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Research Article

An Aging in Place Approach to Barriers and Facilitators of Shelter Utilization by Older Adults Experiencing Homelessness in Upstate South Carolina

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Abstract

The concept of aging in place discusses policies, strategies and methodologies that meet the complex needs of older people in their living environment. For marginalized individuals, however, what defines place is more complex and subject to conflicting influences. This research investigates the determinants of emergency shelter utilization by older people experiencing homelessness using an aging in place framework. Qualitative interviews were conducted with a group of 53 sheltered and unsheltered homeless persons aged 55 and older in Upstate South Carolina, United States of America. Collected data were examined using a thematic content analysis. Recurring themes were categorized into barriers and facilitators. Multigenerational living, regulations, lack of privacy, security concerns and a lack of elderly-friendly accommodations were identified as barriers. Conversely, shelters that established trust, protection, and relationships, complemented with an array of social and medical services, facilitated shelter utilization. These factors were classified into two interacting domains: homeless individuals' psychosocial needs and the shelters' institutional characteristics. An aging in place approach integrates individuals' experiences, social interactions, community-based services, mobility, and the built environment. This study offers a new framework for designing and modifying emergency shelters to increase uptake by elderly clients in a perspective of healthy aging for all.

Keywords: Healthy aging, Aging in place, Homelessness, Housing insecurity, Aged homelessness, Shelter utilization

Introduction

The global increase in life expectancy accelerates the need for new public policies to improve the quality of life of older people, their families, and the communities in which they reside [1]. The World Health Organization (WHO) and United Nations (UN) member states embraced the decade 2021-2030 as the Decade of Healthy Aging. In the United States, current demographic projections suggest that by 2034, the population of adults over 65 will outnumber children under 18 [2]. The policy implications of this unprecedented aging of society are profound and span various fields of research. The field of environmental gerontology discusses the need to develop and adjust living spaces that support individuals as they age. This concept is termed aging in place, and it seeks to identify intersecting socioecological influences that increase vulnerability of older people and to develop new strategies to address them [3].

An important component of healthy aging is equity [4]. Healthy aging and aging in place for all should therefore include older adults living on the margins of society. Often invisible to urban policymaking, social welfare programs, and aging research, aged homelessness poses a growing problem for social inclusion in modern

societies. Available data suggest that one-third to one-half of the total American homeless population is now 65 and over, and this population is expected to double in number by 2050 [5]. According to Hahn and co-authors, the median age of individuals facing housing insecurity increases by 0.66 year every calendar year, and the average total time spent on homelessness more than tripled over the last two decades [6]. It is also well-established that chronic homelessness causes an earlier onset of cognitive and physical declines. Housing insecurity, both in terms of availability and adaptability, therefore, represents an obstacle to healthy aging [7]. Emergency shelters for the homeless play a central role in ending housing insecurity as a temporary stopgap to meet the immediate needs of individuals as they seek stable and supported housing [8]. Since their clients are aging faster than the general population, it has become imperative to analyze the suitability of this emergency housing for older people's needs. In this paper, we investigate the barriers and facilitators of shelter utilization by older adults in Upstate South Carolina where homelessness has increased over the past decade [9]. We use an aging in place framework to identify factors that influence the elderly to adopt emergency shelters as part of their rehousing process. We argue that although shelters are transient places in exit strategies, they still should meet the specific needs of all clients.

Methods

This research addresses the following questions:

i. What factors influence homeless shelter utilization by the elderly facing housing insecurity; and

ii. To what extent should an aging in place perspective be applied to the current shelter system to meet the needs of aged homeless? A qualitative description methodology was used to address these questions.

Conceptual Framework and Study Hypothesis

Bigonnesse and *Chadhury* defined aging in place "as an ongoing dynamic process of balance enabling an individual to develop and maintain place integration, place attachment, independence, mobility, and social participation." [10]. A living space needs to meet these conditions if elderly users are to thrive. *Gelber and Andersen's, et al.* [11] Modified Behavioral Model for Vulnerable Populations distinguishes the different levels that influence social service utilization in that group. The model identifies vulnerable domains that predispose individuals to use social services and enabling factors consisting of the services offered [11]. Finally, *Penchansky and Thomas* [12] posit that social service utilization is determined by accessibility which includes availability, geographic accessibility, affordability, accommodation, and acceptability of the service offered [12]. Based on these models, we hypothesized that adult homeless individuals evaluate the shelter system to determine if the living conditions meet the needs and expectations of advancing age. This hypothesis was used as the study framework and guided our research (Figure 1).

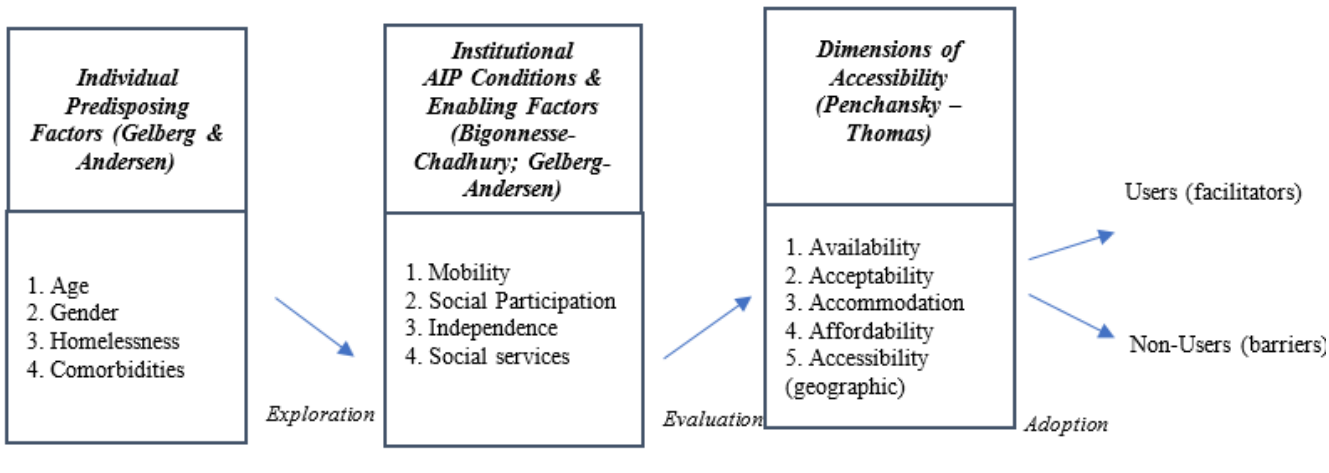

Figure 1: Conceptual Model of Shelter Utilization in Elderly Homeless.

Study Instruments and Data Collection

A semi-structured qualitative interview questionnaire was developed using the study model Figure 1. Information included demographics, duration of homelessness, specific needs of aging, and perceptions and experiences with the shelter system. Open-ended questions allowed participants to share their opinions. Interviews were conducted by trained research assistants unaffiliated with shelters or other service providers and lasted approximately 25minutes. Principal investigators who analyzed the data were blinded to the identity of the participants to maintain confidentiality and reduce subjective coding of data.

Participants

Participants were recruited in the Fall of 2021 from various shelters in Upstate South Carolina Table 1. Unsheltered participants were recruited from a community center that offered daytime ser-

vices for the homeless. Recruitment was by convenience sample when participants agreed to take part in the study and provided informed consent. They were compensated for time with a restaurant gift card. This allowed the team to capture the opinions of both users and non-users. Inclusion criteria were based on age, residence, and health status (participants could not be in a physical or mental status that impeded thought and coherence). The research team reached the saturation point at 22 unsheltered and 30 sheltered, for a total of 52 participants (Table 1).

Table 1: Demographic distribution of study participants by housing status.

Sheltered			Number of Participants	Percent of Total
	Female	African American	5	9.60%
		Caucasian	3	5.80%
		Asian American	0	0.00%
	Male	African American	7	13.50%
		Caucasian	15	28.80%
		Asian American	0	0.00%
Unsheltered	Female	African American	0	0.00%
		Caucasian	4	7.70%
		Asian American	0	0.00%
	Male	African American	12	23.10%
		Caucasian	5	9.60%
		Asian American	1	1.90%
Total Participants			52	

Ethical Considerations

The York University Guideline for Conducting Research with People who are Homeless [13] was adopted for added protection for this vulnerable group. Interview questions were designed to be minimally intrusive, and provision was made for social and psychological support if interviews created a need for counseling. Strict privacy protocols were agreed upon with shelter management, and interviews were blinded for site and name. Each participant signed a consent form. The research proposal was approved by Bob Jones University ERB.

Qualitative Data Analysis

A qualitative descriptive methodology was used with a content analysis approach. Two primary coders (AH and BK) conducted an independent preliminary review on the same five randomly selected transcripts to develop an initial codebook. Using consensus building methods, the coders then met to discuss themes and develop the final codebook. Coded data were organized into barriers and facilitators. Ha and co-authors used a similar analysis method in their study regarding shelter utilization in young adults [14]. Additionally, the research team followed an iterative process, continually identifying categories and explanations to ensure consistency. Regular meetings and an audit trail were maintained to enhance transparency and credibility [15].

Results

Older adults experiencing homelessness candidly discussed reasons for choosing whether to live in a shelter and offered solutions to perceived challenges. Recurring units of meaning were categorized and organized as barriers or facilitators of shelter use.

Barriers

Multigenerational Living: The housing of both the elderly and younger homeless in the same shelter was perceived by sheltered as well as unsheltered participants as a barrier to shelter use. This perception was consistent across the different shelters included in the study. The age-related differences in lifestyle and their preference for a quieter and more socially interactive environment appeared to be the origin of this conflict. Participant 025, a sheltered 64-year-old African American (AA) male, expressed this concern: "*Younger people are lazy and don't do chores*." Participant 016, a sheltered 67-year-old White American (WA) male, added: "*The young take advantage of us and disrespect us*." Participant 007, a sheltered 56-year-old AA female, stated: "*Elderly specific shelters are a must. Younger people often push as aside and run us over*." A similar remark was made by Participant 023, a sheltered 71-year-old AA male: "*Have shelters for just elderly men and women separately*." Those who stopped short of recommending age-segregated shelters advocated for age-based intake procedures. "*Let the elderly*

and the disabled get in an hour early," suggested Participant 016, a sheltered 67-year-old WA male who had lived unsheltered or in hotels for the previous 15 months.

Rules and Regulations: Several participants viewed the rules and regulations in the shelters as a violation of individual autonomy. Age and unwillingness to change appeared to be the factors underpinning their rejection of shelter rules and regulations. This was suggested by the recurring expression "*too old to…*". Participant 037, an unsheltered 61-year-old WA female, reported not using the shelters so that she could "*Do what I want to do, go run late, meet people. I am too old to be told what to do*." For another participant, the rules and regulations were equated to a loss of self-determination. He stated, "*They take over your personal life*." (Participant 047, an unsheltered 73-year-old AA male).

Safety and Security: Safety and security concerns were another recurring theme identified in the participants' narratives. These concerns revolved around theft and violence at the hands of younger roommates. Participant 004, a sheltered 61-year-old AA male, recalled being robbed by a younger occupant, and a similar remark was made by Participant 034, an unsheltered 55-year-old WA female: "*They steal things when you are asleep*." Several interviewees suggested that more personnel be provided in the shelters to protect the most vulnerable and assist with security. Participant 011, a sheltered 57-year-old WA male, stated, "*They are understaffed; they need more security. There are people who are mentally ill, drinking, and taking drugs*."

Privacy: Both sheltered and unsheltered participants expressed a desire for more privacy. Their answers revolved around two different approaches to privacy. First, it was related to the living arrangements and the need for personal space. The typical expression under this subcategory was "*too crowded!*" and occurred more often in interviews with the unsheltered. Shelters offer large, shared spaces, and the participants expressed concerns about living in such a communal dormitory environment. "*There's a lot of people in one room,*" remarked Participant 032, an unsheltered 67-year-old AA male. Participant 036, an unsheltered 64-year-old AA male, expressed a desire for "*one or two roommates instead of all-in-one room*." Participant 034, an unsheltered 55-year-old WA female, adamantly stated that she was willing to stay in shelters only if she would be allowed to stay in a room by herself or with a maximum of three people. The fear of disease transmission in a crowded environment was raised by several in the study group. "*It's too crowded. I am afraid to get Covid 19*," worried Participant 051, an unsheltered 62-year-old WA male, who had recently spent 105 days in the hospital.

The second subtheme of privacy was in relation to personal information. Some participants found the intake process intrusive. Participant 041, an unsheltered 64-year-old AA male who had been homeless for 18 months, summarized his opinion: "*They ask too many questions and want to know everything in your life*."

Shelter Availability and Adaptation of Accommodations: Interviewees unambiguously discussed shelter availability and accessibility for their age group. Participant 003, a sheltered 61-year-old WA female, observed, "*There are not enough shelters, especially for women*." Participant 001, a 56-year-old WA female, agreed, "*Shelters are hard to access, and it's hard to be informed about them*." Additionally, since shelters operated on a first-come, first-served basis, older homeless perceived a disadvantage in access. Participant 031, a sheltered 55-year-old WA male, explained his experience. "*There was a long waiting list to get in. I had to sleep outside in the cold*."

A commonly discussed barrier highlighted the need for housing accommodations that were handicap accessible. Participant 051, quoted previously, stated, "*We need more handicap accessible showers, and we need more handicap ramps*." One participant anecdotally reported "*seeing stairs everywhere*". When available, elevators were not always functional, according to some participants. "*The elevator is out a lot, and I can't do stairs*," stated Participant 021, a sheltered 68-year-old WA male. "*It would be easier if the elevators were fixed. We [the aged homeless] all depend too much on other people,*" reported Participant 012, a sheltered 60-year-old WA male.

In addition to the built environment, clients perceived a lack of accommodation of sleeping conditions. A large consensus of participants criticized the bunkbeds, especially when the occupant had a health issue. A typical example was illustrated by Participant 010, with diagnoses of cirrhosis and cancer of the liver. "*I have to go on the top bunk. The young guys get to the bottom, and I get dizzy from my white blood cell count. I get really dizzy getting out of the top bunk, and I wake up scared*." Participant 032, an unsheltered 67-year-old AA male, summarized the difficulties. "*No handicap bathroom, and the bed is on the floor which is hard for the elderly and handicapped*."

Facilitators

Protection: In contrast to many unsheltered respondents, sheltered participants in the study often viewed rules and regulations as beneficial. They provided structure and offered a stable foundation and protection for rebuilding their lives. Participant 030, a sheltered 58-year-old WA male, stated, "*They are good rules. They help you become a better person*." Participant 008, a sheltered 55-year-old AA female, agreed, "*The rules and regulations are not that hard to abide by. The rules give us stability to get back out and stand on our own*." She even deplored what in her view was a lack of enforcement of the existing rules, especially when it came to applying them to the younger occupants, fueling the multigenerational divide reported above. The rules and regulations allowed the shelters to offer a more predictable environment. "*The rules are about security*." (Participant 054, a sheltered 58-year-old WA female, homeless for 6 years). Participant 005, a sheltered 69-year-old AA woman stated, "*I am thankful for the rules; they [shelters administrators] are picky about outside guests to protect women who have suffered trauma*."

Trust and Relationship: A group of participants expressed gratitude for protection against the perceived vulnerabilities of

age and gender. They described shelters as a safer place to stay in comparison to the streets. "*I am too old to be living in the woods!*" stated Participant 037, an unsheltered 61-year-old WA female. Several mentioned a feeling of trust vis-à-vis the shelter's workers. This was expressed by Participant 041, a housed 64-year-old AA male who had struggled with homeless for 18 months previously, described the relief of "*finding people you can trust to help you*." Protection from inclement weather was also discussed. Most valued the fact that there was an alternative to the streets in cold weather, especially for those suffering from conditions such as arthritis.

Provision of Additional Services: Participants, regardless of their sheltering status, valued the provision of additional social services and support offered in shelters. A series of these services recurred frequently in the responses. Medical care was viewed as of prime importance. Participant 010, quoted earlier, declared, "*I have to see my doctor because of my cirrhosis of the liver and cancer. They [health services] come on a bus every two weeks and help*." Participant 022, a sheltered 66-year-old WA male with 15 years of experience in homelessness, agreed, "*They look out for you. A hospital comes to the shelter all the time*."

Access to work and job opportunities through the shelter system was another expectation. A female respondent (Participant 005, mentioned earlier) summarized the situation in these terms: "*It is easy for us to have opportunities to work. We can participate in chores or get a job*." The interviewees also viewed transport and mobility opportunities as being essential. Most of them, however, expressed a need for these opportunities more often and more systematically as part of a shelter package. "*My car broke down. I need transportation for work. It is too high a cost to use the van. I have to walk to get to work or use a bus,*" shared Participant 029, a sheltered 61-year-old WA male.

Not only were the social services perceived as important, the spiritual and moral support services were also valued. Participant 009, a sheltered 54-year-old WA female, mentioned, "*They have caring and sweet staff. It's Christian-based and helps my mind and spirit as well as my well-being*." Religious experiences such as singing, devotions and Bible studies were a vital part of the shelter offerings for many. Participant 023, a sheltered 71-year-old AA male with 5 years of experience in homelessness, remarked about these religious activities, "*It's uplifting; it gives people hope*."

Discussion

Factors influencing shelter utilization by the elderly homeless in this study could effectively be categorized into two main domains: the individual domain and the institutional domain, as predicted by the study framework. This distinction between individual-level and facility-level facilitators and barriers is consistent with findings from previous work. Ha and co-authors identified two main domains which they termed attitudinal and access [14]. *De Rosa, et al.* [16], *Garrett, et al.* [17], and *Pergamitt and Ernst* [18] also found that an individual's attitude toward shelters was a key determinant of usage [16-18]. However, these studies focused on the demographic needs of younger people experiencing homelessness. The heavy physical and emotional toll of aging while homeless adds complexity to the needs of the elderly [19,20]. Thus, it may be more accurate to describe the individual domain as psychosocial factors rather than attitudinal. *Rothwell, et al.* [21] took a similar approach to aged homelessness [21]. In their study of men new to homelessness in later life, the authors analyzed the influences of psychosocial factors on usage of shelters. They concluded that psychosocial variables such as mobility problems or pending legal issues were critical determinants of shelter use in this age group.

Another study on psychosocial factors suggested that the homeless generally used shelters by necessity rather than by choice [22]. Older clients evaluated the tradeoff of self-esteem, dignity, and autonomy in their decision regarding shelter utilization. Similarly, it appeared in our study that the older adults were not inclined to trade their dignity for a place to stay but rather aspired to a place to stay that upheld their dignity. Hence, willingness to use shelters in this age group depended on the shelter's ability to contribute to and preserve human dignity. Factors reinforcing independence, autonomy, respect, and self-determination in aged individuals functioned as facilitators, and those impeding these needs were instead perceived as barriers.

Interestingly, the other themes identified in the individual domain revolved around the same concepts of respect and autonomy due to age. Multigenerational living posed problems to the study group because of perceptions that younger homeless clients did not respect the elderly and had an unfair advantage in competition for shelter resources.

A point of intersection between barriers and facilitators in this study was participants' perceptions of rules and regulations in shelters. They were seen as an instrument to reinforce the security of the shelters by some. For others, they represented an encroachment on human dignity and autonomy. Previous work suggests that controlling management practices can create conflict which must be resolved in order to facilitate housing [8]. Facilitating the entry of the highest number of aged homeless may require minimally intrusive intake procedures with an equity approach based on specific needs. This dichotomy suggests a need for a mix of low barrier and high barrier shelters may best meet the needs of the diverse homeless population.

The second domain was related to the institutional characteristics of the shelters. This domain can be defined as the ability of the emergency housing institution to meet the principal needs of their aged clients. Two themes became apparent: the built environment with its panoply of housing conditions and the package of additional services to which the clients have access. *Penchansky and Thompson's* [12] dimensions of accessibility were relevant as clients discussed the availability, adaptability and acceptability of both infrastructure and services [12]. Participants desired an elderly-friendly built environment with handicap accessibility, and the lack of these adaptations was a barrier. We previously demonstrated that the homeless age prematurely and are plagued by fall

risks, mobility concerns, and lack of safety at younger ages than the general population Merino's work suggested that aging in place requires modification of housing to maintain independence, mobility, and safety for aged individuals [23].

Additionally, the range of services offered by shelters was vital in addressing both physical and psychosocial needs as well as providing opportunities for social participation. Aged individuals living on the margin still wanted to be part of society, and social services at shelters facilitated that goal. *Carter, et al.* identified social participation as a very important cornerstone for successful aging in place [24]. While this is true for the general population, it is just as critical for the homeless. In their work published over a decade ago, *Walsh and Kuzman, et al.* [25] highlighted that the dimensions of safety and security, mobility, and social participation were important aspects of shelters, especially for women with complex vulnerabilities of gender, ethnicity and age [25].

In summary, given the vital role that shelters play in enabling individuals to exit homelessness, policies and practices in shelter design must consider the needs of the rapidly aging population. The barriers and facilitators identified in this study should inform the structure and services offered by these important institutions. Consideration should be given to developing places that are adapted to the needs of the elderly through equity-focused intake procedures, handicap-accessible design, and strategic partnerships with social service providers [26].

Conclusion

Shelter utilization by the aged homeless is an increasing concern given the changing demographics in the US. Efforts to facilitate exit from homelessness require a proactive analysis of the current transient housing system. An aging in place perspective offers a general framework for designing spaces in which the elderly can thrive. Our study suggests that aging individuals living on the margin could be better served if such a model were applied to emergency shelters. Addressing the psychosocial needs of the most vulnerable and modifying the environment to include care, mobility, and interaction with the larger society may increase uptake. An aging in place approach can help to stem the increasing homelessness in Upstate, SC. As the new field of environmental gerontology develops, the elderly living on the margin should be included in the larger discussion.

Biographical Note

Amy M Hicks, PhD, MPH is the chair of the division of health sciences at Bob Jones University and the assistant director of the Center for Community and Global Health. She earned her PhD in biochemistry from Wake Forest School of Medicine where she also completed two postdoctoral positions. She went on to cofound an educational networking association to facilitate collaboration among biomedical research industries in North Carolina. She then earned a Master of Public Health from Liberty University. Her work at Bob Jones University allows her to teach students while working with academic and public health organizations to conduct research on homeless in SC and research on childhood nutrition in West Africa.

Bernard Kadio, MD, MPH, PhD is the director of the Center for Community and Global Health and a faculty member in the division of health sciences. He earned his MD from Cocody University Medical School, Abidjan, Côte d'Ivoire; his MPH from Senghor International University, Alexandria Egypt & Center for Space Medicine, Toulouse, France; and his PhD in population health from the University of Ottawa, Canada. He directed the Bingerville Humanitarian Hospital. As the PI for the University of Ottawa on a grant from the Canadian Institute for Health Research (CIHR) and the Canadian Ministry of Global Affairs, he developed a maternal mortality reduction program in Nigeria in 2016. After 2 years the project demonstrated a significant reduction in maternal deaths. As the director of the BJU CCGH, his vision is to identify promising options to promote the health of marginalized communities, locally and globally.

Jessica Minor, PhD is the dean of the School of Health Professions at BJU. She received her Master's in Bioethics from Trinity International University in Illinois and her PhD in Health Care Ethics at Duquesne University in Pittsburgh, PA. Her dissertation was published through Springer Publishing as a book entitled Informed Consent in Predictive Genetic Testing: A Revised Model. She served as adjunct faculty at UConn Health Center and was affiliate faculty for Health Care Ethics with Regis University in Denver, CO. She completed two clinical ethics internships at UPMC Mercy and UConn Health Center. Susan McLarty Susan is the first Coordinator of the Greenville Homeless Alliance. Susan served on the 2016 Affordable Housing Steering Committee for the City of Greenville, The Greenville Housing Authority Board, United Ministries Executive Board as Chair of Congregational Relations and Greenville Area Interfaith Hospitality Network (GAIHN) Board. She is a graduate of North Carolina State University, of Diversity Leaders Initiative (DLI) with The Riley Institute at Furman University, an elder with Presbyterian Church (USA), and serves as the Secretary of the Well-Being Partnership of Greenville County.

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Conflict Statement

The authors report there are no competing interests to declare.

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