CGNA Canadian Gerontological Nursing Association

PERSPECTIVES

Journal of the Canadian Gerontological Nursing Association

Vol. 46, Number 2

CGNA HEAD OFFICE
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GUIDELINES FOR AUTHORS:

Perspectives, Journal of the Canadian Gerontological Nursing Association (CGNA), formerly the Journal of the Gerontological Nursing Association (Ontario) welcomes original manuscripts describing qualitative or quantitative studies, pilot studies, research protocols, discussion papers, practice or quality improvement projects, literature reviews (e.g., systematic, scoping, rapid), and clinical, educational and administrative innovations of interest to gerontological nursing. Manuscripts from nurses and others in the field of gerontology, and from students in collaboration with their instructors or advisors will be accepted for review.

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The Editorial Team affirms our commitment to ensuring use of an equity, diversity and inclusivity lens in our journal. The mission of Perspectives is to advance the scholarship of gerontological nursing by:

- Promoting the scholarship of gerontological nursing in Canada and internationally;
- Sharing the practice innovations of gerontological nurses;
- Facilitating the dissemination of gerontological nursing knowledge and expertise;
- Encouraging interprofessional collaboration; and
- Promoting scholarly debate on issues across the continuum of care.

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The cover letter must declare any conflict of interest, acknowledge funding and list all the authors, their educational degrees, diplomas and certifications, and their affiliation

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- Authors must use bias-free language
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IN THIS ISSUE:

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WITNESSING YOSHI: HOMELESSNESS, DIGNITY, AND THE ETHICS OF CARE

He was in his late 60s and lived without home. In a brisk morning of winter, wearing layers of oversized jackets and holding two huge plastic bags in both hands, he lined up at a meal service. His darkish wrinkled skin made him look older and weary under the shadow of his dusty hoodie. He always carried a quiet demeanour and preferred to be alone. He roamed around the busy downtown during the day and slept at the silent underground shopping arcade at night.

His name is Yoshi. When I met Yoshi outside a soup kitchen in Japan, he had been homeless for twenty years. His hesitance to share his experiences with me were evident when we first had a conversation in a small meeting room at a local agency. Yet, over a couple of months, Yoshi slowly began to unveil his life and share his experience of being homeless (Kubota, 2017). At the end of that year, I wrote him a Christmas card and sent it to the address of the soup kitchen with a hope to connect with him again. However, Yoshi stopped visiting the soup kitchen and nobody knew where he went and how he was doing.

Knowing Yoshi has changed my life. The conversations with Yoshi gave me a deeper insight into the gap between the interpretation of homelessness in society and how people who are homeless experience being homeless in their life. Once I came to know Yoshi, it transformed my standpoint from an outside and distant place to a more intimate and relational viewpoint of homelessness. I still remember out first conversation. After ten minutes into our first conversation, Yoshi ran away. Looking afraid, he said in a trembling voice, “I am not homeless!”. Holding two big plastic bags, he stumbled to go outside the meeting room and into the outside in the pouring rain. Looking at his curled back, swing side to side with heavy luggage in hands, I ruminated about the implication of what being ‘homeless’ means to Yoshi. This simple word was shaped by the depth of his life. Yoshi was raised in an orphanage after his parents had left him when he was in elementary school. After he divorced his wife, he was apart from his two children and lost his job and home. He kept looking for a job, but without an address and older age, he found it hard to secure a job. Looking at him swinging back and forth in the heavy rain seemed to me like watching a wreaked ship in the storm. I still picture his image in the rain, but with the undertone of his strength and endurance in the midst of his struggles for survival and a feeling of abandonment and isolation.

Despite him running away from our first conversation, Yoshi agreed to meet with me again. In one of our conversations, Yoshi searched for something in his bag. When he found what he was searching for, he stretched his hand out to me; in his hand, there was a slice of bread. I could see that it was the last piece of bread. Yoshi took the bread out of the package and gave it to me. Yoshi once told me that he obtained a decent meal only four times a week, but he insisted that I take this bread. In our last conversation, Yoshi went through the pocket in his jacket. In his dusty hand, he held a bottle of green tea for me. I was struck by his gestures. Over time, Yoshi and I created a space for both of us to be seen, to be heard (Arendt, 1958) and to be transformed through our relationship. Both of us appeared in our relationship and equally contributed to shaping our relationship through kindness, care, and a sense of friendship.

By slowly weaving words together to recount his experiences, Yoshi dared to unfold his life story to me. I wonder how Yoshi is doing now. Where did his life take him next? Holding a returned Christmas card in my hand, I dwell in my thoughts. I wish I could see Yoshi and talk with him again, but this may no longer be a realistic dream. His oversized winter jackets, two loaded plastic bags, his trembling voice, the last piece of bread, his hesitant smile, the bottle of green tea, all remain part of my memory. His life remains vivid, colorful, warm, and full of emotions in my eyes, which inspires me and affects how I understand what it means to be homeless.

WITNESSING YOSHI: HOMELESSNESS, DIGNITY, AND THE ETHICS OF CARE

I wonder how our life would change if stories told by people who are homeless all come alive to us. Yoshi's life and the moments we spent together touched all my senses. He allowed me to walk alongside his life through our conversations through which we have built trust and promoted dignity and compassion for each other. Homelessness is not an issue. It is about people: people with unique life stories, experiences, weakness, kindness, and hopes. It is not about how to resolve the situation. It is about who sees and listens to them. It is about with whom we are willing to build a community, and how we will envision a world where we are a part of each other's lives. Listening to the stories of people who are homeless is not merely an attitude; rather it is a political action to shift the world to keep our society transforming and acknowledging differences based on people's voices, presence, and experiences. Each of us consists of and shapes elements of the world, environment, society, history, culture, and the life of people around us. I wonder if we see the world through a kaleidoscope what image each of us would add to the world. Yoshi added such depth and richness for me; he allowed me to contemplate what it means to be home in ways that are more complex and nuanced. He helped me experience kindness even under great duress. Thank you for this opportunity to be part of the special edition of Perspectives.

Hiroko Kubota, RN, PhD, MN
Alberta Health Services

REFERENCES

Arendt, H. (1958). The Human Condition. Chicago: University of Chicago Press.

Kubota, H. (2017). A narrative inquiry into the experiences of people who are homeless in Japan (Unpublished doctoral dissertation). University of Alberta, Canada.

MISSION AND VISION

A. VISION

The vision of CGNA is to promote excellence in gerontological nursing through leadership, knowledge, and scholarship.

The vision of the *Perspectives Journal* is to be the premier Canadian journal in gerontological nursing.

B. MISSION

The Mission of the Canadian Gerontological Nursing Association (CGNA) is to address the health of older Canadians and the nurses who participate with them in health care. The Canadian Gerontological Nursing Association is an organization that represents gerontological nurses and promotes gerontological nursing practice across national and international boundaries.
The mission of the *Perspectives Journal* is to advance the scholarship of gerontological nursing by:

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- encouraging interprofessional collaboration; and
- promoting scholarly debate on issues of interest to nurses about older adults across the continuum of care.

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Dawn Prentice
Editor, Perspectives

PALLIATIVE CARE WITH PEOPLE EXPERIENCING INEQUITIES: POVERTY AND HOMELESSNESS

Kelli Stajduhar, RN, PhD, Professor, School of Nursing and Institute on Aging & Lifelong Health at the University of Victoria, Victoria, B.C. Email: kis@uvic.ca.

(Foreword an afterword written by Lorna Guse, BN, PhD, Past Editor, *Perspectives*)

FOREWORD

Dr. Kelli Stajduhar is a Canadian researcher, educator and practicing nurse who has worked in oncology, palliative care, and gerontology for more than 30 years. She was the opening Keynote Speaker at the Canadian Gerontological Nursing Association (CGNA) Biennial Meeting and Conference in Winnipeg in May 2025. The substantive theme of the conference was "inclusivity in gerontological nursing practice" and Dr. Stajduhar was asked to speak based on her extensive background as a nurse and a clinical scientist. She has achieved a prestigious Tier 1 Canada Research Chair in Palliative Care, Aging and Community Health and has generated a dynamic world-class network of scholarship and translational research aimed at system-level approaches to how we think about, plan for and deliver palliative care. She works across interdisciplinary academic and governmental healthcare system levels as well as with media experts, non-profit organizations and community advocates to envision, develop, test and integrate better ways of delivering care to people who are dying, to their family caregivers, and to those made vulnerable though structural inequities (poverty and homelessness) and the marginalizing experiences of mental illness and substance use. Dr. Stajduhar agreed to share her thoughts, passion and experiences of her work for *Perspectives* readers through this interview.

1. What inspired you to practice and conduct research on palliative care with people experiencing inequities.

My work in palliative care started in the 1980s during the AIDs epidemic. It was 1986, and I was a new nurse working in Winnipeg. I was working on a ward at the Health Sciences Centre and the head nurse said to me, "We have a patient, and no one wants to look after him". And it was a young patient; I will call him Robert, and he had previously had a kidney transplant, and his body was rejecting the kidney. He was gay and he had AIDS, and that was why the nurses didn't want to provide his care. I had only been a nurse for about three months, and it really struck me that people are not treated the same way. As a young nurse, I had been hired to do a job and *how is it that nurses could refuse to provide care for someone?* Robert was dying. And I got to know Robert and his partner really well.

I grew up in rural Manitoba. If I knew anybody who was gay, I wouldn't have really known because people were still in the closet. Because they weren't free to say that they were gay. Because of the nature of AIDS, there was a lot of fear of AIDS in public perception. So, firstly, my experience as a nurse in Winnipeg really brought me into palliative care, and secondly, it made me start to question how the healthcare system was treating these people and why they were treated differently from other people. Later, I moved from Winnipeg to Victoria, and I cared for another patient; she was a young 27-year-old woman named Sherry. She had come from Toronto and had ended up on the streets of Victoria. When she arrived in Victoria, she was very sick, and she was admitted to an acute care hospital. At this time, I was working as a palliative care nurse clinician, and I was asked to go and see her in the hospital. Sherry was spunky and had all kinds of spicy language. And she said angry things to me...and I heard her, and I thought, *my God, what are we doing to people*? And I realized that there were populations of people who were dying and who, like Sherry, were not getting the care that other people did.

In those days, palliative care was not super well-developed. I started doing a lot of volunteer work in the AIDS community. I was a volunteer clinical nurse specialist, and I did this because everybody with AIDS was dying. And everything that I learned from working in palliative care and from what I learned from doing research in palliative care with people who were living with inequities came from those early years in Winnipeg and Victoria. And you probably had the best example of a community taking care of each other because the healthcare system wasn't there. So, I learned a lot from that work, and I feel that I carry that with me to this day, really.

2. Back in those early days, how were palliative care services set up and provided?

When I was working in palliative care early in my career, the palliative care movement was still in front of us. A few years prior to my work as a palliative care nurse, the first palliative care services opened at St. Boniface Hospital in Winnipeg, and this happened in Montreal, as well.

In palliative care, the core philosophy is that it is *all about the person and their family* - but the family takes many forms. There was work to be done in those early days

when I saw, for example, that partners were there, and I would see these partners being completely pushed aside because they weren't recognized as family members. Gay relationships weren't recognized as legitimate in our society. It was a really difficult situation. And I am talking specifically about men because I was working mainly with men. These men had moved away from their communities to go to other cities where a larger population of people who were gay lived. They left their families and often were estranged from their families because their families didn't accept them. One of the first research studies I did was with people who were dying from AIDS, and I was looking at who provided care for someone who was dying, in the context of family caregiving. And I remember interviewing one of the moms who had come into the west end of Vancouver from another part of Canada, and she couldn't, she wouldn't tell anyone where she was going and that she was leaving to take care of her dying son, because being gay was so stigmatized. People were dying in the shadows without a lot of support from families or the healthcare system. We had some places like BC House Hospice and there were hostels in Toronto and Vancouver. But at that time, there were so many people dying from AIDS, and they were dying without care.

3. How did you begin your work with people experiencing homelessness who needed palliative care?

With people living with homelessness, I see many similarities with my earlier work with those who were living and dying with AIDS because both groups are vulnerable, living with inequities and being judged by this. When I talk about people who are homeless, it is important to say that there are many definitions of homelessness. Many people think it means that these people don't have a house or housing and they're living on the street and that is one group. But homelessness also means living in places that aren't fit for human habitation; it's about staying in temporary or emergency shelters, or couch surfing, or living with friends. People are homeless because they are living with financial insecurity, or other kinds of trauma like separation or divorce, or violence.

When we consider people who are homeless, we are talking about people who live in poverty because of the high cost of living; people who don't have a lot of support. We are talking about people who have severe physical and mental health issues. And poverty, lack of support and illness are all the things that people who are homeless are judged on. People are being judged for being poor, or otherwise not able to care for themselves. We live in a society where we have a stigma associated with homelessness. We also have a situation where a lot of people who are homeless are estranged from their biological families, but that doesn't mean they don't have other sources of support. But these sources of support are not recognized as legitimate in our healthcare system. There are *street families*, and their primary sources of support are each other and the people who work with them such as shelter workers, peer support workers and these workers are not often listened to in the healthcare system. So, we have a similar situation when we look at homelessness to the one that we had during the AIDS epidemic.

For the last 15 years, I have been doing work focusing on palliative care and people who live with inequities, who are homeless. Around 2011, I started a project looking at an outbreak of HIV among a group of people who were using drugs. I worked with a group of street nurses and one of the things we identified was the deep grief that was being felt by inner city people. One of the street nurses I worked with had been poking at me for several years, saying Kelli, we have some issues here and finally she phoned me, and she said, *we have so many deaths, and deaths from opioid poisoning and we need to do something*. She said that we needed to convince the health authority to give us some money to do palliative care in the inner city. And I said I haven't any influence there; *I don't work for the health authority anymore*. But I knew I could do the research, and it was 15 years ago when my work began with people who were homeless, living with inequities and needing palliative care.

4. The National Shelter Study stated that older adults (age 50 +) experiencing homelessness doubled since 2009. Are more people growing old while living homeless, or are more older people becoming homeless for the first time, or both?

The average life expectancy of a person who is homeless in Canada is between 34-49 years of age. I want to put that out there first. And we see younger people, and we see older people sometimes, 60 or 70, even 80 years of age. Yes, we are seeing more older people. Because of inequities, we are seeing more older people who are homeless for the first time, and then there are some older people who have experienced some form of homelessness for their entire lives. I would say there is a rise in first-time homelessness due to long-term housing and financial insecurity. We found in some of our studies that people are outliving their pension incomes and their pensions can no longer manage the cost of living and rent increases. There was one woman's home that I was in a few years ago and there was no food in her fridge and in the cupboard, there was cat food, and she didn't have a cat. She didn't have the necessary income, and she didn't have the wherewithal to get services to help her. So, older people live the life of housing precarity, and we are seeing more of this.

Living rough means that you do not have a good place to sleep or live; you do not have healthy food or all the other things that make a person healthy. There are older people who have co-morbidities and who are living that rough life, and there are older people who are homeless for the first time. I have a lot of concerns around that because if you've lived a life of *living rough*, you know how to do it, you know how to protect yourself, you know where the safe places are, you know how to not get into trouble, and you develop survival skills. But for older people who are homeless for the first time, for example, women living in their cars, older women who are showing up at homeless shelters – they haven't learned these survival instincts. That is not to say it will be bad. But if you are homeless for the first time and you have never developed those survival skills in those environments, it can be scary. The main message is that anyone who is experiencing homelessness is on an accelerated aging pathway.

It is difficult to say at what age a person is considered to be an older person in this group. As I said, anyone who is experiencing homelessness is on an accelerated aging pathway. We tend to say that young people who are homeless are basically young people living inside aging bodies. You can be 35 years old and have the same health concerns as an 85-year-old has because of the way that you have had to live your life for many years. It is dire and it's also inspiring. People who are homeless cannot get access to resources like you or I could. But it is inspiring to see how people develop skills and manage to survive.

Services for people who are homeless are not necessarily well designed for older people. We had a research participant, an older woman who lost her housing. She came to a low-barrier shelter which is typically one where there is a tolerance for active drug use. This woman was uncomfortable in this environment, and it was not the best place for her. Low-barrier shelters are a good fit for those who use them because they are designed for their needs. But being in a low-barrier shelter was not a good fit for this woman, and it would not be a good fit for others who have not experienced homelessness and have not been exposed to drug use.

5. Are there specific health concerns and service needs identified for older adults who are experiencing homelessness?

There are differences between older adults who are homeless for the first time and those who have lived this life for a long time. And the strategic directions and service profile might be different. For older adults who have been living rough for a long time and whose health is declining, we are starting to see a lot of these folks going into long-term care homes (nursing homes, personal care homes) because there is no place else for them to go. Currently, long-term care is neither staffed nor equipped to understand the life that these people have lived. Homecare should be offered to everyone who needs it, but sometimes living conditions mean that homecare services will not be offered. For example, sometimes people are using drugs, or there is hoarding, or a lot of smoking and in those situations, a homecare program will not send staff in because the setting is considered an unsafe place for their workers.

In some cities, homecare nurses will not be referred to homeless shelters, so there is no homecare for older adults living with homelessness. It is an interesting thought that "home" is the first part of "homecare." Many people live in boarding houses and single room occupancy hotels and that's their "home." Some healthcare providers don't want to go into those places. I don't know what you call them in other cities but here we call them "no-go buildings." And maybe ten years ago, something happened in one of these buildings and now healthcare providers will not go back into them to see people. There are people in single room housing who need healthcare and want healthcare, but they are not getting it.

Recently, one of our research participants was placed in a long-term care home; he needed palliative care support. And this facility was a far distance from his friends and support community. He had a partner, his common-law wife. His support community was very poor, couldn't afford transportation to visit him so he was losing his street family support. His wife did manage to visit but both he and his wife use substances. This was not allowed, and long-term care staff were not prepared to manage the situation. The staff did not necessarily understand the nature of substance use and addiction; they couldn't understand why people can't just stop using substances and get clean. The facility banned his wife from visiting. So now, he is in long-term care; he has lost all of his friends, and he has lost his wife. The only way she can visit is if someone takes him outside of the facility property. So, I ask, *what does that say about quality care at the end of someone's life?* Our healthcare system is not designed for people who are dying and face inequities; it does not work well with people who are living different lives from you and me. So, that's why we are focused on some promising practices and policy models for palliative care services.

6. Can you talk more about these practices and policy models?

The focus of our work for the last 15 years is on *how we get palliative care for the people that need it.* And that's why we talk about *meeting people where they are at*, whether it's in a park, in a boarding house or a hotel room, in a shelter and we do it in safe ways; it's not that we are disregarding the need for safety. We are not foolhardy.

Mobile palliative care services are a good example of *meeting people where they are at.* In Montreal, palliative care is integrated into one of the shelters, and we are doing something similar in a pilot project. We have a couple of palliative care beds sited at a shelter so people can stay there rather than go to the hospital. There are a few hospices in Canada, and Ottawa has always been a leader in care of homelessness and palliative care. Ottawa stands out with their palliative care model; it is a peer support model.

Meeting people where they are at isn't just about going physically to where they are. It is about trying to understand the person and where they are in their living situation; it means you get to know the person. People who are homeless lead hard lives, *live rough*, and the healthcare system hasn't treated them well. They are not going to come to us; it's our job to figure out how we can best build trust with them. We should ask ourselves about how we approach people who face inequities just because they are poor and don't have a lot of support. And if we are uncomfortable, we ask for help and we help each other. Working with people who are homeless is not for everyone.

The peer support model is a very valuable model, and it is about building trust. The peer support model has really been embraced in the 'harm reduction" world. We work a lot with peer support workers, and housing and harm reduction workers. Trust is important in this world and trust may not be handled well in the healthcare system. Peer support workers are often a bridge between the person who is homeless and the healthcare system and it will happen when there is trust. And healthcare providers have to trust peer support workers who are not always listened to in the healthcare system, a frustrating experience for them.

The primary support for people who are homeless is not doctors, nurses, or social workers. The primary support is peer support workers, and housing, outreach and harm reduction workers. These workers require us in the healthcare system to think about how we build relationships within the homeless community. The documentary film, "The Challenge: Planning Without Tomorrow" highlights the work of two peer support workers in the palliative care program in Ottawa. I know one of them, Bobby, and he is someone who has his own lived experience and is supported financially now to be a peer support worker.

Not every healthcare system will financially support this model; sometimes the system depends on free labor. The peer support model is a good model as long as it is financially well-supported and supports the peer support workers. A fair bit of their work with people who are homeless comes from peer support workers' own lived experience, but a lot of coaching and mentoring is needed to aid them in their work. I have hired peer support workers as Research Assistants. And I learned something from my earlier work on HIV drug use. I hired someone who had been a drug user but hadn't used substances for about 6 years. He was working in the organization as a peer support worker. We were trying to understand what was happening with drug use practices, where people were getting and using their drugs, their drug supplies. And it was clear that this person was clean for 6 years, but he was still feeling vulnerable. And he was around people who were pulling out drugs and he was feeling quite vulnerable about it. He was giving support to others, but he himself also needed support. So, the peer support model is a good model but it's complicated and it requires financial support and resources for peers to be coached and mentored in support of their work.

7. What do gerontological nurses need to know to be informed, sensitized, and act as advocates and allies?

Gerontological nurses and really, all nurses need to challenge their assumptions about homelessness and educate themselves about the inequities in our society. The gap between the rich and poor in our society is widening and *why is it that some people live with inequities, live in poverty and are treated differently in the healthcare system?* Nurses have a valuable contribution to make to the healthcare system and in society by asking and responding to these critical questions.

It is very important that everyone working in the healthcare system practices trauma-informed culturally sensitive care. We don't need to know a person's history to practice trauma-informed care. We can assume that people who are homeless have likely experienced some form of trauma in their life, so we just need to say that we will respectfully practice with a trauma or violence informed lens and be culturally sensitive. We must actively incorporate this statement into our everyday nursing practice regardless of where we work and who we work with.

There are more homeless people in this country than ever, and they are becoming more visible in the community, and in acute care and long-term care settings. The number of older people living with homelessness has increased and when their health declines, they are sent to hospitals, and the hospitals don't want them. The hospital is not a good place if you need palliative care and if you have been *living rough* for most of your life or are homeless for the first time. So, these older people are placed in long-term care homes, and we are seeing more older people who have been homeless and are very sick and dying in long-term care homes. Gerontological nurses must recognize that these people have *lived rough*, have survived but are not healthy; and they can be fiercely independent.

These people have spicy language; they are not willing to follow the rules, and acute care and long-term care are regimented in their rules. *How will gerontological nurses respond to this situation?* It will take respectful planning.

Twenty years ago, homeless people weren't in long-term care homes. So, let us be aware of where we are now and look to the future. And it is not just about staff or staff training; it is about how to work with and around systems and institutions. We need to start a conversation now, a conversation about harm reduction policy, and then put it into action. If the facility policy is that *there is absolutely no substance use*, then that policy needs to be talked through. People who have addictions are not really going there and then the question is *where else do people go?* We have vulnerable people for whom our systems are not designed. And I think the public is more aware that there are many people who are homeless because they can see them; people who are homeless are becoming more visible.

A proportion of homeless people are Indigenous people and in some provinces like Manitoba, they are a large proportion. My job as a privileged white person is to get out of the way; to be an ally. My role is to work alongside Indigenous workers and organizations in a culturally safe manner because they are the ones who know best how to work within their community. Gerontological nurses in their workplaces can work toward cultural safety, recognizing that healthcare systems will never be safe for Indigenous people because they are colonized systems. We can try to provide culturally safe care; we can consciously put it into practice; and we can work alongside those who know their community. In my research, I work with Dr. Holly Prince, my colleague at Lakehead University.

8. Any final messages for us?

It is easier for me to train workers in palliative care skills than it is for me to train palliative care people to work with people who are homeless. For all our skills in palliative care, we all still have our biases. Unconscious biases. No one wants to do a bad job. No one chooses to go into healthcare work so they can make a lot of money. They do it because they want to help people and if any of us fall short at times, we do the same thing that we do for the people we serve; we don't judge each other, we help each other to do better.

Working with people who are homeless requires that *you walk lightly and step gently; be nimble as you do your work*. There are many challenges for gerontological nurses, and wherever you work, some day you will meet a very sick older person who has lived a life of homelessness or who is homeless for the first time, and they need care in their dying. Practice trauma-informed culturally sensitive care. Listen to that person, their families, and the workers who know about the life of living homeless. Anticipate that the biggest issues in providing care might be coming from the healthcare system. And believe what I believe – there is a way through every issue. Absolutely.

AFTERWORD

According to the National Shelter Study, the percentage of older adults (age 50-64) and seniors (65+) using [homeless] shelters is increasing, and this finding cannot be fully explained by the demographics of aging in the Canadian population. This report can be downloaded:

https://publications.gc.ca/collections/collection_2017/edsc-esdc/Em12-17-2017-eng.pdf

Furthermore, Dr. Stajduhar has explained the association between poverty, homelessness and the vulnerability of people who are experiencing these inequities. Her consultive work with documentary filmmakers is expressed in two films (from Kublacom Pictures) that provide a visual education on homelessness, and palliative care for people experiencing homelessness.

https://www.kublacom.ca/the-challenge---planning-without-tomorrow.html

https://www.kublacom.ca/blue-roses.html

By learning more about aging and the inequities of poverty and homelessness, gerontological nurses can inform and enhance their practice with older adults in acute care settings, long-term care homes and the community.

PALLIATIVE CARE ACCESS AND OLDER ADULTS WITHOUT STABLE HOUSING: A DISCUSSION

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ABSTRACT

Aging is a complex process and older adults experience variations in physical comorbidities, frailty and cognitive changes. When experiencing a life-threatening illness, palliative care is essential. However, providing palliative care requires a setting, making it challenging for older adults without stable housing to access care. Barriers to accessing palliative care exist at structural, systemic, and individual levels. Therefore, flexible palliative care models, harm reduction, increased education and training for the healthcare staff and initiating advanced care planning are necessary to improve palliative care access. In Canada, four major cities - Toronto, Ottawa, Victoria and Calgary have programs based on a flexible palliative care model. However, further research is required to understand the effectiveness of these programs. The federal and provincial health sectors must adequately fund these programs for their structural and operational functionality, thereby improving the palliative care access for older adults living without stable housing.

Introduction

One of the United Nations (2017) sustainable development goals is "ensuring healthy lives and promoting well-being at all ages" (para. 1) by equipping everyone with universal healthcare access and a healthy lifestyle. In 2017, one-third to half of the population worldwide had access to health care, including palliative care (United Nations, 2017). Palliative care is defined as providing care to patients and families facing problems with a life-threatening illness to improve their quality of life; it aims to prevent and relieve pain and suffering through early identification, and treatment of physical, psychosocial, and spiritual aspects (World Health Organization [WHO], 2020). In 2020, COVID-19 drew attention to the importance of palliative and end-of-life care among older adults (Van Den Noortgate & Van den Block, 2022).

Aging is a complex process and older adults experience variations in physical comorbidities, frailty and cognitive changes. When experiencing a life-threatening illness, palliative care is essential (Van Den Noortgate & Van den Block, 2022). Palliative care can be offered in various settings, including hospitals, clinics, physician offices, hospices, and homes (de Veer et al., 2018). Because palliative care requires a setting/place where care can be provided, older adults with unstable housing face a unique challenge in accessing this type of care (Henry et al., 2017). According to the Canadian definition of homelessness, Homeless Hub (n.d.), "Homelessness describes the situation of an individual, family or community without stable, safe, permanent, appropriate housing, or the immediate prospect means and ability to acquire it" (p. 1).

Every night, 35,000 Canadians experience homelessness. Approximately 235,000 people are homeless every year. Of this population, 24.4% are older adults (50 – 64 years) and seniors (65 + years) and an estimated 2,950 are veterans (Gaetz et al., 2016). Understanding the barriers and challenges in accessing palliative care for those with unstable housing is essential to provide effective symptom management and improve their end-of-life quality of life. In this paper, the vulnerabilities in housing and barriers to accessing palliative care will be identified, and available supports in Canada will be explored. As well, the gaps in the existing services will be identified, with recommendations to improve palliative care access for people living with housing vulnerabilities, with a focus on older adults.

Why Are Older Adults Who Experience Homelessness Vulnerable?

The Homelessness Hub is a project of the Canadian Observatory of Homelessness housed at the Faculty of Education at York University. This website collects, collates and presents information on homelessness in Canada and has general information as well as information focused on older adults and their experience of homelessness. Presented on the website are the results of the annual nationally coordinated Point-in-Time (PiT) enumeration of homelessness across Canadian communities. According to the 2020-2022 PiT count, 27% of people experiencing homelessness are 50 years of age or older (and 4% are 65+) and that these percentages have doubled since 2005-2009 (Homelessnesshub.ca, n.d.). The website clearly

states that homelessness among older adults is under researched and it does not have specific information on aging, homelessness and palliative care. However, having a deeper understanding of the vulnerability of older adults who live with unstable housing will assist in advocating for their access to palliative care resources.

The vulnerability of these older adults is based on the social determinants of health, such as poverty owing to low income and the lack of a social support system (Schneider et al., 2021). These determinants of health affect older adults' ability to meet their basic necessities, such as food and shelter, thereby negatively influencing their health and well-being. For example, social housing is subsidized affordable housing, and according to the 2023 Scotia Bank Economic Report (Young, 2023), the available social housing stock is only 3.5% of the total market housing stock, resulting in many years of social housing waitlist. Recent increased housing costs further challenge older adults to afford housing with a fixed income (Boozary et al., 2024). Additionally, most people without stable housing experience multiple chronic health conditions such as cardiovascular and respiratory conditions, liver diseases, and cancer (Hudson et al., 2017; Klop et al., 2018; Slockers et al., 2018). The relationships among unstable housing, substance use, and mental illness are complex. The experience of trauma before and after becoming homeless can be another factor. Without stable housing and access to "stable" supports and healthcare, risks increase for mental illness experiences and communicable diseases such as tuberculosis, HIV and COVID-19 (Henry et al., 2017; Slockers et al., 2018). Such factors reduce their average life expectancy, estimated to be 43 years in males and 53 years in females, which is nearly half of that of the general population; 80 years for men and 84 years for women in Canada (Shoemaker et al., 2020).Consequently, people with unstable housing are considered older adults at the age of 50 years because they begin to experience life-limiting geriatric syndromes such as frailty, falls, and cognitive impairment at a younger age compared to the general population (Alston et al., 2024).

The recent COVID-19 pandemic heightened these vulnerabilities. People living in shared accommodation shelters experienced an increased risk of contracting COVID-19 because of an inability to socially isolate and poor access to hygiene and sanitation (Culhane et al., 2020; Perri et al., 2020). Most people with unstable housing have multiple comorbidities and are at an increased risk of contracting COVID-19 which further worsens their symptom burden. These factors add additional layers of vulnerability to people with life-limiting illnesses (Giesbrecht et al., 2018).

Because of the increased risk factors and vulnerability, early integration of palliative care to the persons with unstable housing is essential to manage their symptoms and improve their quality of life.

Despite their increased care needs, people with unstable housing frequently experience significant barriers in accessing healthcare, and palliative care remains inaccessible to them (de Veer et al., 2018; Purkey et al., 2019). As a result, emergency department use is nine times higher in people with housing vulnerability and they are admitted to hospitals six times more often and have longer hospital stays than the general population (Bowen et al., 2019; Tobey et al., 2017). Exploring and understanding these barriers will help improve palliative care provision for persons experiencing homelessness with life-limiting illnesses and positively affect their quality of life. This may also lead to a more effective way of allocating healthcare resources.

BARRIERS IN PROVIDING PALLIATIVE CARE

Receiving quality palliative care is recognized as a human right (WHO, 2020). The provision of holistic and effective palliative care must be a part of the continuum of care in people with unstable housing who are living with life-limiting illnesses (Hudson, 2017). However, several barriers to palliative care continue to hinder their right to palliative care and dignity. These barriers exist at the structural, systemic, and individual levels.

Structural Barriers

The most fundamental gap is the structural inequality in the health-care system (Henry et al., 2017). Many palliative care models are predominantly home-based because most people prefer to die at home (Armstrong & Devlin, 2022). The palliative care model necessitates a place where care can be provided, making it impossible for people who do not have a house to receive treatment (Giesbrecht et al., 2018; Mackenzie et al., 2019). Although many individuals without stable housing live in shelters, hostels, and the streets, the structures of most shelters and hostels are not designed to offer palliative care (Mackenzie et al., 2018). For example, in many shelters, residents are requested to leave for the day and cannot receive care during the day.

Another structural barrier is the inflexibility of policies, which creates challenges for people with housing vulnerability in accessing end-of-life care (Shulman et al., 2017). For instance, abstinence policies at hospices are required because care providers need to ensure other residents' safety. The relationships among unstable housing, mental illness, substance use, and trauma are complex.

DISCUSSION

Mental illness, substance use, and trauma may precipitate the loss of stable housing, and these continuing health issues may create a barrier for access to hospice care (Purkey et al., 2019; Slockers et al., 2018). Many people with unstable housing may avoid or delay seeking medical attention due to long emergency waiting hours and previous experience of stigma, particularly those individuals with a history of substance use (Mackenzie et al., 2018).

Systemic Barriers

The health care system assumes patients will have family social support networks (primary caregivers) and stable residences (West et al., 2020). For instance, most of the community palliative care programs are designed to provide collaborative care at the patient's residence, supporting the patient and family in improving their quality of life and better symptom management for patients (Canadian Home Care Association, n.d.; Healthcare Excellence Canada, n.d.). Palliative care services can be challenging to obtain when people do not have stable housing and fewer social support resources (Giesbrecht et al., 2018). Furthermore, challenges such as unstable addresses, financial difficulties, limited access to cell phones for appointment notifications, and transportation to healthcare services make it difficult for these individuals to follow up on their healthcare appointments (Mackenzie et al., 2018).

Another barrier is identifying people who would benefit from palliative care because many care providers (for example, shelter workers) are not medically trained professionals (Stajduhar et al., 2019). This results in inappropriate care or a lack of referral for specialist care and support. The next barrier is the requirement of a family physician referral to palliative care and the lack of continuity of care (Mackenzie et al., 2018). People with unstable housing access a high level of emergency services and hospital admissions; many do not have primary care physicians, making it challenging to access specialized care (Bowen et al., 2019; Hirst et al., 2021)

Individual Barriers

According to Stajduhar et al. (2019), individuals with unstable housing tend to avoid seeking medical care for many personal reasons. For many individuals, meeting basic needs such as food and shelter is an everyday challenge. Making medical appointments and refilling medications are secondary needs to them (Stajduhar et al., 2019). Persons living without stable housing may not seek care until their illness is severe, and when fewer options are available to them for treatment and care (Mackenzie et al., 2018).

Many individuals living with unstable housing feel ignored and discriminated against; researchers have documented perceived stigmatization as one of the major barriers to seeking care (Giesbrecht et al., 2018; Mackenzie et al., 2018). Reluctance to access palliative care can stem from past negative experiences, leading to distrust of the medical system and expectations of inadequate and unsatisfactory care (Purkey et al., 2019; West et al., 2020). Fear of not receiving adequate pain management in a system not oriented toward harm reduction in people with substance abuse is a common concern (West et al., 2020). People without homes fear dying alone in acute care, shelters, or on the streets and are often ambivalent about seeking support (Stajduhar et al., 2019). Currently, palliative care remains inaccessible to people with housing vulnerabilities.

How to Improve Access to Palliative Care for Older Adults Experiencing Unstable Housing

People without stable housing are at risk of increased vulnerability and of experiencing various barriers to accessing palliative care. People with housing vulnerability are considered older adults at the age of 50, as they show signs of aging earlier than others. Evidence shows that experiencing housing vulnerability in early life can affect people's health as they get older (Alston et al., p. 224). Therefore, addressing the barriers to access palliative care requires multidisciplinary approaches such as flexible care models, promoting harm reduction, providing more education and training for the staff, and promoting advanced care planning.

Flexible Care Models

Given the realities experienced by the people with unstable housing, revisions of current home-based care models are necessary to reach vulnerable populations *where they are*. For example, palliative care can be delivered through mobile methods by meeting older adults at shelters or on the streets (Hwang et al., 2017). This model would require collaboration between the healthcare system and community organizations, such as shelters and drop-in facilities (Armstrong et al., 2021). Such a partnership will not only address the medical concerns but also strengthen the holistic approach by addressing other determinants of health, such as social support and housing.

McNeil et al. (2012) observed that people with unstable housing tend to develop trust with the community facilities like shelters and drop-in centre staff. A flexible care model would include training staff at these facilities to identify changes in the health of their community clients and to navigate the palliative care program. The navigation role will ensure that community clients can be connected with the palliative care team when needed.

Lastly, flexible policies with minimal admission requirements are required for hospice placements (McNeil et al., 2012). For instance, instead of abstinence from alcohol and substance use, the hospice may implement harm reduction policies and train staff to incorporate trauma-informed de-escalation techniques (McNeil et al., 2012).

Harm Reduction

The relationships among unstable housing, substance use and addiction are complex and facility-based abstinence policies prohibit help-seeking behaviour. These same policies inhibit visits from family and friends who may be supportive but who also may have similar substance use and addictions. Additionally, some substance use may lead to a high tolerance for analgesics so that adequate pain control can be challenging (Hwang et al., 2017). The harm reduction approach can be helpful in overcoming this barrier. Research has shown that harm reduction improves the unhoused individual's end-of-life care (Hwang et al., 2017) by providing sterile syringes, allowing patients to take illicit drugs with the supervision of staff, and/or dispensing alcohol every hour to promote comfort and prevent withdrawal symptoms (Cook et al., 2022; Hwang et al., 2017). The harm reduction approach can assist people with unstable housing in developing trust toward health-care providers, improve their access to palliative care, and improve pain and emotional management.

Education and Training

Developing trust is essential in improving access to palliative care in older adults. Negative attitudes from healthcare providers often stem from a lack of knowledge and experience with addiction among people with unstable housing (Klop et al., 2018). To change these attitudes among healthcare providers, addressing their knowledge gap and providing training on the unique needs of these individuals, symptom burdens, and addiction are necessary (Hwang et al., 2017). Greater awareness of illnesses, healthcare disparities and issues experienced by people with unstable housing will change healthcare providers' negative attitudes and promote respect and dignity towards these individuals (Giesbrecht et al., 2018).

Also, palliative care staff should be trained to manage addiction-related behaviours (Cook et al., 2022; Hwang et al., 2017). Conversely, educating and training staff caring at community organizations, such as homelessness shelters and drop-in centres, about palliative care needs is also critical. Supporting staff who work in shelters with adequate training in identifying palliative care needs, harm reduction, and referral to palliative care services will improve their ability to provide care and effective symptom management (Tobey et al., 2017).

Advanced Care Planning

Advanced Care Planning (ACP) is the process of understanding a person's life goals, values, and preferences and making sure that their medical care aligns with their goals and preferences (Sudore et al., 2017). Research has shown increased interest in completing ACP among the people with unstable housing, but it rarely gets completed (Kaplan-Weisman et al., 2019). ACP has been proven to improve vulnerable people's autonomy and dignity and promotes their feelings of empowerment (Hwang et al., 2017). Vulnerable people may experience inadequate family or social support; initiating ACP earlier, when individuals can make decisions and know their goals and preferences, can be invaluable in providing quality end-of-life care (Kaplan-Weisman et al., 2019).

AVAILABLE SUPPORT IN CANADA

The Worldwide Hospice Palliative Care Alliance's (2021) theme for 2021 was "Leave no one behind – equity in access to palliative care." In support of this theme, the Canadian government initiated the Canadian Palliative Care Framework. One of the guiding principles of the framework is "equitable access to palliative care" regardless of the social determinants of health (Health Canada, 2018, p. 23). In Canada, four major programs are currently available in Toronto, Ottawa, Victoria, and Calgary to improve palliative care accessibility for the unhoused population. These innovative programs are specifically designed to address the unique needs of the people with unstable housing.

Palliative Education and Care for the Homeless (PEACH)

The Palliative Education and Care for the Homeless (PEACH) program is a Toronto-based palliative program launched in 2014 by the Inner-City Health Associates (Inner City Health Associates [ICHA], n.d.). The Inner-City Health Associates has more than 60 healthcare providers, including palliative care physicians, nurses, health navigators, and care coordinators, and it works under a publicly funded home care system (Aleman, 2017). Schneider et al. (2021) conducted a retrospective study on the PEACH program from 2014 to 2017, concluding that PEACH plays a critical role in providing palliative care to those experiencing unstable housing. The main aim of PEACH is to provide outreach palliative care wherever people with a life-limiting illness live, such as homeless shelters, drop-in centres, and even on the streets (Aleman, 2017; ICHA, n.d.). The program provides care and aims to build a partnership with homeless community agencies to support end-of-life care.

The Diane Morrison Hospice

The Diane Morrison Hospice is an Ottawa-based 24-hour palliative care program available for people with unstable housing who are terminally ill. It was launched in 2001 as a partnership between Ottawa Mission and Ottawa Inner City (Ottawa Mission, 2021). The facility has a six-bed capacity for people at the end of life requiring 24-hour nursing care, and it also offers nine beds for chronic palliative care patients at various stages of illness (Aleman, 2017). The staff members are well trained to provide high-quality palliative care. Individuals also have access to religious caregivers, Indigenous spiritual support, and family and friends interested in their care (Ottawa Mission, 2021). The program's unique feature is the harm reduction approach, with patients allowed to use substances if they are not harmful to others in the facility (Aleman, 2017; Ottawa Mission, 2021).

Palliative Outreach Resource Team (PORT)

Palliative Outreach Resource Team (PORT) assists with palliative care access to vulnerable people such as those with unstable housing, those facing a lack of social support, and those living in poverty with life-limiting illnesses in Victoria. Palliative Outreach Resource Team is a collaborative program managed by the University of Victoria, Island Health, Victoria Hospice Society, and Victoria Cool Aid Society (Stajduhar et al., 2019). The main goal of PORT is to meet the people with unstable housing at their location in the community and ensure they receive timely palliative care support without needing to visit a health care facility (Equity in Palliative Approaches to Care, n.d.). The team consists of doctors, nurses, and social workers who collaborate to provide holistic care tailored to individual needs.

Calgary Allied Mobile Palliative Program (CAMPP)

CAMPP is a non-profit program established in 2016. The main goal of this program is to assist people living with unstable housing and life-limiting illnesses by addressing gaps in accessing palliative care, and helping them access adequate and appropriate palliative care support (Government of Alberta, 2021). The CAMPP team reaches individuals at their location, such as drop-in facilities, rehab centres, alpha houses, and even on the streets, providing palliative care and connecting patients with appropriate community resources and healthcare systems (Aleman, 2017). CAMPP provides individualized care based on each individual's needs, including connecting with a primary care provider, assisting with transportation to appointments, providing medication education, linking with community services, and supporting documentation (Healthcare Excellence Canada, 2024).

GAPS AND RECOMMENDATIONS

The Canada Palliative Care Framework (Health Canada, 2018) aims to provide equitable palliative care access with short, medium, and long-term goals. These goals mainly focus on identifying barriers to accessing palliative care, implementing strategies to facilitate consistent access to palliative care, and adopting a multidisciplinary approach to achieve these goals (Health Canada, 2018). Similarly, Alberta Health Services' (AHS) palliative framework's guiding principle is "equitable and accessible" (AHS, 2014, p. 9). Although these frameworks aim to improve palliative care access for the overall population, they do not specifically focus on enhancing access to palliative care for people with unstable housing. Researchers have documented that mainstream palliative care programs are not addressing the unique care needs of those living with unstable housing (Giesbrecht et al., 2018; Schneider et al., 2021).

Flexible palliative care models are mostly concentrated in larger urban areas, with limited reach in smaller communities and rural areas in Canada. There has been limited research conducted to evaluate these models. For example, only one retrospective study has been conducted on the PEACH program (Schneider et al., 2021), and one pilot project was conducted in 2006 at Diane Morrison Hospice (Podymow et al., 2006). Similarly, a mixed-methods study was conducted to evaluate the effectiveness of the CAMPP over a four-year period, involving 128 clients. The participants' age group ranged between 22 years and 86 years, with an average age of 58.9 years. This study reports that 97% of participants agreed that palliative care is an essential service and expressed a high level of client satisfaction (Petruik & Colgan, 2022). Although this study included a wide age range of participants, the perspectives of older adults, who are the predominant recipients of palliative care, were not reported separately. Older adults often experience unique health challenges such as multiple chronic conditions, polypharmacy, functional decline, reliance on caregivers, and complex end-of-life decision-making. Further research evaluating these programs' effectiveness and operational challenges is essential to make changes at the structural and systemic level barriers and offer a rationale for implementing similar programs throughout Canada. In a pilot project conducted at Diane Morrison, 28 terminally ill patients aged 32 to 74 years received 24-hour shelter-based palliative care for approximately 120 days; the savings in healthcare costs was estimated to be $1.39 million (Podymow et al., 2006). However, programs such as PORT lack financial support to sustain their activities, and physicians, nurses, and counsellors from the team have been reassigned to other positions (Stajduhar et al., 2019).

DISCUSSION

The federal and provincial health sectors must adequately fund these programs. Policymakers should collaborate with these programs and community organizations to improve access to palliative care by people living with unstable housing.

CONCLUSION

Palliative care is a human right, but it is not easily accessible for people with unstable housing. Despite their increased vulnerability, mortality, and morbidity, these people still experience some barriers at the structural, systemic, and individual levels. To overcome these barriers and improve accessibility, flexible care models, harm reduction policies, and staff education and training are required. In Canada, some palliative programs are available for people with housing vulnerability. Further research on these programs' efficiency and operational challenges is required for changes at the structural and systemic level and for attaining equitable palliative care for those who live with unstable housing.

CONFLICT OF INTEREST

The author has no conflict of interest to declare.

REFERENCE

Alberta Health Services. (2014). *Palliative and end of life care: Alberta provincial framework 2014*. https://www.albertahealthservices.ca/assets/info/seniors/if-sen-provincial-palliative-end-of-life-care-framework.pdf

Aleman, A. (2017). *What are the palliative care services available to the homeless population in Canada?* https://homelesshub.ca/blog/what-are-palliative-care-services-available-homeless-population-canada.

Alston, J., Baral, S., Orkin, A., & Straus, S. (2024). Tackling late-life homelessness in Canada. *Canadian Medical Association Journal, 196*(19). https://doi.org/10.1503/cmaj.231493

Armstrong, C. D., & Devlin, R. A. (2022). Dying at home: A privilege for those with time and money. *Canadian Public Policy, 48*(S2), 81–98. https://doi.org/10.3138/cpp.2022-033

Armstrong, M., Shulman, C., Hudson, B., Brophy, N., Daley, J., Hewett, N., & Stone, P. (2021). The benefits and challenges of embedding specialist palliative care teams within homeless hostels to enhance support and learning: Perspectives from Palliative Care Teams and hostel staff. *Palliative Medicine, 35*(6), 1202–1214. https://doi.org/10.1177/02692163211006318

Boozary, A., Varner, C., & Laupacis, A. (2024). Homelessness is a health crisis: Why hospitals are resorting to building housing. *Canadian Medical Association Journal, 196*(19). https://doi.org/10.1503/cmaj.240649

Bowen, M., Marwick, S., Marshall, T., Saunders, K., Burwood, S., Yahyouche, A., Stewart, D., & Paudyal, V. (2019). Multimorbidity and emergency department visits by a homeless population: A database study in Specialist General Practice. *British Journal of General Practice, 69*(685). https://doi.org/10.3399/bjgp19x704609

Canadian Home Care Association. (n.d.). *Community-based palliative care.* https://cdnhomecare.ca/community-based-palliative-care/

Cook, O., Doran, J., Crosbie, K., Sweeney, P., Millard, I., & O'Connor, M. (2022). Palliative care needs and models of care for people who use drugs and/or alcohol: A mixed methods systematic review. *Palliative Medicine, 36*(2), 292–304. https://doi.org/10.1177/02692163211061994

Culhane, D., Doran, K., Schretzman, M., Johns, E., Treglia, D., Byrne, T., Metraux, S., & Kuhn, R. (2020). The emerging crisis of aged homelessness in the US: Could cost avoidance in Health Care Fund Housing Solutions? *International Journal of Population Data Science, 4*(3). https://doi.org/10.23889/ijpds.v4i3.1185

de Veer, A. J., Stringer, B., van Meijel, B., Verkaik, R., & Francke, A. L. (2018). Access to palliative care for homeless people: Complex lives, complex care. *BMC Palliative Care, 17*(1). https://doi.org/10.1186/s12904-018-0368-3

Equity in Palliative Approaches to Care. (n.d.). *Palliative outreach resource team (PORT)*. https://www.equityinpalliativecare.com/port

Gaetz, S., Dej, E., Richter, T., & Redman, M. (2016). *The state of homelessness in Canada 2016*. Canadian Observatory on Homelessness Press. Retrieved March 24, 2022, from https://www.homelesshub.ca/sites/default/files/attachments/SOHC16_final_20Oct2016.pdf

Giesbrecht, M., Stajduhar, K. I., Mollison, A., Pauly, B., Reimer-Kirkham, S., McNeil, R., Wallace, B., Dosani, N., & Rose, C. (2018). Hospitals, clinics, and palliative care units: Place-based experiences of formal healthcare settings by people experiencing structural vulnerability at the end-of-life. *Health & Place, 53*, 43–51. https://doi.org/10.1016/j.healthplace.2018.06.005

Government of Alberta. (2021). *Advancing Palliative and End-of-Life Care in Alberta: Palliative and End-of-Life Care Engagement Final Report.* Alberta Health. https://open.alberta.ca/dataset/130eb68f-c7b5-4ab1-8a4a-ce6181c34610/resource/69c4fd85-8206-4d63-b43f-94d447c55c31/download/health-advancing-palliative-end-of-life-care-in-alberta.pdf

Health Canada. (2018). *Framework on palliative care in Canada*. Canada.ca. https://publications.gc.ca/collections/collection_2018/sc-hc/H22-4-16-2018-eng.pdf

Healthcare Excellence Canada. (n.d.). *Embedding palliative approaches to care (EPAC)*. https://www.healthcareexcellence.ca/en/what-we-do/all-programs/embedding-palliative-approaches-to-care-epac/

Healthcare Excellence Canada. (2024). *Promising Practice: Community Allied Mobile Palliative Partnership (CAMPP)*. https://www.healthcareexcellence.ca. http://campp.ca/

Henry, B., Dosani, N., Huynh, L., & Amirault, N. (2017). Palliative care as a public health issue: Understanding disparities in access to palliative care for the homeless population living in Toronto, based on a policy analysis. *Current Oncology, 24*(3), 187–191. https://doi.org/10.3747/co.24.3129

Hirst, V., & Cuthill, F. (2021). Benefits of GP care in outreach settings for people experiencing homelessness: A qualitative study. *British Journal of General Practice, 71*(709). https://doi.org/10.3399/bjgp.2020.0749

Homelesshub.ca. (n.d.). *Who is homeless?* Retrieved March 23, 2022, from https://www.homelesshub.ca/about-homelessness/homelessness-101/who-homeless

Hudson, B. F., Shulman, C., Low, J., Hewett, N., Daley, J., Davis, S., Brophy, N., Howard, D., Vivat, B., Kennedy, P., & Stone, P. (2017). Challenges to discussing palliative care with people experiencing homelessness: A qualitative study. *BMJ Open, 7*(11). https://doi.org/10.1136/bmjopen-2017-017502

Hwang, S., Dowbor, T., Devotta , K., & Pedersen, C. (2017). *Palliative Care Services for people experiencing Homelessness in Toronto: A preliminary needs Assessment.* portailpalliatif.ca/. https://www.portailpalliatif.ca/Assets/TC%20LHIN%20REPORT%20Pall%20Care%20Services%20for%20Homeless%20Needs%20Assess%20May%202017_20180430143153.pdf

Inner City Health Associates (n.d.) *PEACH-Palliative Education and Care for the Homeless*.icha-toronto.ca. https://www.icha-toronto.ca/programs/peach-palliative-education-and-care-for-the-homeless

Kaplan-Weisman, L., Tam, J., & Crump, C. (2019). Utilization of advance care planning for homeless adults: Case studies. *Journal of Urban Health, 96*(5), 726–733. https://doi.org/10.1007/s11524-019-00369-x

Klop, H. T., de Veer, A. J. E., van Dongen, S. I., Francke, A. L., Rietjens, J. A. C., & Onwuteaka-Philipsen, B. D. (2018). Palliative care for homeless people: A systematic review of the concerns, care needs and preferences, and the barriers and facilitators for providing palliative care. *BMC Palliative Care, 17*(1). https://doi.org/10.1186/s12904-018-0320-6

MacKenzie, M., & Purkey, E. (2019). Barriers to end-of-life services for persons experiencing homelessness as perceived by health and social service providers. *The Journal of the American Board of Family Medicine, 32*(6), 847–857. https://doi.org/10.3122/jabfm.2019.06.190066

McNeil, R., Guirguis-Younger, M., & Dilley, L. B. (2012). Recommendations for improving the end-of-life care system for homeless populations: A qualitative study of the views of Canadian health and social services professionals. *BMC Palliative Care, 11*(1). https://doi.org/10.1186/1472-684x-11-14

Ottawa Mission (2021). *Diane Morrison Hospice: Compassion. Dignity. Community: The Ottawa Mission Hospice at 20*. https://ottawamission.com/wp-content/uploads/2022/02/hospice-report_20-years.pdf.

Petruik, C., & Colgan, S. (2022). Extending palliative approaches to care beyond the mainstream health care system: An evaluation of a small mobile palliative care team in Calgary, Alberta, Canada. *Palliative Medicine Reports, 3*(1), 87–95. https://doi.org/10.1089/pmr.2021.0059

Perri, M., Dosani, N., & Hwang, S. W. (2020). Covid-19 and people experiencing homelessness: Challenges and mitigation strategies. *Canadian Medical Association Journal, 192*(26). https://doi.org/10.1503/cmaj.200834

Podymow, T., Turnbull, J., & Coyle, D. (2006). Shelter-based palliative care for the homeless terminally ill. *Palliative Medicine, 20*(2), 81–86. https://doi.org/10.1191/0269216306pm1103oa

Purkey, E., & MacKenzie, M. (2019). Experiences of palliative health care for homeless and vulnerably housed individuals. *The Journal of the American Board of Family Medicine, 32*(6), 858–867. https://doi.org/10.3122/jabfm.2019.06.190093

Schneider, E., & Dosani, N. (2021). Retrospective study of a Toronto-based palliative care program for individuals experiencing homelessness. *Journal of Palliative Medicine, 24*(8), 1232–1235. https://doi.org/10.1089/jpm.2020.0772

Shoemaker, E. S., Kendall, C. E., Mathew, C., Crispo, S., Welch, V., Andermann, A., Mott, S., Lalonde, C., Bloch, G., Mayhew, A., Aubry, T., Tugwell, P., Stergiopoulos, V., & Pottie, K. (2020). Establishing need and population priorities to improve the health of homeless and vulnerably housed women, youth, and men: A Delphi consensus study. *PLOS ONE, 15*(4). https://doi.org/10.1371/journal.pone.0231758

Shulman, C., Hudson, B. F., Low, J., Hewett, N., Daley, J., Kennedy, P., Davis, S., Brophy, N., Howard, D., Vivat, B., & Stone, P. (2017). End-of-life care for homeless people: A qualitative analysis exploring the challenges to access and provision of palliative care. *Palliative Medicine, 32*(1), 36–45. https://doi.org/10.1177/0269216317717101

Slockers, M. T., Nusselder, W. J., Rietjens, J., & van Beeck, E. F. (2018). Unnatural death: A major but largely preventable cause-of-death among homeless people? *European Journal of Public Health, 28*(2), 248–252. https://doi.org/10.1093/eurpub/cky002

Stajduhar, K. I., Mollison, A., Giesbrecht, M., McNeil, R., Pauly, B., Reimer-Kirkham, S., Dosani, N., Wallace, B., Showler, G., Meagher, C., Kvakic, K., Gleave, D., Teal, T., Rose, C., Showler, C., & Rounds, K. (2019). "Just too busy living in the moment and surviving": Barriers to accessing health care for structurally vulnerable populations at end-of-life. *BMC Palliative Care, 18*(1). https://doi.org/10.1186/s12904-019-0396

Stajduhar, K.I. (2019). *Too Little, too late: How We fail Vulnerable Canadians as they die and what to do about it*. University of Victoria https://www.uvic.ca/research/groups/palliative/assets/docs/publications/report-too-little-too-late.pdf

Tobey, M., Manasson, J., Decarlo, K., Ciraldo-Maryniuk, K., Gaeta, J. M., & Wilson, E. (2017). Homeless individuals approaching the end of life: Symptoms and attitudes. *Journal of Pain and Symptom Management, 53*(4), 738–744. https://doi.org/10.1016/j.jpainsymman.2016.10.364

United Nations. (2017). *Take action for the sustainable development goals - united nations sustainable development*. United Nations. Retrieved March 23, 2022, from https://www.un.org/sustainabledevelopment/sustainable-development-goals

Van Den Noortgate, N. J., & Van den Block, L. (2022). End-of-life care for older people: The way forward. *Age and Ageing, 51*(7). https://doi.org/10.1093/ageing/afac078

West, K. J., Wrobel, B., Pallotta, S., & Coatsworth, A. (2018). Bearing witness: Exploring the end-of-life needs of homeless persons and barriers to appropriate care. *OMEGA - Journal of Death and Dying, 82*(1), 63–91. https://doi.org/10.1177/0030222818801150

World Health Organization. (2018). *Palliative care*. Retrieved from https://www.who.int/westernpacific/health-topics/palliative-care

Worldwide Hospice Palliative Care Alliance. (2021). *A report for World Hospice Palliative Care Day 2021*. https://wfrtds.org/. https://wfrtds.org/wp-content/uploads/2021/10/WHPCD_2021_Equity_Report.pdf

Young, R. (2023). *Canadian Housing Affordability Hurts - Scotiabank global site*. Scotiabank. com/economics. https://www.scotiabank.com/content/dam/scotiabank/sub-brands/scotiabank-economics/english/documents/insights-views/insightsandviews_2023-01-18.pdf

CHALLENGES FACED BY OLDER ADULTS EXPERIENCING HOMELESSNESS CONTRIBUTING TO FROSTBITE IN CANADA

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ABSTRACT

Background: Older adults experiencing homelessness in Canada face severe health risks stemming from unsafe living conditions, limited access to healthcare, and extreme weather exposure. Frostbite is a common and serious health concern, leading to amputations and serious health complications.

Aim: The aim of this narrative review is to identify the challenges encountered by older adults experiencing homelessness in Canada, which increases their risk of frostbite. It will also explore the role of the gerontological nurse in planning and implementing strategies to reduce the risk of frostbite.

Methods: A comprehensive literature search was conducted in three databases, focusing on older adults experiencing homelessness and the risk of frostbite. The data were analyzed and categorized into two key themes that identified the main challenges experienced by this population.

Results: Two key themes emerged: Structural Barriers to Managing Frostbite and Barriers to Health and Well-being.

Conclusion: The heightened vulnerability of older adults experiencing homelessness to frostbite is deeply intertwined with social determinants of health, stigma, and marginalization, all of which exacerbate health inequities. Through raising public awareness, navigating resources, and compassionate care, gerontological nurses can significantly reduce frostbite-related complications in older adults experiencing homelessness in Canada.

Major Findings:

- As Canada's aging population grows, the risk of homelessness among older adults rises, leading to increased disparities and challenges.
- The rising rate of older adults experiencing homelessness increases their vulnerability to frostbite and the potential risk of amputation during the winter months in Canada.
- Nurses play a vital role in prevention and advocacy, working to mitigate barriers to healthcare access, providing education, and developing essential resources.
- By collaborating with a multidisciplinary team, nurses can create change, enhance care for older adults, and reduce the risk of frostbite and amputation.

INTRODUCTION

Homelessness among older adults in Canada is a growing but often overlooked crisis. Each year, an estimated 150,000 to 300,000 individuals experience homelessness, with older adults comprising a significant portion of this population (Government of Canada, 2023). In 2021, 18.5% of shelter users were aged 50–64, while 3.3% were older adults over the age of 60 years. Alarmingly, 40.6% of older adults in Canada face some form of homelessness crisis each year (Government of Canada, 2021).

Older adults experiencing homelessness face disproportionately high rates of acute and chronic health conditions, including a heightened prevalence of mental health concerns (Herring, 2023; Waldbrook, 2013). They commonly suffer from chronic conditions such as diabetes, cognitive decline, cardiovascular diseases, and skin-related illnesses, all of which heighten their vulnerability to frostbite and other complications (Om et al., 2022). This can be exacerbated by compounded health risks associated with inadequate living conditions, malnutrition, poor hygiene, and limited access to healthcare services (Grenier et al., 2016; Waldbrook, 2015; Weldrick et al., 2023). Canadian older adults experiencing homelessness are particularly susceptible to preventable yet serious conditions, such as frostbite, which can result in severe physical harm and significantly reduce their quality of life (Canham et al., 2021; Government of Canada, 2021).

Frostbite, a severe and potentially life-threatening condition, disproportionately affects Canadian older adults

experiencing homelessness due to prolonged exposure to harsh environmental conditions and limited access to basic hygiene and healthcare services (Government of Canada, 2021; Klammer et al., 2023; Paradis-Gagne et al., 2020). Older adults experiencing homelessness are particularly vulnerable to extreme weather, which increases the risk of skin breakdown and frostbite (Rathjen et al., 2019).

Shelters are facilities that offer short-term, temporary housing for individuals and families without stable housing or people in need of transitional support, including older adults, street-involved youth, survivors of domestic violence, and individuals recently released from incarceration (Statistics Canada, 2019). Many shelter strategies in Canada are designed with younger adults in mind, often overlooking the specific needs of older adults (Grenier et al., 2016). This lack of age-appropriate shelter options increases health risks, such as frostbite, among older adults experiencing homelessness (Atsma & Lane, 2021; Grenier et al., 2016; Om et al., 2022; Reynolds et al., 2016).

Addressing frostbite as a public health concern requires a comprehensive understanding of the broader social determinants of health, such as poverty, stigma, inadequate housing, aging, and limited social support, which increase risk and contribute to health disparities among older adults experiencing homelessness in Canada. This underscores the critical role of nurses with gerontological expertise in advocating for shelter programs and policies that are designed to provide age-inclusive care to reduce the risk of frostbite in older adults experiencing homelessness.

PURPOSE

The purpose of this narrative review is to explore the existing literature on the challenges and barriers faced by Canadian older adults experiencing homelessness, with an emphasis on factors that significantly increase their risk for frostbite. This population experiences a bifactor disadvantage due to homelessness and aging, which limits their access to shelter, hygiene care, and chronic disease management, and increases their susceptibility to frostbite, frostbite-related amputation, and hospitalization. By identifying these challenges, nurses can better understand how to prevent frostbite and improve the quality of health of Canadian older adults experiencing homelessness.

METHOD

A systematic search was conducted on CINAHL, Scopus, and Google Scholar from 2000 to 2024. Articles were screened and selected using Covidence systematic review software (Covidence, 2025), a web-based tool designed to streamline study selection, data extraction, and quality assessment processes in literature reviews. There is scant published research and literature in the Canadian context on older adults experiencing homelessness and frostbite; therefore, we used grey literature, including news websites, Canadian public agency websites, and non-government organizations (NGOs) websites (See Figure 1 & Table 1). The literature search used the terms homeless older adults, frostbite, amputation, homelessness, Canada, winter, and homeless shelter homes.

Inclusion Criteria

Studies included in this narrative review met the following criteria: (a) examined the challenges and risks associated with frostbite among homeless older adults in Canada; (b) focused on individuals aged 60 or older or analyzed age-related influences on homelessness and health challenges, including frostbite;(c) for studies including older adults as part of a sub-analysis, data specific to older adults, homelessness, and frostbite-related health challenges were extracted; 4) Addressed the Canadian context, including primary research studies utilizing qualitative, quantitative, or mixed-method approaches, as well as systematic reviews; (d) included grey literature such as theses, dissertations, organizational briefs, conference abstracts, newspaper articles, and opinion papers; and (f) published in English between 2000 and 2024 to ensure relevance to current healthcare needs (See Table 1).

Exclusion Criteria

Studies were excluded if they met the following criteria: (a) did not focus on homelessness in older adults; (b) addressed homelessness or frostbite in non-Canadian contexts; (c) were published in languages other than English; and (d) predated the year 2000 (See Figure 1).

Data Extraction and Analysis

This paper employs a narrative review approach, which aims to provide broad summaries of existing published literature and highlights the key points of each included study (Green et al., 2006). Data extraction for this narrative review was conducted based on a thematic focus aligned with the research purpose. Relevant information was identified through full-text reading of the selected articles and included author and country, methodological approaches, and key findings (See Table 1). Thematic analysis was used to identify common themes and patterns across the literature (Braun & Clarke, 2022). Through an iterative process, themes were developed and synthesized to provide a comprehensive overview of the challenges faced by homeless older adults contributing to frostbite in the Canadian context. Two reviewers (SM-K and SS) were involved in analyzing the data themes and sub-themes and were consulted frequently to discuss the data until they agreed on the essential sub-themes, which were then combined into themes.

FINDINGS

The search generated 30 articles, including grey literature. The review process yielded 11 articles published from 2000-2024 - *Table 1*. There were four literature reviews (Alston et al., 2024; Darkwah et al., 2012; Weldrick & Canham, 2024; Wu & Duff, 2024), four qualitative studies (Reynolds et al., 2016; Waldbrook, 2013; Waldbrook, 2015; Weldrick et al, 2023), two meta-syntheses (Murphy & Eghaneyan, 2018; Om et al., 2022), and one mixed-methods study (Grenier et al., 2016).

Among the articles included in the review, six studies addressed housing issues and shelter use (Alston et al., 2024; Darkwah et al., 2012; Grenier et al, 2016; Waldbrook, 2013; Waldbrook 2015; Weldrick et al., 2023); five studies explored challenges related to accessing shelter facilities (Darkwah et al., 2012; Murphy & Eghaneyan, 2018; Reynolds et al., 2016; Waldbrook, 2015; Weldrick et al., 2023); five studies examined the lived experiences of homelessness, including coping mechanisms and resilience (Grenier et al., 2016; Murphy & Eghaneyan, 2018; Om et al., 2022; Reynolds et al., 2016; Waldbrook, 2013); and four studies emphasized the importance of inclusivity in promoting the health of older adults experiencing homelessness (Grenier et al., 2016; Reynolds et al., 2016; Weldrick, & Canham, 2024; Weldrick, et al., 2023). There were five studies that discussed experiences of discrimination (Alston et al., 2024; Darkwah et al., 2012; Grenier et al., 2016; Murphy, & Eghaneyan, 2018; Weldrick, & Canham, 2024); three focused on physical health challenges (Alston et al., 2024; Reynolds et al., 2016; Waldbrook, 2015); and one article specifically addressed frostbite (Wu & Duff, 2024). From the analysis of these studies, two overarching themes were identified regarding frostbite management in older adults: Structural Barriers to Managing Frostbite and Barriers to Health and Well-Being.

Theme 1: Structural Barriers to Managing Frostbite

Unstable Living Conditions

Persons experiencing homelessness have limited housing options, often being forced to choose between living in shelters, other forms of assisted living, or living on the streets (Om et al., 2022; Waldbrook, 2015). Most community programs and shelter initiatives often exclude the needs of older adults in designing shelter programs (Alston et al., 2024; Grenier et al., 2016; Weldrick et al., 2023). Shelter homes are often not well-designed and equipped with physical infrastructure to accommodate the needs of older adults (Alston et al., 2024). With rising housing costs, increasing unemployment, and insufficient support systems, many homeless older adults find themselves trapped in a cycle of homelessness, facing the compounded challenges of aging without stable housing (Murphy & Eghaneyan, 2018; Om et al., 2022; Reynolds et al., 2016; Waldbrook, 2013).

Furthermore, shelters often impose restrictive rules such as time limits on shelter stays, waiting in line-ups for food or beds, restriction on personal belongings, separation from partners or pets, and lack of consistent access to medical care within the facility, which undermine older adults' autonomy and respect, leading some to feel isolated, discriminated and neglected (Atsma & Lane, 2021). Consequently, some older adults may choose to live on the streets to avoid stigma and negative attitudes towards them and consider it preferable despite the risks of frostbite, injuries, and amputation (Grenier et al., 2016). The shortage of shelters tailored to address the health needs of older adults is missing in the Canadian context, which further increases the health complications and risk of injuries in older adults experiencing homelessness (Alston et al., 2024; Grenier et al., 2016; Weldrick et al., 2023).

Financial Instability

Financial instability and lack of access to care are often major barriers that may increase the risk of homelessness in older adults (Weldrick & Canham, 2024). Age-related physical and mental impairments, compounded by the stigma associated with aging, make securing employment nearly impossible for older adults (Murphy & Eghaneyan, 2018; Waldbrook, 2015; Weldrick & Canham, 2024). Without a stable income, some are forced to rely on begging or external aid (Weldrick & Canham, 2024). Many chronically homeless older adults have been out of work for years, have never held stable employment, or have worked only in low-paying jobs that do not qualify for pensions or employment insurance (Waldbrook, 2013; Weldrick & Canham, 2024). This lack of financial support leaves older adults vulnerable and unable to afford essentials, such as medications for their chronic illness, appropriate winter clothing, hygiene supplies, and health essential products which increases their risk of frostbite, especially among older adults who seek shelter on the streets or in poorly insulated spaces (Murphy & Eghaneyan, 2018).

Financial instability also leads to malnutrition, further impairing wound healing, weakening skin resilience, and creating nutritional deficiencies that worsen health outcomes for older adults experiencing homelessness (Murphy & Eghaneyan, 2018; Waldbrook, 2015). The combined effects of poor nutrition, unmanaged chronic conditions, and harsh living conditions elevate the risk of frostbite, with untreated cases sometimes leading to severe tissue damage and even amputation as a last resort (Alston et al., 2024). Addressing these compounded challenges requires robust, targeted interventions prioritizing financial,

medical, and nutritional support which are tailored to address the physical and emotional needs of older adults experiencing homelessness.

Theme 2: Barriers to Health and Well-being

Health Disparities

Managing chronic conditions such as diabetes, hypertension, chronic obstructive pulmonary disease (COPD) and arthritis is especially challenging for older adults experiencing homelessness due to limited access to consistent medication, nutrition, and monitoring (Om et al., 2022). This often leads to accelerated health decline and increased hospitalizations from unmanaged or untreated illnesses (Alston et al., 2024). Living in shelters or on the streets further worsens older adults' conditions, as they lack timely access to medications, routine health and wellness follow-ups on presenting or pre-existing conditions, consistent care, and preventive measures, increasing the risk of complications. As a result, older adults experiencing homelessness often delay seeking medical attention until their health conditions deteriorate significantly (Wu & Duff, 2024). This delay prevents early prevention and intervention and may lead to complex health issues (Darkwah et al., 2012; Om et al., 2022).

Hospitalization and transitioning to shelter homes with necessary health resources and equipment, with follow-up care, is also a critical and complex issue in older adults experiencing homelessness (Canham et al., 2019; Reynold et al., 2016). Moreover, if older adults don't have an address or place to stay, they are sent back to shelters or the streets, leaving them ill-equipped to manage their health (Canham et al., 2019). This cycle frequently results in multiple hospital readmissions due to serious complications like amputations or worsening health conditions (Wu & Duff, 2024).

Maintenance of Hygiene and Personal Care

For older adults experiencing homelessness, maintaining skin health is particularly challenging due to unstable living conditions and limited access to essential resources, such as clean water, soap, and hygienic facilities. Often, the environments are unsanitary, such as makeshift camps, abandoned buildings, street corners, and alleys, which expose the older adult experiencing homelessness to environmental hazards such as dirt, pollutants, and toxins that can contribute to skin damage (Waldbrook, 2013). Although shelters may provide temporary relief, they are often overcrowded and equipped with outdated or inadequate facilities (Weldrick & Canham, 2024). Such conditions increase the risk of exposure to communicable diseases and pests, which can further aggravate existing skin conditions (Grenier et al., 2016; Weldrick et al., 2023). For older adults with limited mobility or complex health needs, maintaining personal hygiene can become challenging (Darkwah et al., 2012). The absence of specialized facilities or caregiving support within shelters exacerbates these challenges, leaving older adults particularly vulnerable to hygiene-related health risks (Weldrick et al., 2023).

DISCUSSION

The rising number of Canadian older adults experiencing homelessness and presenting with frostbite in acute care hospital settings signals an urgent need for policy and healthcare interventions (Atsma & Lane, 2021; Endorf et al., 2022). Delayed care due to stigma and negative perceptions of the healthcare needs of older adults experiencing homelessness can lead to complex health issues, such as frostbite-related amputations (Paradis-Gagne et al., 2020; Waldbrook, 2013; Wu & Duff, 2024). The lack of studies and statistical data on the quality of life among Canadian older adults experiencing homelessness and the prevalence of frostbite in this age group limits awareness and hinders policy-level change. Our narrative review sought to examine the healthcare barriers for Canadian older adults experiencing homelessness and propose nursing-focused strategies to address these challenges, emphasizing frostbite prevention as a critical intervention.

Increasing awareness is essential to shifting attitudes and practices around care for Canadian older adults experiencing homelessness. Ageist and biased attitudes among nurses and healthcare providers toward the healthcare needs of older adults experiencing homelessness create barriers for older adults to seek dignified care (Canham et al., 2021; Paradis-Gagne et al., 2020; Weldrick & Canham, 2024). By addressing common biases, such as misconceptions linking homelessness with substance use disorder, criminal activity, or poor lifestyle choices, nurses can improve the quality and accessibility of care (Alston et al., 2023; Canham et al., 2021). Additionally, acknowledging the increase in frostbite-related hospitalizations and amputations among this group emphasizes the need for inclusive healthcare practices and interventions that can address the healthcare needs of older adults experiencing homelessness (Weldrick & Canham, 2024). Nurses play a vital role in promoting harm reduction strategies across primary, secondary, and tertiary levels.

Implementing preventive measures such as promoting awareness in the community, where nurses, as experts, actively engage with older adults experiencing homelessness, conduct ongoing assessments, and collaborate with community partners to prevent health complications and reduce risk of illness (Canham et al., 2019; Weldrick & Canham, 2024). Preventative measures may include providing learning opportunities for older

adults experiencing homelessness about staying warm and protecting their skin from the cold weather, as well as ensuring homeless older adults have reliable access to hygiene resources, including regular shower facilities, laundry services, and wound care supplies. Outreach programs and mobile clinics equipped with trained nurses can help, ensuring routine wound cleaning, limb assessments, and guidance on personal hygiene practices as per policies by the Public Health Agencies of Canada (Government of Canada, 2021).

Nurses play a vital role in preventing frostbite among older adults experiencing homelessness by promoting self-care, assessing lifestyle needs, and recognizing the resilience of this population (Grenier et al., 2016). By reinforcing healthy coping strategies and fostering a sense of community, nurses can help individuals navigate the challenges of homelessness and aging (Atsma & Lane, 2021; Reynolds et al., 2016; Waldbrook, 2015). They can also connect older adults to age-friendly shelters and facilities offering free or affordable hygiene products and clothing (Alston et al., 2024; Waldbrook, 2015). Promoting recognition of early signs of frostbite and how to access support services, such as crisis hotlines, can be life-saving (Klammer et al., 2023; Wu & Duff, 2024). Through targeted guidance and resource navigation, nurses help reduce health risks and improve outcomes (Alston et al., 2024).

At the secondary level, nurses should advocate for accessible healthcare in the community (Wu & Duff, 2024). This includes pushing for enhanced outreach services that connect with older adults experiencing homelessness, both individually and in group settings, to provide preventive care and regular follow-ups. By assessing older adults' health and identifying their risk for frostbite, nurses can implement appropriate measures to prevent frostbite or ensure timely treatment for persons already affected (Klammer et al., 2023; Paradis-Gagne et al., 2020).

At the tertiary care level, nurses play a critical role in supporting older adults experiencing homelessness who are hospitalized for frostbite or related complications. Providing respectful, bias-free care, while remaining aware of one's own potential biases related to homelessness and ageism, can help create a more compassionate healthcare environment (Weldrick & Canham, 2024). Moreover, recognizing older adults' risk factors and health needs early in their hospitalization journey can help nurses explore resources and support that older adults experiencing homelessness need upon discharge, creating a smooth transition from hospital to community (Canham et al., 2019). Connecting older adults experiencing homelessness to shelter resources, social workers, and providing opportunities for learning about frostbite prevention and resources to help mitigate risks of infections post-hospitalization (Klammer et al., 2023; Rudolph et al., 2023). Interdisciplinary collaboration with community organizations and social services is essential for advocating for age-appropriate shelters that accommodate mobility, chronic conditions, and mental health needs (Alston et al., 2024; Herring, 2023; Om et al., 2022; Waldbrook, 2015). Furthermore, nurses must take on leadership roles and actively engage with local, provincial, and federal governments to advocate for systemic solutions, including affordable housing and accessible mental health services (Atsma & Lane, 2021; Lambert, 2023; Waldbrook, 2015).

IMPLICATIONS FOR GERONTOLOGICAL NURSING

Gerontological nurses are uniquely positioned to address the complex care needs of Canadian older adults experiencing homelessness, particularly older adults at risk of frostbite. By emphasizing prevention, collaboration, and advocacy, nurses can play a pivotal role in mitigating health risks and improving outcomes.

Nurses play a vital role in prevention and enhancing outreach to community resources. They are well-positioned to proactively identify risk factors, conduct comprehensive assessments, and anticipate the increased healthcare needs of older adults experiencing homelessness, particularly during winter months in Canada (Atsma & Lane, 2021). This includes regular screenings and the early detection of frostbite in both the hospital and community settings. Effective prevention efforts must extend beyond direct care to include outreach to communities, healthcare institutions, and policymakers. Providing targeted education on frostbite prevention and promoting equitable access to care and services are essential steps in addressing the complex needs of this vulnerable population (Grenier et al., 2016; Paradis-Gagné et al., 2020).

Nurses are uniquely positioned to coordinate care and contribute to the development of interdisciplinary resources that support comprehensive and continuous care for older adults experiencing homelessness (Sacco et al., 2024). Through multidisciplinary collaboration with social service providers and community agencies, nurses can help ensure access to essential services such as shelter, wound care supplies, medications, and follow-up care. Partnerships with local shelters are particularly valuable in creating safer, age-friendly environments by improving physical accessibility, training staff in geriatric-sensitive approaches, and advocating for additional resources to enhance service delivery (Atsma & Lane, 2021; Grenier et al., 2016; Reynolds et al., 2016).

The lack of data on frostbite among older adults experiencing homelessness represents a critical gap (Atsma & Lane, 2021; Grenier et al., 2016). Gerontological nurses

can advocate for frostbite tracking systems and document cases to provide insights into their frequency, severity, and outcomes. This data can inform resource allocation, justify funding for winter preparedness programs, expand warming centers, and improve frostbite prevention training for healthcare providers (Om et al., 2022).

Through collaboration with policymakers and community organizations, nurses can disrupt the cycle of homelessness by promoting affordable housing, employment opportunities for older adults, and social inclusion initiatives (Weldrick & Canham, 2024). These systemic efforts can help prioritize the health, dignity, and self-reliance of older adults experiencing homelessness while fostering long-term change (Grenier et al., 2016; Reynolds et al., 2016). By integrating prevention, advocacy, and collaboration into their practice, gerontological nurses can drive meaningful improvements in care delivery, address health disparities, and uphold the dignity of older adults experiencing homelessness.

CONCLUSION

The rising number of frostbite cases among Canadian older adults experiencing homelessness over the past decade highlights an urgent need for awareness to address this complex issue. Nurses, as frontline caregivers in the healthcare system, have a vital role in tackling this preventable problem by recognizing the broader social determinants that limit access to essential care for older adults experiencing homelessness. Through a person-centred, inclusive approach, nurses can implement effective strategies to reduce the incidence of frostbite and ultimately lower the rates of frostbite-related amputations, contributing to improved quality of aging for older adults experiencing homelessness.

CONFLICT OF INTEREST

The authors have no conflict of interest to declare.

REFERENCES

Alston, J., Barai, S., Orkin, A., & Straus, S. (2024). Tackling late-life homelessness in Canada. *Canadian Medical Association Journal, 196*(19), 662–665. https://doi.org/10.1503/cmaj.231493

Atsma, M., & Lane, A. M. (2021). Causes and complexities of homelessness among older adults: System issues and nursing implications. *International Journal of Nursing Student Scholarship, 8*. https://journalhosting.ucalgary.ca/index.php/ijnss/article/view/74057

Braun, V., & Clarke, V. (2022). Toward good practice in thematic analysis: Avoiding common problems and be(com)ing a knowing researcher. *International Journal of Transgender Health, 24*(1), 1–6. https://doi.org/10.1080/26895269.2022.2129597

Canham, S. L., Bosma, H., Palepu, A., Small, S., & Danielsen, C. (2021). Prioritizing patient perspectives when designing intervention studies for homeless older adults. *Research on Social Work Practice, 31*(6), 610–620. doi:10.1177/1049731521995558

Canham, S. L., Custodio, K., Mauboules, C., Good, C., & Bosma, H. (2019). Health and psychosocial needs of older adults who are experiencing homelessness following hospital discharge. *The Gerontologist, 60*(4), 715–724. https://doi.org/10.1093/geront/gnz078

Covidence. (2025). *Covidence systematic review software*. Veritas Health Innovation. https://www.covidence.org

Darkwah, V., Yamane, H., Richter, S., Caine, V., Maina, G., Chambers, T., & Johnson, L. (2012). A systematic review on the intersection of homelessness and healthcare in Canada. *Journal of Nursing & Care, 1*(5). https://doi.org/10.4172/2167-1168.1000115

Endorf, F. W., Alapati, D., Xiong, Y., DiGiandomenico, C., Rasimas, C. S., Rasimas, J. J., & Nygaard, R. M. (2022). Biopsychosocial factors associated with complications in patients with frostbite. *Medicine, 101*(34), e30211. https://doi.org/10.1097/MD.0000000000030211

Government of Canada. (2021, October 19). *Extreme cold.* Health Canada. https://www.canada.ca/en/health-canada/services/healthy-living/your-health/environment/extreme-cold.html

Government of Canada. (2023, August 10). *Homelessness data snapshot: The national shelter study 2021 update.* Housing, Infrastructure and Communities Canada. https://housing-infrastructure.canada.ca/homelessness-sans-abri/reports-rapports/data-shelter-2021-donnees-refuge-eng.html

Green, B. N., Johnson, C. D., & Adams, A. (2006). Writing narrative literature reviews for peer-reviewed journals: secrets of the trade. *Journal of Chiropractic Medicine, 5*(3), 101–117. https://doi.org/10.1016/S0899-3467(07)60142-6

Grenier, A., Sussman, T., Barken, R., Bourgeois-Guerin, V., & Rothwell, D. (2016). 'Growing old in shelters and 'on the street': Experiences of older homeless people. *Journal of Gerontological Social Work, 59*(6), 458–477. https://doi.org/10.1080/01634372.2016.1235067

Herring, J. (2023, January 18). It's horrifying: Frostbite diagnoses, amputations spiked in Calgary last year. *Calgary Herald*. https://calgaryherald.com/news/local-news/frostbite-diagnoses-amputations-spiked-in-calgary-last-year

Klammer, L., Ollier, M., Gauthier, J., Allen, L. R., Davidson, M., Ahmed, Y., Smith-Turchyn, J., Hansen-Jaumard, D., Hebert, S., Logsetty, S., Morris-Jantzen, D., Peet, R., Poole, A. J., & Champion, C. (2023). Exploring the development of a Canadian frostbite care network and the future of frostbite care in Canada using a qualitative approach. *Wilderness & Environmental Medicine, 34*(4), 427–434. https://doi.org/10.1016/j.wem.2023.06.001

Lambert, T. (2023, January 11). Frostbite amputations hit 10-year high in Edmonton Last Winter, New Data Show. *CBC News*. https://www.cbc.ca/news/canada/edmonton/frostbite-amputations-hit-10-year-high-in-edmonton-last-winter-new-data-show-1.6709778

Murphy, E. R., & Eghaneyan, B. H. (2018). Understanding the phenomenon of older adult homelessness in North America: A qualitative interpretive meta-synthesis. *British Journal of Social Work, 48*(8), 2361–2380. doi:10.1093/bjsw/bcx163

Om, P., Whitehead, L., Vafeas, C. & Towell-Barnard, A. (2022). A qualitative systematic review on the experiences of homelessness among older adults. *BMC Geriatrics, 22*, 363. https://doi.org/10.1186/s12877-022-02978-9

Paradis-Gagne, E., Pariseau-Legault, P., Villemure, M., & Chauvette, S. (2020). A critical ethnography of outreach nursing for people experiencing homelessness. *Journal of Community Health Nursing, 37*(4), 189–202. https://doi.org/10.1080/07370016.2020.1809858

Rathjen, N. A., Shahbodaghi, S. D., & Brown, J. A. (2019). Hypothermia and cold weather injuries. *American Family Physician, 100*(11), 680–686. www.aafp.org/afp

Reynolds, K. A., Isaak, C. A., DeBoer, T., & Medved, M. (2016). Aging and homelessness in a Canadian context. *Canadian Journal of Community Mental Health, 35*(1), 1–13. doi:10.7870/cjcmh-2015-016

Rudolph, K. A., Stewart, M., & Borba, C. P. C. (2023). "Shelter is stressing me out": Challenges meeting health care needs of older adults in congregate shelters. *Journal of Health Care for the Poor & Underserved, 34*(3), 1003–1020. doi:10.1353/hpu.2023.a903059

Sacco, V., Stolee, P., MacEachen, E., & Boscart, V. (2024). Canadian health care providers' perspectives on working with older homeless adults in outreach settings. *Canadian Journal on Aging / La Revue Canadienne Du Vieillissement, 43*(1), 23–32. doi:10.1017/S0714980823000405

Statistics Canada. (January 31, 2019). *Shelters, temporary housing and homelessness*. Statistics Canada. https://www23.statcan.gc.ca/imdb/p3VD.pl?Function=getVD&TVD=440885&CVD=440885&CLV=0&MLV=1&D=1

Waldbrook, N. (2015). Exploring opportunities for healthy aging among older persons with a history of homelessness in Toronto, Canada. *Social Science & Medicine, 128*, 126–133. http://dx.doi.org/10.1016/j.socscimed.2015.01.015

Waldbrook, N. (2013). Formerly homeless, older women's experiences with health, housing, and aging. *Journal of Women & Aging, 25*(4), 337–357. https://doi.org/10.1080/08952841.2013.816213

Weldrick, R., & Canham, S. L. (2023). Intersections of ageism and homelessness among older adults: Implications for policy, practice, and research. *The Gerontologist, 64*(5), 1–7. https://doi.org/10.1093/geront/gnad088

Weldrick, R., Canham, S. L., Sussman, T., Walsh, C. A., Cormier, É., & Mahmood, A. (2023). Delivering services to older persons experiencing homelessness: Providers' perspectives of what does and does not work. *Journal of Gerontological Social Work, 66*(1), 29–42. doi:10.1080/01634372.2022.2087128

Wu, Y., & Duff, E. (2024). Management of frostbite injury in primary care. *The Journal for Nurse Practitioners, 20*(2), 104897. https://doi.org/10.1016/j.nurpra.2023.104897

Table 1

Extraction table of selected studies from databases

	Author, Year, Country	Title	Type of Paper	Population Sample	Key Findings
1	Alston, J. et al., 2024 Country: Canada	Tackling late-life homelessness in Canada	Literature Review	N/A	• People experiencing homelessness develop geriatric syndromes and medical conditions that occur more commonly with older age, including cognitive and functional impairment, at younger ages than their counterparts who have not experienced homelessness. • The proportion of people 50 years and older using shelters is increasing, but most shelters in Canada are not adequately designed and resourced to meet the needs of older adults. • Older adults experiencing homelessness, who often have a history of injustice and trauma, require individualized and integrated approaches to meet their needs; these approaches require collaborations between health and long-term care, public health, housing, and other community agencies.
2	Darkwah, V. et al., 2012 Country: North America including USA and Canada	A Systematic Review on the Intersection of Homelessness and Healthcare in Canada.	Literature Review	The inclusion criteria that guided the review were studies conducted in Canada and focused on the needs and barriers of people who are homeless when they intersect with health care providers. The review team included research articles that ranged from quantitative designs such as quasi experimental designs, longitudinal, case-control, descriptive and correlation studies, as well as qualitative studies and grey literature. The study population covers people experiencing homelessness which involves men, women, children, youth, adult and elderly who resided in shelters, street, parks, bridges, or were couch surfing in Canada.	• Eight themes emerged from the study as follows: chronic physical and mental health conditions, inability to obtain health care services, fragmentation of supports, discrimination and stigmatization, lack of health insurance, increased needs among women experiencing homelessness, unfixable and abandoned, and moral worth. • Health is a secondary need for people experiencing homelessness since they are more concerned about finding a roof over their head and food to eat before considering health. People without a permanent place of abode have complex needs and concerns ranging from housing, employment, income, education, and health. Furthermore, they suffer from chronic physical and emotional problems such as fatigue, frustration, and depression.

	Author, Year, Country	Title	Type of Paper	Population Sample	Key Findings
3	Grenier, A. et al., 2016 Country: Canada	'Growing Old' in Shelters and 'On the Street': Experiences of Older Homeless People	Mixed-methods study	This article presents the results of 40 semi-structured, qualitative interviews carried out to understand the experiences of homeless men and women aged 50 to 75 in 2014 in Montreal, Canada.	• This article reports on the five key themes from the interviews with older people who are homeless: Age and stigma exacerbate shame, anxiety, and worry, Exclusion and isolation challenge the exit from homelessness, Managing significant challenges and the need for socio-emotional support, Shifting needs and desires for 'home', and Resilience, strength, and hope. • The detailed lived experiences presented in this article highlight how structural challenges related to housing, poverty, and income are experienced across time, and in relation to well-being, family relationships, and social inclusion/exclusion. Experiences of homelessness in later life, including those of shame, anxiety, and worry, are exacerbated by aging and social exclusion.
4	Murphy, E. R., & Eghaneyan, B. H., 2018 Country: North America including USA and Canada	Understanding the Phenomenon of Older Adult Homelessness in North America: A Qualitative Interpretive Meta-Synthesis	Meta-Synthesis	Eight studies were found which analyzed data provided by 150 individuals. For the purposes of this meta-synthesis, quotes provided by persons younger than fifty years of age were excluded. A majority of individuals (n = 99, 66 per cent) were male, one-third (n = 50) were female and one person identified as transgender. Racial and ethnic backgrounds of participants were diverse. Participants were recruited from the USA (n = 67, 45 per cent) and Canada (n = 83, 55 per cent). Participants were unable to secure food, water, shelter, clothing, health care and social inclusion.	• Synthesis of the eight articles resulted in two themes that describe older adult homelessness: systemic failings and coping mechanisms and survival behaviours. • Each of the included studies provides a unique glimpse into the phenomenon of older adult homelessness. • This research provides social workers with insight into the larger, systemic concerns contributing to and impacting older adult homelessness.

	Author, Year, Country	Title	Type of Paper	Population Sample	Key Findings
5	Om, P. et al., 2022 Country: Canada, USA, and Thailand	A qualitative systematic review on the experiences of homelessness among older adults.	Meta-synthesis	Qualitative and mixed-method studies with ample qualitative data in their results sections to allow secondary data analysis met the inclusion criteria. The sample comprised of older adults aged between 45 and 80 years that had experienced homelessness for at least one period. This analysis followed the Joanna Briggs Institute (JBI) method for systematic reviews. A qualitative assessment and review instrument (JBI-QARI 10 item tool) was used to facilitate the meta-synthesis. Results from the studies were extracted, categorized, and synthesized. Searches were conducted in PsycINFO, Web of Science, Google Scholar, Medline, PubMed, and CINAHL	• An overarching theme was identified: 'the journey of homelessness'. Within this context, three core themes were identified: 1) Pathways to homelessness; 2) impact of homelessness; and 3) outcomes and resolutions, where each of these 3 themes had relevant sub-themes. • This review collates current evidence on what is known about the experience of homelessness among older adults. In this study, homeless older adults identified a wide range of challenges associated with the experience of homelessness.
6	Reynolds, K. A. et al., 2016 Country: Canada	Aging and Homelessness in a Canadian Context	Qualitative Review	Data for this study were collected as part of the Winnipeg At Home / Chez Soi Project, a multisite study of Housing First initiatives implemented in Vancouver, Winnipeg, Toronto, Montreal, and Moncton. This five-year study, developed and funded by the Mental Health Commission of Canada, intended to examine the effectiveness of a Housing First initiative with adults with severe and persistent mental health problems and a history of chronic homelessness In total, 513 participants were recruited and enrolled to participate in the Winnipeg At Home / Chez Soi Project. Recruitment occurred over an 18-month period, from 2009 to 2011. The mean age of participants at the time they were enrolled in the project was 39 years, with an age range of 18 to 71 years A subsample of participants, termed the narrative subsample (n = 45) was selected from the larger sample (N = 513) to complete the semi structured qualitative interview portion of the Winnipeg At Home / Chez Soi Project.	• Researchers categorized participants' interviews into five main themes: pathways to homelessness (individual, relational, and structural/societal sub-themes); controlled lives; centrality of social relationships; shame and desire for self-reliance; and the challenge of disentanglement from the cycle of homelessness. • The theme of controlled lives illustrates the ways in which mobility issues and physical health problems act as barriers to accessing scheduled support from shelters and related services. Policy improvements could involve the creation of more flexible timelines for older adults to access shelters and services, and increased access to transportation for older adults. • A significant implication emergent from the theme of centrality of social relationships is the importance of offering holistic services to older homeless adults that incorporate a familial/ relationship-building focus, with the hope of enhancing feelings of connection.

	Author, Year, Country	Title	Type of Paper	Population Sample	Key Findings
7	Waldbrook N., 2015 Country: Canada	Exploring opportunities for healthy aging among older persons with a history of homelessness in Toronto, Canada	Qualitative Review	The qualitative evidence presented in this article was gathered as part of a large mixed-methods doctoral study on homelessness, health, and aging. The fieldwork was conducted between January and July 2011. The site of research was in the downtown, inner-city neighborhoods of Toronto, Canada's largest urban centre. The qualitative findings are derived from in-depth interviews with 29 older persons, who self-reported a history of homelessness. The selection criteria required participants to have been stably housed for six months or longer.	• Interview excerpts are presented to demonstrate the aspects of housing that participants commonly perceived to be responsible for improving their health and well-being. • The qualitative evidence presented in this article offers important insight into the role of stable housing in shaping the health and well-being of formerly homeless older persons. The in-depth discussions with participants offer new insights to understand the barriers to healthy aging among older persons who were previously homeless, and continuing to live in relative poverty. • The "healthy aging" concept was a useful analytical tool in this study for identifying the social determinants that might be absent from the lives of formerly homeless older persons. Most of the barriers described related to earning a low income, and this prevented participants from affording nutritious food, medications, and other basic necessities. Participants also described chronic health problems and disabilities, which were limiting their mobility and opportunities for positive experiences of aging. Some of the findings also contribute to a better understanding of the long-term effects of homelessness on emotional well-being.
8	Waldbrook N., 2013 Country: Canada	Formerly Homeless, Older Women's Experiences with Health, Housing, and Aging	Qualitative Review	Between January and July 2011, a group of formerly homeless, older women were surveyed (N = 15) and interviewed (n = 11) in Toronto, Canada. From the initial 15 participants who were surveyed, 4 participants were unable to be followed up with during the interview process due to either cognitive impairment or a refusal to participate by choice. The female participants were recruited using three types of convenience sampling methods: agency-based sampling, street-based sampling, and recruitment flyers.	• The qualitative themes explored include the women's perceptions of their current health, coping with low incomes, dealing with addictions to alcohol and drugs, and the importance of supportive housing and other community services. The female participants' views on adapting to home, planning for their elderly years, and views on growing older are also explored.

	Author, Year, Country	Title	Type of Paper	Population Sample	Key Findings
9	Weldrick., R. & Canham., S., 2024 Country: Canada and USA	Intersections of Ageism and Homelessness Among Older Adults: Implications for Policy, Practice, and Research	Literature Review	N/A	• Ageism among minority groups and across older people facing multiple exclusions. • Older adults have been victimized because of their age in the shelter home by young users • Discrimination based on age, ethnic identity, and gender in accessing services. • Negative perceptions that they are "dirty, marginally capable, and mentally ill. • Enhanced trauma-informed and person-centered care training and workplace supports for health, housing, and social service providers. • Increasing funding and community support for affordable, age-friendly housing developments are integral in creating spaces where older persons experiencing homelessness are free from ageism. • Need for improved policies to prohibit discrimination based on the intersection of age and homeless status.
10	Weldrick, R. et al., 2023 Country: Canada	Delivering Services to Older Persons Experiencing Homelessness: Providers' Perspectives of What Does and Does Not Work.	Qualitative study	Conducted 15 in-depth, semi-structured qualitative interviews with service providers working with older people with experiences of homelessness (OPEH) to investigate perceptions of what supports OPEH to age in the right place (AIRP), and what hinders or impedes AIRP for OPEH. Participants included 13 female and two male service providers, five from each promising practice. Participants ranged in age from 21 to 59 years, although one participant did not disclose their age.	• Findings from fifteen qualitative interviews revealed three overarching themes: 1) *barriers to providing individualized support* (e.g., staff turnover); 2) *shifting contexts and structures* (e.g., housing market changes); and 3) *mechanisms of success* (e.g., facilitating smooth transitions into permanent housing).

	Author, Year, Country	Title	Type of Paper	Population Sample	Key Findings
11	Wu, Y. & Duff, E., 2024 Country: Canada	Management of frostbite injury in primary care.	Literature Review	N/A	• Frostbite injury is increasing with debilitating long-term disability complications. It is critical that Nurse Practitioners (NPs) manage superficial and severe frostbite injury as well as the long-term sequelae. Primary care NPs are well situated to manage patients with frostbite injury that optimizes their function and quality of life in considering social determinants and health disparities. Primary care NPs are ideally positioned to educate patients, who are predisposed to frostbite injury and its associated complications to mitigate injury and improve outcomes. NPs preventative care and multidisciplinary collaboration can improve patient outcomes and reduce the burden of frostbite injury on the health care system.

Figure 1

PRISMA Flow Diagram of Literature Search (Covidence, 2025)