Assessment of social situation and health of homeless people over 65 years of age in urban environment

Ocena sytuacji społecznej i zdrowotnej osób bezdomnych po 65 roku życia w środowisku wielkomiejskim

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Wprowadzenie. Rosnąca liczba osób w wieku ponad 65 lat i wydłużanie średniej długości trwania życia, stawia wyzwania dla szeroko rozumianej polityki społecznej. Problem starzenia się społeczeństwa staje się widoczny również w populacji osób bezdomnych.

Cel. Ocena sytuacji społecznej oraz zdrowotnej osób bezdomnych po 65 r.ż. w środowisku wielkomiejskim.

Materiały i metody. Badania przeprowadzono w oparciu o dane uzyskane z wywiadów środowiskowych przeprowadzonych przez pracowników socjalnych z osobami bezdomnymi korzystającymi ze świadczeń pomocy społecznej. Przeanalizowano wszystkie wywiady przeprowadzone w środowisku wielkomiejskim miasta Szczecin w 2015 r. Spośród 1261 wywiadów środowiskowych do dalszych badań wybrano 117 kompletów dokumentacji dotyczących osób bezdomnych po 65 roku życia.

Wyniki. Przeciętny profil bezdomnego, to 70-letni mężczyzna, bez orzeczenia o niepełnosprawności, o wykształceniu podstawowym, utrzymujący się z zasiłku stałego, stroniący od rodziny oraz żyjący w schronisku dla bezdomnych. Istnieje istotna statystyczna zależność pomiędzy stanem zdrowia a przyczynami bezdomności. Choroba była częstą przyczyną bezdomności, a fakt bycia osobą bezdomną dodatkowo pogarszał stan zdrowia ze względu na brak odpowiednich warunków bytowych. Wraz ze wzrostem wieku osób bezdomnych, pogarszał się ich stan zdrowia w kontekście zagrożenia niepełnosprawnością.

Wnioski. Profilaktyka bezdomności powinna być kierowana przede wszystkim do mężczyzn stroniących od rodziny oraz do osób z orzeczeniem o niepełnosprawności. Ponadto powinna obejmować przeciwdziałanie bezrobociu i promowanie legalnych form zatrudnienia, aby mężczyźni ci po osiągnięciu wieku emerytalnego nabyli prawo do emerytury.

Słowa kluczowe: *bezdomność, stan zdrowia, ocena niepełnosprawności*

Introduction. An increase in the number of people over 65 years of age and in the average length of human life are some of the key challenges for the broadly defined social policy. The phenomenon of ageing of population also concerns the homeless.

Aim. To assess the social situation and health of the homeless over 65 years of age in the urban environment.

Material & method. The studies were based on data collected from interviews made by social workers with the homeless benefiting from social assistance services. All interviews conducted in the urban area of the city of Szczecin in 2015 were analyzed. Among 1261 homeless people surveyed, 117 interviews conducted with people aged 65 and older were included in the study.

Results. An average profile of a homeless person was a 70-year-old man without a certificate of disability, with primary education and a permanent benefit, with no contacts with the family, living in a homeless shelter. There is a significant statistical relationship between health status and causes of homelessness. A disease was a common cause of homelessness, and the fact of being a homeless person further deteriorated the health status due to the lack of adequate living conditions. Along with an increase in the age of the homeless, their health status deteriorated in the context of the risk of disability.

Conclusion. Prevention of homelessness should be aimed first of all at men who are not in contact with the family and at persons with disabilities. In addition, it should include counteracting unemployment and promoting legal forms of employment so that these men acquire the right to a retirement pension after reaching the retirement age.

Key words: *homelessness, health status, disability evaluation*

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Nadesłano: 28.07.2017
Zakwalifikowano do druku: 15.09.2017

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Introduction

In Poland, the total number of homeless people amounted to 36.1 thousand [1]. However, it is estimated that the real number of the homeless in Poland can even be as high as 300 thousand, which is almost 1% of the population of adult Poles [2]. A big impediment in the scientific diagnosis of homelessness is the lack of one constitutive feature of homelessness, which differs the analysis of this phenomenon from other social problems, which often correlate with homelessness, e.g. poverty, unemployment, family violence [3]. There are many definitions of homelessness and a homeless person, however initially these were intuitive and imprecise definitions, e.g. "...the homeless is a person who does not have a home, or an individual with a specific predisposition, who does not accept social norms, and who made a choice of the way of life in the name of freedom – a type of a homeless wanderer" [4]. For this reason in 2004, along with an amendment of the Act on social assistance the definition was clarified and allowed considering the homeless: "a person who does not reside in a dwelling within the meaning of provisions on protection of the rights of tenants and municipal housing stock, who is not registered for permanent residence within the meaning of the provisions on registration of population and identity cards, as well as a person who does not reside in a dwelling and is registered for permanent residence in premises which are impossible to be settled in" [5].

In the scientific research approach to the phenomenon of homelessness, the following typologies dividing the population of homeless people in a bipolar way have been established: homelessness by necessity, involuntary (random) vs. homelessness by choice, voluntary [6-8]; statutory homelessness meaning actual lack of roof over one's head vs. hidden homelessness [6, 7]; shelter homelessness vs. non-shelter (street) homelessness [8]; transitory, temporary, short-term homelessness [9]; shallow, unfixed, partial situational homelessness vs. deep, fixed, total, chronic homelessness [10]. The factors leading to homelessness can be divided into two main groups: external, which include such factors as unemployment, poverty, bad situation on the housing market, poor efficiency of the social welfare system and health care system, non-adjustment of legal regulations; internal, among which the most common are addiction, domestic violence, crime, family breakdown, mental disorders, chronic diseases [11].

The fact of becoming a homeless person deepens the unfavorable social situation, among other things due to prejudices and stigmatization of the homeless. These persons usually arouse fear, are associated with poverty, misery, dirt, loneliness, stench, begging, collecting scrap metal and waste paper [12, 13]. Health problems contribute to social problems of the homeless and their negative perception. The most common ones are malnutrition, emaciation, anemia, ulcers, lice/scabies, neglected psoriasis, diabetes, wounds, cancer [13-15], mental disorders [16, 17], especially depression [5]. Homeless people are particularly vulnerable to TB [18], as well as a wrong course of its treatment [19-22]. A frequent problem among the homeless is acute ethanol intoxication, alcohol withdrawal syndrome [23], hypothermia in the winter period [24], suicide [25], HIV [22].

The phenomenon of ageing of population also applies to the homeless. This means that soon the main recipients of help addressed to the homeless will be disabled, elderly people requiring full time care. For this reason, it is important to provide adequate health care and activities in the field of health education directed to the homeless [14, 26]. Poor health can be both a consequence and a cause of homelessness [14]. At the same time, it affects the social situation of the homeless, for example making employment impossible [27].

Aim

To assess the social situation and health of the homeless over 65 years of age in the urban environment.

Material and method

The research method was a diagnostic survey based on the analysis of documents. The analyzed documents were environmental interviews conducted among homeless people benefiting from social assistance (Municipal Family Assistance Centre in Szczecin). Environmental interviews are standardized tools used in the work of a social worker to determine the family and health status, income and wealth situation of people and families applying for social assistance. The medical record (medical records, medical certificates, disability certificates) were also collected. These interviews were conducted by social workers in 2015. Then, the collected data was analyzed quantitatively by filling in the authors' questionnaires on the basis of environmental interviews. The questionnaires included questions about age, education, sources of income, family situation, place of residence, reasons for homelessness and disability certificate. From a group of 1261 homeless people benefiting from social assistance in Szczecin in 2015, 117 interviews with people aged 65 and older were included in the study.

The study was conducted in 2015 at the Department of Assistance to the Homeless of the Municipal Family Assistance Centre in Szczecin, Poland. In the statistical analysis, the level of significance was $\alpha \leqslant 0.05$.

Results

Among 1261 registered homeless individuals, 117 (9.28%) were over 65 years of age. The average profile of an elderly homeless is as follows: a 70-year-old man without a certificate of disability, with primary education and a permanent benefit, with no contacts with family, living in a homeless shelter (Table I).

The phenomenon of homelessness, despite the numerical superiority of women in the population, dominates among men. The largest group were men aged 65-70 years. In the following age brackets, the tendency decreased among both genders and the reasons for this should be searched for, either in cessation of homelessness (being moved to a nursing home) or death (Table I).

As shown in Table I, a majority of the respondents had primary education (60.7%) or vocational education (20.5%). Individuals with higher education were a group of 2.6%.

Homeless people are often unemployed as well. If they take a job, they mainly undertake casual or seasonal activities without a formal contract signed [28]. For 22.2% of the studied homeless people in Szczecin aged over 65 years, a pension was the source of income, which means that these people had acquired pension rights from an employment relationship in the past. However, a vast majority (70.9%) are people with no right to pension or allowance, and their income is social assistance in the form of a permanent benefit (Table I), which also makes them eligible to health insurance.

A vast majority (60.68%) of the homeless aged over 65 decide to stay in a homeless shelter which guarantees all-day stays with meals. A part of homeless seniors (25.64%) lodge in wooden houses on garden allotments, which their authorities continually campaign to ban. Nearly 14% of the homeless aged over 65 from the area of Szczecin decided to stay in non-residential places, such as basements, garages, uninhabited buildings, encampments, railway stations, parks, warehouses, heating centers or garbage chutes (Table I). Most often these are people who do not comply with the rules and regulations for the homeless in shelters, especially those related to staying sober.

More than half of the homeless (59.0%) did not keep in touch with their families. This contact was kept by 9.4% of people only, and every third person had no family (Table I).

The documentation collected during an environmental interview makes it impossible to determine the precise health status of the homeless. However, it contains elements of medical records, among others, certificates of disability and such a statement was issued for 26 people (22.2%). It was examined whether there is a relation between owning a certificate of disability and socio-demographic characteristics (Table II).

There is a significant statistical relation between health status and causes of homelessness. Other socio-demographic factors do not significantly affect the health status of the homeless. To determine the degree and direction of the relationship between health status and a statistically significant factor, the correlation coefficient was calculated. The following correlative relation is statistically significant ($p=0.000$), and is of a positive but pretty weak nature (level of the correlation coefficient equal 0.203). A disease was a common cause of homelessness, and the fact of being a homeless person further deteriorated the health status due to the lack of adequate living conditions.

The main causes of homelessness were eviction and debt (49; 41.9% of respondents; eviction was not always associated with debt), disease (25; 21.4%), family conflicts including divorce (24; 20.5%) (Table I). It was studied whether there is a relationship between the causes of homelessness and socio-demographic variables (age, sex, education, income, family status, health status, place of residence). There is a statistically significant relation between the causes of homelessness and the health status ($p=0.000$). There is no significant statistical relationship between the causes of homelessness and other socio-demographic features.

The support system functioning within the social assistance provides shelter for the homeless in four basic forms: warming-up facility, night-shelter, shelter and protected apartment, but none of these forms is intended for the elderly, the disabled and the chronically, physically ill. Hence, the homeless are sent to nursing homes based on criteria accepted in the Act on social assistance, however, this process is associated with time of waiting for a place, and some people need protection and care urgently, especially after completing hospitalization. As the scale of the dependent and old homeless is high, more and more people stay in hospitals for social reasons, generating significant costs for healthcare institutions. Facing this ever-growing problem, Poland's first shelter for homeless people requiring full-time care and support, in which 28 people resided at the time of the study, was established in Szczecin.

Discussion

An increase in the number of people over 65 years of age and in the average length of human life are two of the key challenges for the broadly defined social policy. The main problem of old age concerns a growing number of people who, at the same time, belong to other marginalized groups, namely people with disabilities, mental disturbances, addictions, and the homeless.

Table I. Socio-demographic characteristics of study group and significance test for structure index for particular socio-demographic characteristics
Tabela I. Charakterystyka socjodemograficzna badanej grupy oraz test istotności dla wskaźnika struktury dla poszczególnych cech socjodemograficznych

Parameter /Parametr			Age (in years) /Wiek (w latach)								u	df	p
			65-70 N=68		71-75 N=30		+76 N=19		Total /Razem N=117				
			n	%	n	%	n	%	n	%			
gender /płeć		W /K	13	19,1	7	23,3	4	21,1	24	20,5	5.471	116	0.000
		M /M	55	80,9	23	76,7	15	78,9	93	79,5			
education /wykształcenie	primary /podstawowe N=71	W /K	8	11,8	4	13,3	2	10,5	14	12,0	7.132	116	0.000
		M /M	36	52,9	16	53,3	5	26,3	57	48,7			
	vocational /zawodowe N=24	W /K	1	1,5	1	3,3			2	1,7			
		M /M	12	17,6	5	16,7	5	26,3	22	18,8			
	secondary /średnie N=15	W /K	3	4,4	2	6,7	1	5,3	6	5,1			
		M /M	4	5,9	2	6,7	3	15,8	9	7,7			
	higher /wyższe N=3	W /K					1	5,3	1	0,9			
		M /M	1	1,5			1	5,3	2	1,7			
	not determined /nieustalone N=4	W /K	1	1,5					1	0,9			
		M /M	2	2,9			1	5,3	3	2,5			
income /dochód	none /brak N=3	M /M	3	4,4					3	2,6	-6.613	116	0.000
	pension /emerytura N=26	W /K	4	5,9	3	10,0	2	10,5	9	7,7			
		M /M	4	5,9	4	13,3	9	47,4	17	14,5			
	allowance /renta N=5	W /K	1	1,5	1	3,3			2	1,7			
		M /M	2	2,9	1	3,3			3	2,6			
	permanent benefit /zasiłek stały N=83	W /K	8	11,8	3	10,0	2	10,5	13	11,1			
		M /M	46	67,6	18	60,0	6	31,6	70	59,8			
place of stay /miejsce pobytu	shelter /schronisko N=71	W /K	5	7,4	5	16,7	3	15,8	13	11,1	7.895	116	0.000
		M /M	29	42,6	18	60,0	11	57,9	58	49,6			
	garden allotment /działka N=30	W /K	6	8,8			2	10,5	8	6,8			
		M /M	15	22,1	3	10,0	4	21,1	22	18,8			
	other /inne N=16	W /K	2	2,9			1	5,3	3	2,6			
		M /M	11	16,2	2	6,7			13	11,1			
family status /status rodzinny	keeps contact with family /utrzymuje kontakt z rodziną N=11	W /K	3	4,4	2	6,7	1	5,3	6	5,1	3.984	116	0.000
		M /M	3	4,4			2	10,5	5	4,3			
	no contact with family /bez kontaktu z rodziną N=69	W /K	6	8,8	1	3,3	1	5,3	8	6,8			
		M /M	35	51,5	18	60,0	8	42,1	61	52,2			
	no family /brak rodziny N=37	W /K	4	5,9	4	13,3	2	10,5	10	8,5			
		M /M	17	25,0	5	16,7	5	26,3	27	23,1			
health status /stan zdrowia	certificate of disability /orzeczona niepełnosprawność N=26	W /K	2	2,9					2	1,7	5.757	116	0.000
		M /M	14	20.6	9	30,0	1	5,3	24	20,5			
	no certificate of disability /brak orzeczenia o niepełnosprawności N=91	W /K	11	16,2	7	23,3	4	21,1	22	18,8			
		M /M	41	60,3	14	46,7	14	73,7	69	59,0			
causes of homelessness /przyczyna bezdomności	disease /choroba N=25	W /K	2	2,9	2	6,7	2	10,5	6	5,1	-4.441	116	0.000
		M /M	8	11,8	8	26,7	3	15,8	19	16,2			
	debt and eviction /zadłużenie i eksmisja N=49	W /K	6	8,8	4	13,3	1	5,3	11	9,4			
		M /M	22	32,4	7	23,3	9	47,4	38	32,5			
	alcohol addiction /uzależnienie od alkoholu N=14	M /M	11	16,2	1	3,3	2	10,5	14	12,0			
	family conflicts (including divorce) /konflikty rodzinne (w tym rozwód) N=24	W /K	3	4,4	1	3,3	1	5,3	5	4,3			
		M /M	12	17,6	7	23,3			19	16,2			
	leaving prison /opuszczenie zakładu karnego N=2	M /M	2	2,9					2	1,7			
	other /inne N=3	W /K	2	2,9					2	1,7			
		M /M					1	5,3	1	0,9			

Table II. Results of Chi² test of independence between health status and particular socio-demographic variables
Tabela II. Wynik testu niezależności Chi² między stanem zdrowia a poszczególnymi zmiennymi socjo-demograficznymi

Variable /Zmienna		No disability /Brak niepełnosprawności		Disability /Niepełnosprawność		Chi²	df	p
		n	%	n	%			
Sex /płeć	women /kobiety	22	24.2	2	7.7	3.37	1	0.068
	men /mężczyźni	69	75.8	24	92.3			
Education /wykształcenie	primary /podstawowe	55	60.4	16	61.5	4.404	4	0.354
	vocational /zawodowe	16	17.6	8	30.8			
	secondary /średnie	13	14.3	2	7.7			
	higher /wyższe	3	3.3					
	not determined /nieustalone	4	4.4					
Age (in years) /wiek (w latach)	65-70	52	57.1	16	61.5	4.279	2	0.118
	71-75	21	23.1	9	34.6			
	+76	18	19.8	1	3.9			
Income /dochód	none /brak	2	2.2	1	3.8	2.401	3	0.493
	pension /emerytura	23	25.3	3	11.5			
	allowance /renta	4	4.4	1	3.9			
	permanent benefit /zasiłek stały	62	68.1	21	80.8			
Family status /status rodzinny	keeps contact with family /utrzymuje kontakt z rodziną	11	12.1			3.47	2	0.176
	no contact with family /brak kontaktu z rodziną	52	57.1	17	65.4			
	no family /brak rodziny	28	30.8	9	34.6			
Causes of homelessness /przyczyna bezdomności	disease /choroba	13	14.3	12	46.2	24.516	5	0.000*
	debt and eviction /zadłużenie i eksmisja	46	50.5	3	11.5			
	alcohol addiction /uzależnienie od alkoholu	13	14.3	1	3.8			
	family conflicts (including divorce) /konflikty rodzinne (w tym rozwód)	16	17.6	8	30.8			
	leaving prison /opuszczenie zakładu karnego	2	2.2					
	other /inne	1	1.1	2	7.7			
Place of stay /miejsce pobytu	shelter /schronisko	50	54.9	21	80.8	5.69	2	0.058
	garden allotment /działka	27	29.7	3	11.5			
	other /inne	14	15.4	2	7.7			

The homeless are people living in shelters, on garden allotments, as well as those without an established place of residence, people who often move from one place to another, staying on staircases, in basements, heat centers, parks, abandoned warehouses or buildings. Homeless people are an extremely difficult group to work with, devoid of virtually all goods and property, rejecting the generally accepted standards, often with chronic diseases which have not been diagnosed or treated. In Poland, homelessness was distinguished from among a variety of social problems such as poverty, domestic violence and unemployment as an area for serious interest for intervention, prevention and reintegration only in the 1990's of the 20th century. Homelessness is a dynamically changing phenomenon and monitoring its changes has become a challenge both for social welfare and for health care services.

The problem of homelessness is widely discussed in literature in the United States and Western Europe [29]. Most scientific, European publications concern the situation in the UK and in France while a small percentage of publications concerns Europe as a whole, and a particularly low percentage of literature refers to the situation of homeless people in Eastern Europe countries [12]. Research on homelessness in Poland mainly concerns attitudes towards people affected by this condition and their health problems. The analysis of social and health situations of the homeless in old age has not been made so far.

Based on the results of our own research, a general characteristic of homeless people over 65 years of age can be made. Although in Poland there are more women, who in total represent 51.6% of the population (and in the age group of 70-74 years nearly 60%) [29], in the authors' study, most of the homeless were men. The homeless in Poland usually have primary and vocational education, while less than 3% have higher education [28]. This data is consistent with the outcomes of a study conducted in Szczecin, in which a group of 2.6% was found to have higher education. The level of education has a significant impact on undertaking a job and having a source of income, which for the majority of the respondents was a permanent benefit from social welfare. The analysis of the situa-

tion of the homeless also shows that they have children but they do not maintain contact or a permanent relationship with them. They live in homeless shelters, and because of their age and previous unhygienic lifestyle, they require constant care.

The results of the research conducted in Szczecin are consistent with nationwide trends. The studies conducted among the homeless in Bialystok, the Tri-City, Slupsk and Warsaw show that an average age of the homeless in 2003 was 46 while in 2013 it increased to 52.4 years, which confirms that we are dealing with the process of ageing of the homeless. More than 80% of the homeless are men of whom only 2% have higher education, 16.1% completed secondary schools, and the rest had vocational education at most. 63% of the respondents were in homeless shelters. As the main source of income, 45% pointed to social welfare benefits [28, 30, 31]. This picture fits the stereotype of a homeless person as an elderly, poor and lonely man [12, 13].

The main causes of homelessness shown in the authors' study are debts and eviction, whereas eviction is not always associated with debt. A person who is a perpetrator of violence is also subject to eviction under Polish provisions: Art. 11a of the Act of 29th July, 2005 on counteraction of domestic violence [32], Art. 17 and 25d of the Act of 21st June, 2001 on protection of the rights of tenants, housing stock of municipalities and amending the Civil Code [33], Art. 58 § 2 of the Act of 25th February, 1964 – Family and Guardianship Code [34]. Other causes include alcohol addiction, divorce, family conflicts, leaving prison. This data is in line with the social perception of the causes of homelessness [2, 34].

Other studies also confirm empirical results of the research conducted in Szczecin, recognizing that the issue of health should become a key problem for the social assistance system concerning the homeless. Age, lower motivation to undertake actions related to recovery from homelessness, limited access not only to specialist doctors but to appropriate treatment and addictions result in a decline in the overall health of the homeless. Compared to the general population, the homeless report worse mental health, and they are characterized by a higher percentage of abnormal health behaviors, such as alcohol abuse, smoking, coming down with chronic diseases [35]. A separate and important problem is the homeless staying outside shelters, in the so-called public space (channels, district heating, railway stations, parks, plots). Staying in such places is the reason for irreversible health and mental changes. Those referred to as 'people with no roof over their heads' are more prone to suffering from skin diseases (fungal infections, scabies), lung diseases (asthma, tuberculosis), wound infections, and in the winter period – limb frostbites leading to amputation. Alcohol abuse is the cause of frequent stays in detoxification detention centers. Along with health problems, there are changes in the psyche such as social maladjustment and mental disorders. As a result, the homeless perceive their health status as good and they do not accept medical assistance or protection in a shelter, and even refuse to go to a nursing home. Therefore, these individuals are often perceived as 'difficult customers' and unfortunately, actions undertaken between sectors of social welfare and health care are limited in scope in terms of regulations (insurance), and limited efficacy if a homeless person shows no willingness to cooperate [28].

Homelessness is a complex problem that will not be resolved by providing a dwelling only. The results of the studies conducted in Lodz show that 60% of the respondents felt angry that the state did not do enough to solve the problem of homelessness [2]. These studies also showed a significant percentage of contrasting emotions and feelings towards the homeless prevalent in society which, on the one hand showed pity and deep compassion (65% of women and 44% of men), but on the other hand, fear of touch and infection, skin diseases (74.3% of women and 62.2% of men) [36].

Despite the well-known importance of the problem of homelessness, there are no proposals to solve it based on scientific evidence [37]. One of the most common forms of prevention of homelessness is to provide periodic financial support to people at risk of eviction, to enable them to remain in their current place of residence. The research conducted in Chicago showed that the possibility of funding contributed to a 1.4% drop in the need for using homeless shelters over a period of 3 months and a 1.6% drop over a period of 6 months. Both relationships were statistically significant. However, the costs of homelessness can be very high (mortality, separation of children from parents), so even a small reduction in homelessness can generate significant benefits. Taking into account the impact on the health status of the homeless, the research conducted in California showed the effectiveness of prevention programs in terms of reducing the use of alcohol and marijuana among young homeless people (aged 15-25). The studies conducted in the USA show that an effective form of reducing morbidity among the homeless is health care for the homeless, which comprehensively secures social and health needs [38, 39].

The problem of homelessness requires undertaking multidimensional actions in the fields of law, psychological care, health care, wielding influence on cultural, economic and ethical factors [12, 40]. Living conditions of the homeless need to be taken into account in clinical procedures in the case of which

cooperation between health care and social assistance is required [41]. The research in this field should be developed, as well as the research on factors predisposing to obtaining home stability.

The problem of homelessness among the elderly mainly affects men with primary education who take a permanent benefit. Along with an increase in the age of the homeless, their health status deteriorates in the context of the risk of disability. Taking into account the phenomenon of ageing of society, it would be appropriate to develop prevention of homelessness (supportive measures for people at risk of home loss) and conducting systematic and interdisciplinary solutions to protect the elderly and the disabled homeless (standardization of social assistance services).

Conclusion

1. It has been shown that the health status is significantly related to the causes of homelessness. Illness is the most common cause of homelessness among people with disabilities. Among people without a disability certificate, the main causes of homelessness are debt and eviction.
2. There is no relationship between socioeconomic characteristics such as gender, education, age, income, family contact, place of residence and the health states of the homeless.
3. Prevention of homelessness should be aimed first of all to men who are not in contact with the family and to persons with disabilities. In addition, it should include counteracting unemployment and promoting legal forms of employment so that these men acquire the right to a retirement pension after reaching the retirement age.

Źródło finansowania: Praca nie jest finansowana z żadnego źródła.

Konflikt interesów: Autorzy deklarują brak konfliktu interesów.

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