2,4,5,6] who may also possess a higher and earlier risk of developing dementia,[2,7] FSP and PSH programs could be expanded to more easily include and treat older adults suffering from less severe mental illnesses but are displaying signs of cognitive impairments and are at risk of homelessness. This would slow down the accelerated cognitive aging that older homeless adults experience, reducing further despair and possible dementia. The intensive case management offered by FSP and PSH programs may also help to monitor dementia symptoms—initial signs are most noticeable by a person's social networks, which may be lacking in adults suffering from homelessness.[2] ERC could also be expanded for clients with cognitive impairments who might require less intensive case management. An addition of the ARCF class could also streamline a standard of care for those experiencing complex behavioral needs.

The California Statewide Study of Older Adults Experiencing Homelessness by UCSF also recommends increasing funding for social services and on-site assistance in PSH programs to support older adults with complex behavioral and functional needs.[1] This is important as many older adults leave homelessness through PSH programs. Barriers to receiving in-home support services such as Medicaid Home and Community Based Services and assisted living waivers should also be reduced. Healthcare systems need increased availability for behavioral health care providers. Shelter access should also accommodate those with various functional, mobility, and cognitive needs.[1]

Potential Impact

Studies estimate that 25-35% of adults above the age of 50 suffering from homelessness experience cognitive impairments in memory, concentration, orientation, or visuospatial functioning.[2] While there are no studies specifically estimating the proportion of older homeless adults suffering from both cognitive impairments and mild or severe mental illness, a study conducted in Toronto, Canada found that around 75% of homeless adults (of any age) with mental illness show evidence of neurocognitive impairment[13] and a study by UCSF found that 63% of older homeless adults reported mental health symptoms.[1] This means that around 47% of older homeless adults could be experiencing both cognitive impairment and mental illness and may benefit from increased PSH or ERC eligibility.

[13] https://doi.org/10.1111/acps.12391