

Title: Social Participation for Older People Experiencing Homelessness: A Sociocultural Framework

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Abstract

Older people experiencing homelessness (OPEH) are a rapidly growing demographic worldwide, including in Hong Kong, posing complex challenges for policymakers as populations age. This article introduces key findings from a study of OPEH, emphasizing the underexamined role of social participation in addressing homelessness. Emerging from Hong Kong's unique context, this study prioritizes how sociocultural factors affect social participation among OPEH. Constructivist Grounded Theory was employed to analyze the social participation of 44 OPEH, collecting data from them and seven service providers in Hong Kong. Six key themes were identified: three barriers (“saving face,” mental health issues, and chronic pain and age-related decline) and three facilitators (volunteerism, hidden dreams and talents, and incentives as catalysts), from which a socioculturally informed framework was developed to enhance engagement for OPEH. Drawing on voices and experiences of OPEH and service providers, this study develops a theory to support their social participation. Although specific to Hong Kong, the findings are relevant for practitioners and policymakers globally, providing a starting point for working with diverse populations and underscoring the importance of sociocultural values in understanding social participation. Through this study, a socioculturally grounded, strengths-based approach to designing and implementing programs for these individuals is offered.

Keywords: Older Homelessness, Social Participation, Constructivist Grounded Theory, Sociocultural Framework

Introduction

Older people experiencing homelessness (OPEH) face unique challenges and are an under-researched group within the broader aging population. They suffer from higher morbidity rates and a significantly higher risk of developing geriatric health conditions such as memory loss and mobility issues than their housed counterparts do (Martins & Sullivan, 2006). These conditions often lead to difficulties with activities of daily living (ADLs) and contribute to a markedly reduced life expectancy—15 to 25 years lower than average (Milaney et al., 2020). The longer they remain homeless, the more their health deteriorates, escalating their risk of premature death. In the homeless literature, “older” typically refers to individuals aged just 50 and above because their health conditions mirror those of people aged 70 or older in the general population (Hurstak et al., 2017).

As global populations age, societies and policymakers encounter challenges and opportunities, but a particularly pressing challenge is the rise in older people who experience homelessness (OPEH)—one of the fastest-growing homeless demographics worldwide and in Hong Kong. In the United States, older individuals (50+) now make up almost 50% of the homeless population, a significant rise from just 11% in 1990 (Pope et al., 2020). Similarly, in Canada, a National Shelter Study found that adults aged 50 and older were the only age group to experience an increase in shelter use, climbing from 13.5% in 2005 to 24.2% in 2014 (Segaert, 2017). By 2021, OPEH officially constituted 32% of shelter users, likely fewer than the actual number by excluding individuals who were unsheltered or in temporary accommodations (Dionne et al., 2023). In England, 9–12% of unhoused are now over 55, and

the number of homeless individuals aged 60 and older has doubled since 2009, exceeding 2,500 in 2018, with approximately 4,000 older adults in hostels each night (Age UK, 2019).

The prevalence of OPEH is also increasing in Hong Kong, where older persons 50+ years of age accounted for 65.8% of the homeless population in 2021, an increase of 13.2% since 2011 (Legislative Council Secretariat, Hong Kong SAR, 2019, 2022). Further alarming is the fact that the number of persons 70+ has nearly quintupled in the same timeframe. Notably, these government statistics, which focus solely on those visibly unsheltered, almost certainly underestimate Hong Kong's homelessness.

The consistent rise in homelessness among older adults across nations highlights an emerging trend toward an aging homeless population both globally and in Hong Kong, possibly accelerated by the economic recession triggered by the COVID-19 pandemic coupled with unprecedented rates of population aging (Flaming et al., 2021). This trend presents a significant area of concern for policymakers, social services, and researchers and demands prompt attention and strategic action.

Pathways to Older Homelessness

Homelessness among older adults is intensifying and extends beyond mere demographic aging, following two primary pathways: chronic homelessness, when individuals age while already homeless, and first-time homelessness post-50, which research indicates is now the case for the majority (Grenier et al., 2016; Kushel, 2020). The first-time group typically arises from a blend of gradual personal decline (e.g., persistent unemployment or underemployment) and acute life events (e.g., loss of a spouse/partner). Older homelessness is a complex issue underpinned by a mix of individual and structural factors. On a structural level, significant drivers include a lack of affordable housing, scarce employment opportunities, pervasive poverty, and restrictive policies that limit access to essential supports

such as healthcare and pensions. Individually, factors such as diminished social networks, isolation, bereavement, mental health challenges, and persistent underemployment or unemployment are critical contributors. Together, these elements underscore an intricate interplay of personal and societal forces precipitating homelessness among OPEH.

Pathways Out of Older Homelessness

The majority of research has explored the factors leading to older adults becoming homeless, while studies focusing on the pathways out of homelessness and on preventive measures are scarce (Bairéad & Norris, 2024). A dominant paradigm in addressing homelessness, prevalent in both policy and research, is the Housing First (HF) approach, which emphasizes immediate access to permanent housing without the need for individuals to demonstrate readiness, and includes voluntary supportive services (Clarke et al., 2019). This approach gained popularity in the 2000s and marks a significant departure from traditional models, particularly the “staircase” approach, which conditionally grants housing only after individuals demonstrate their “housing readiness.”

More than two decades of research robustly demonstrates that the HF approach effectively provides stable housing and quicker exits from homelessness (Kerman et al., 2021), but many questions remain (Tsai, 2020). Most studies have compared HF to treatment-as-usual, which does not adhere to standardized care approaches to housing. A mixed-methods analysis of 44 studies comparing various housing models, including HF, revealed no significant differences in housing stability across the models; all were beneficial (Leff et al., 2009). This suggests that the crucial factor may simply be the presence of any structured housing initiative, rather than the specifics of the HF approach. Furthermore, the evidence regarding health and social outcomes from these housing models is minimal and mixed. For instance, Kerman et al.’s (2021) systematic review of 35 studies found no significant differences in reduction of substance misuse between HF and treatment-as-usual.

Furthermore, a four-year longitudinal study in France reported an increase in alcohol misuse over time within the HF group compared with the treatment-as-usual group (Loubière et al., 2022).

Another limitation of the dominance of the Housing First paradigm in addressing homelessness is that it has primarily relied on research and policy initiatives from North America, with fewer contributions from Australia and Europe. This geographic concentration raises critical questions about the model's applicability and effectiveness across diverse contexts and emphasizes the need to explore how various sociocultural, political, economic, and welfare contexts might influence the pathways into, experiences of, and exits from homelessness. Two decades on, the persistence of older homelessness and its increasing overall numbers, combined with lingering questions about the HF approach, highlight the critical need to explore alternative, complementary pathways that align with diverse contexts.

Social Participation: An Underexamined Key Factor in Addressing Older Homelessness

Social participation by older people, or their “involvement in activities that provide interaction with others in society or the community” (Levasseur et al., 2010, p. 7), has been studied extensively and has been found to be associated with lower rates of morbidity and mortality (Hsu, 2007), reduced depressive symptoms (Mechakra-Tahiri et al., 2009), attenuated age-related functional changes (Lovden et al., 2005), improved well-being (Litwin & Shiovitz-Ezra, 2006), and reduced loneliness (Newall et al., 2009). For OPEH, social participation may enhance access to networks and resources and heighten their self-concept. Rutenfrans-Stupar et al. (2019) found that for older people living in a homeless shelter, social participation improved their social support network, mental and physical health, communication skills, self-esteem, and personal growth. These impacts of social participation

can facilitate community (re)integration—a primary outcome of programs supporting the homeless (Marshall et al., 2020).

Enhanced community (re)integration may in turn reduce older people's likelihood of returning to homelessness. Aubry and colleagues' (2016) longitudinal study of homeless individuals residing in emergency shelters found that for those who were housed after having been homeless, having larger social support networks was a predictor of their housing stability. Enhancing the social participation of OPEH is crucial not only for directly improving their health and well-being and building or strengthening their social support networks, but also as a foundational step toward employment—a key pathway out of homelessness (Marshall et al., 2022)—because they often face significant barriers, such as mental health issues, substance misuse, stigma, and discrimination. However, despite social participation's function in minimizing overall homelessness and its impact, empirical knowledge is quite limited about the role of social participation in addressing homelessness among older adults, who have distinct differences from their domiciled counterparts (Rutensfrans-Stupar et al., 2019).

Most extant research on social participation and homelessness is not specific to older people and focuses primarily on housing (Rutensfrans-Stupar et al., 2019), with mixed findings. The research has indicated a positive association between housing and social integration (Gulcur et al., 2007), no relationship between being housed and social integration (Tsai et al., 2012), a negative association between housing supports and social participation (Chang et al., 2015), and an undesirable side effect (loneliness) of housing approaches (Busch-Geersema, 2013), making it unclear whether housing alone can facilitate social participation. Supplementary and alternative approaches are therefore necessary to enhance social participation and tackle homelessness (Rutensfrans-Stupar et al., 2019).

Homelessness in older people is a complex, global issue that concerns policymakers worldwide as populations continue to age. This article presents the findings of a study that contribute to the literature on OPEH in several key ways. First, a novel focus on social participation, an aspect frequently overlooked, is introduced as a vital element in both addressing and preventing homelessness. Notably, in 2023, Hong Kong’s housing market was the least affordable in the world for the fourteenth consecutive year (Centre for Demographics and Policy, 2024). Furthermore, Hong Kong’s sociocultural landscape differs significantly from the typical settings of most homelessness research, thus offering a unique perspective on the issue. Last, this study pioneers as the first known qualitative research focused exclusively on OPEH in Hong Kong. By using qualitative methods, the study amplifies the often-marginalized voices of these individuals, drawing out their lived experiences, perspectives, and insights. This approach not only enriches our understanding of homelessness, it enables the co-creation of solutions that are informed and shaped by the voices of those most directly impacted. This study sought to answer three research questions: “What barriers and facilitators influence social participation by older people experiencing homelessness in Hong Kong?” and “What are the relationships among those factors, and how do they guide efforts to enhance such social participation?”

Materials and Methods

Recruitment and Sample

To address our research questions, Constructivist Grounded Theory (CGT), a qualitative approach that involves multiple cycles of sampling, data collection, and analysis (Charmaz, 2014) was employed. Each cycle informs and refines the subsequent one, enhancing theoretical sampling and contributing to theory development. Five such cycles were

conducted, with the findings from each helping to refine the data-collection tools (e.g., interview guides) and further develop emerging concepts.

This study sought to recruit a total of 50 participants (40 OPEH and 10 service providers), with each cycle comprising eight OPEH and two service providers. The 40 OPEH interviews were deemed sufficient for theoretical saturation, in alignment with Thomson's (2010) analysis of 100 grounded theory (GT) studies, which suggested that 30 interviews were needed to thoroughly develop the study elements. This sample size, primarily comprising OPEH perspectives supplemented by those of service providers, would provide rich data that effectively addressed the research questions.

The initial sample ($n=10$) was recruited by convenience and purposive sampling. The eligibility criteria for the recruitment OPEH required that participants be: (a) age 50+, (b) currently or previously homeless at an older age (50+), and (c) a Hong Kong resident. A maximum diversity sampling (Patton, 2015) was also employed to aim to recruit across various characteristics, such as gender and age. This study used a broad definition of homelessness, encompassing both the visibly homeless on the streets and the invisibly homeless in unstable or temporary accommodations (e.g., couch surfing, hostels, or overcrowded spaces) (Wong et al., 2016). Those OPEH unable to provide informed consent due to cognitive impairments were excluded.

Two non-governmental organizations (NGOs) involved in homeless services collaborated with us to recruit participants: a government-funded provider, and an independently funded NGO, located respectively on Hong Kong Island and in Kowloon, and thus representing a geographical spread. Their support was crucial for accessing this hard-to-reach population, as the NGOs referred participants who were receiving their services and with whom they had trust and rapport; they also helped ensure that referrals met the study's

inclusion criteria. The service providers recruited for the study were staff from the two NGOs.

Data Collection and Analyses

An initial open-ended interview guide was created and refined after each cycle based on the findings, aligning with CGT's approach where interview questions should emerge naturally (Charmaz, 2014). Interviews were conducted at NGO centers, locations comfortable and accessible for participants, and lasted 30 to 60 minutes. Each OPEH participant received an HK\$150 supermarket voucher to acknowledge their time. Interviews were audio-recorded and transcribed with identifying information removed, and then deleted to ensure confidentiality. Participants provided written informed consent and were assured of anonymity and confidentiality, with guarantees that participation would not impact their services from the referring NGOs. Staff were also assured that any identifying information would be removed.

Data collection began with an initial sample and progressed through four cycles of theoretical sampling and analysis, adhering to Charmaz's (2014) two-stage coding framework. The first stage, initial coding, involved detailed line-by-line analysis to stay close to the data and identify theoretical gaps. This process explored potential theoretical insights and also directed subsequent data collection to enrich the theory development. Theoretical sampling allowed the research team to identify additional participants, such as staff and OPEH with specific demographics and backgrounds, and to refine interview questions and prompts. Memo-writing and diagramming were CGT techniques used throughout the study to strengthen and clarify the analyses (Charmaz, 2014). These methods, combined with reviews after each cycle, enhanced the credibility and reliability of the emerging theoretical framework.

Results

The final sample consisted of 44 OPEH, whose demographic characteristics are detailed in Table 1. In addition, seven service providers (three females and four males) were interviewed, including frontline social workers, project assistants, a mental health nurse, and program managers, with three providers from one NGO and four from the other.

We identified six key themes: three barriers and three facilitators to social participation. The barriers were the need to “save face,” severe mental health issues, and chronic pain and age-related decline, and the facilitators were volunteerism, hidden dreams and talents, and incentives as catalysts. Although qualitative research traditionally emphasizes rich descriptions rather than numerical representations, specific indicators to enhance the transparency of the analytical process were included. For each theme, two numerical indicators were provided: ($n = \#$) represented the number of participants who contributed to each theme, demonstrating its prevalence across the sample, while ($\#$ refs) indicated the frequency of coded references within that theme, offering insight into the depth of discussion. These numerical indicators were not intended to quantify the qualitative data but rather to provide additional context about the distribution and richness of the themes that emerged from the analyses.

Barrier One: Saving Face—How Shame and Stigma Deter Help-Seeking and Participation ($n = 38$, 130 refs)

Shame and stigma, which are deeply tied to the Chinese concept of saving face (Kong et al., 2020), were significant barriers reported by the majority of the OPEH participants. One described how the stigma and shame associated with homelessness led to social withdrawal, with his isolation intensifying the longer he remained unhoused:

I had no social interaction. When you're a street sleeper and you feel dirty, it's natural to want to be alone. It's normal to feel low self-esteem out on the streets. You might not feel it on the first day, but it builds up over time. And without self-confidence, it's hard to show your worth. (I11, Male, 63 years old [yo])

Another participant recounted how, despite having a strong support network, stigma and shame led him to avoid reaching out to his close friends:

He [his god brother] was looking for me everywhere. He heard from my friend and knew that I got into trouble. He and I have a very good relationship. One day, randomly, I met him in a public washroom. He was surprised to see me. He seemed to want to cry when he saw me. I was like a beggar. I didn't want to see him. I turned around and walked away. He caught me. Each of them dotes on me. They are very caring, I don't want to see them, each of them lives well. Everyone has grandchildren. They are kind. My god brother told me: "I never thought you would become like this." I didn't dare to reply, I didn't even want to answer him. I don't know how to answer him ... It's not that there is no one to help you, but you really don't want their help. Maybe it's your own feelings of inferiority. If I ask for help at this age, how low have I really gone? (I11, Male, 63 yo)

Another participant shared that despite knowing there was access to resources and support, the need to save-face was stronger than her basic needs:

I don't want people to know that I'm homeless. I don't want this. They will provide us with meals and biscuits. I don't want to take these from them. I'd rather drink water to be full. They just come here to distribute food, soup, and they will give me a lot of things. They also buy me bread. I don't want to be pitied. On the one hand, I don't have enough money to pay back. I don't think it's good to get others' food But I don't have money, I have no job—so, I cannot give them food in return. I don't like this. I lose

my face even more. Yes, I would rather go hungry and drink water. I am a person like this. (I33, Female, 65 yo)

Another participant explained why she chose to only participate in activities facilitated by homeless service providers and churches, which she perceived as less stigmatizing:

So, if I participate, I will participate in activities for homeless people, they will not judge us. See, if I want to participate in some other activities, where all participants own a house and are wealthy, well, they will judge us and disrespect us. I won't participate, because I'm worried that they will look down on us or see us as inferior people. Apart from activities for the homeless, I like going to church. The church respects us homeless people. God loves everyone We won't go to participate in those activities where people will look down on us. We try to flock together with those people who are in the same situation. We do the same things and participate with them. They know what we have all been through or [are] going through being homeless. (I23, Female, 63 yo)

This theme was also found in the service provider interviews ($n = 4, 5$ refs), as one participant illustrated:

How do we make the 50+ with nonsocial behaviors and [who] are isolated, join our small group activities? It is not easy. Some of them never got services from NGOs and they also feel that seeking help from the social workers brings shame upon themselves. (S7)

Barrier Two: Severe Mental Health Issues ($n = 37, 175$ refs)

Most participants described experiences and symptoms that suggested significant mental health challenges, which they felt created substantial barriers to their social participation. Although not diagnostic, their accounts frequently alluded to serious conditions, such as

major depression and trauma. For example, one participant explained how his depressive symptoms diminished his motivation to engage:

I feel like this ... I don't know, is it? Some people say it is depression. Actually, that's a type of mental illness. There are many things ... and I don't have the motivation to deal with those things. Basically, you don't have the mood for it. You need to have this kind of mood. For example, we chat together—maybe hiking tomorrow, having a barbecue, or going swimming, but I don't have this kind of mood at all, to do these activities. (I9, Male, 71 yo)

Another participant described how her mental health declined following her brother's suicide—a traumatic event she had discovered firsthand. This experience not only led to her homelessness but continued to affect her daily mood and motivation to engage in activities.

In 2020, my younger brother committed suicide, and it took me about three years to start letting go a little bit. Because of the pandemic, he had just gotten married and started his own business. With the pandemic and not communicating with us, I was the first one to find him, but he didn't come back It was already too late when I found [him]. It had a significant impact on me... and it's been tough for me. I've been relying on medication for a long time At least 10 tablets of 7.5mg sleeping pills. But even lying down, I can't fall asleep. I just want to knock myself out quickly. If I take the medication, I'll feel better the next day. I've been relying on medication to maintain my physical stamina. I have tried to learn some classes before, and I wanted to join. First, it was because of financial reasons, and second, my life has had ups and downs, so I lost my motivation. I don't want to trouble others too much. Sometimes I wonder why I'm like this, being constantly pessimistic is exhausting. (I41, Female, 50 yo)

This theme was also referenced 17 times by six service providers, with one noting that their most challenging cases involved OPEH individuals who struggled with mental health issues and/or substance misuse. The complexity increased when these individuals were mixed with others who did not face these issues, making it more difficult to facilitate group programs effectively. “The toughest challenges are mental illness and drug addiction. We haven’t found a way to effectively help these groups, yet ... and it’s affecting the other homeless people too.” (S7)

Barrier Three: Chronic Pain and Age-Related Decline (*n* = 21, 69 refs)

Nearly half of the OPEH participants cited chronic pain and age-related decline, making it the third most discussed barrier to social participation. One participant shared that his chronic pain prevented him from joining the running club at an NGO center:

It’s been a long time. I can’t do this right now. I am too old and have too much pain.

When it rains, my whole body hurts. I fell from a truck once when I was working and hurt my back. So, I don’t run anymore, not now, my back hurts. I just walk. (I8, Male, 63 yo)

Another participant explained that despite his desire to join activities with others, he preferred to go alone due to his physical limitations:

I sometimes go hiking, usually by myself. Why? While it’s nice to have company, hiking is often a solitary thing for me. I can’t always keep up with others because of my age and health issues. Sometimes I’m just not able to keep pace. (I11, Male, 63 yo)

Other participants mentioned that aging and related health issues limited their social activities. For example, one explained that her hearing loss made it difficult to interact with others:

I don’t really have hobbies, and I had major surgery, but I’d rather not get into that. You see, one of my ears doesn’t work, so I can’t hear out of it, and my other ear always has

this constant ringing My hearing isn't great, and it really shows when I'm at the [NGO center]. My friends there ask me things, and I often get the answers wrong. They end up complaining about my responses. That's why I tend to avoid chatting too much.

(I31, Female, 72 yo)

Another participant shared their experience with cognitive decline, specifically memory issues:

I don't have any family left; my parents passed away when I was very young. I can't even remember when exactly, because these days my memory isn't what it used to be—sometimes I forget a lot of things. Like when I'm at the street stall where they measure blood pressure, I sit down and they ask for my name, and I just can't recall it. I end up having to check my senior citizen card. Maybe I am starting to develop dementia? Lately, even when people ask for my name, sometimes I just can't answer.

(I46, Female, 67 yo)

This theme was reflected by several service providers ($n = 5, 7$ refs), with one staff member explaining how their team discovered that many of their OPEH had vision problems.

Of course, their medical conditions can be more advanced, or they may have conditions that bother them a lot, such as unknown pains. There are many things that if you don't check, you don't actually know. For example, half of them can't see clearly. How do we know? We and a charity organization conducted eye tests for them, [and] we discovered this problem with their eyesight. We generally believed that mental illness, cancer, or high blood pressure are the important conditions, right? But actually, they have issues that will affect them in their daily life. Think about it: if you take off your glasses—see what I mean? (S3)

Facilitator One: Volunteerism ($n = 29, 117$ refs)

When asked about meaningful types of social participation activities, over half of the participants talked about volunteering, thus highlighting that volunteerism may be a gateway to community re-engagement for these OPEH. For example, one participant's interest in volunteering led him to NGO outreach services and eventually to formal employment:

It took a long time for [NGO] to persuade me. It wasn't until ... almost a year and a half that I really started to talk to them. Actually, some of them had been in contact with me for a long time, but I didn't care, until [staff] said, "I have a volunteer job. Would you like to try it?" I looked up, and finally started to talk to him, and I said, okay, [I'll] give it a shot, and that's how it started, but it went from volunteering, to them asking me to work part-time, until now, that I've found a job. (I17, Male, 60 yo)

Another participant discussed the impacts of volunteering for people even older than he, and its influence on his mood, "It affects everyone. Sometimes I see elders older than me with weaker legs, even worse off than I am. If I can help, it makes me happier When they feel happy, I feel happy too. Everything has two sides." (I11, Male, 63) Another participant noted that volunteering not only improved his mood but also expanded his social support network:

I used to be pretty short-tempered, and when I first got to Hong Kong, all I cared about was making money. I never thought about volunteering; to me, working for free was just foolish. But then I started helping out at [NGO], and things changed. I've made lots of friends through volunteering, and some of these friendships are really strong now. Like with [Name of Friend]—he doesn't even live in my dorm, but we met while delivering meals and doing volunteer stuff together. He's a really nice guy. He used to ignore me, but now he's always ready to lend a hand with our projects. It feels great to be part of a group that has the same goals, to walk together and help out together. It makes you happy. And the biggest thing for me, after all these years of volunteering, is that it's helped me feel less lonely. (I43, Male, 68)

Another participant echoed that volunteering boosts mental health:

I volunteer sometimes, mostly to pass the time and keep from feeling lonely or thinking negative thoughts. A lot of people get into trouble with their minds when they have too much time on their hands. Helping others, well, it kind of lifts my spirits and is good for me. If I've got the time, I'll do it. If not, then I won't. (I22, Male, 57)

This theme, too, emerged in the service provider interviews ($n = 4$, 5 refs). "Yesterday, I took them to bring hot soup to a sick homeless person. As soon as we left, they said, 'Let's go together. Let's go.' They now care about helping others. I see this social transformation as a great help." (S4)

Facilitator Two: Hidden Dreams and Talents ($n = 15$, 29 refs)

When asked about their current interests in activities, approximately one-third of the participants reflected on past dreams and talents, sharing a variety of unique talents and interests:

You used to have dreams and then you stopped thinking about them after growing up, those things, right? ... For decades, I only have [had] one dream ... it's just a dream ... Chinese medicine. I've had it since I was young. My grandfather was a traditional Chinese medicine practitioner. Um, I also studied in Hong Kong, and I took some short-term courses. No, but they are all dreams ... (I10, Male, 52, Male)

It's not smoking or drinking. Those [interests and hobbies] are all things you can't guess. I liked raising fish when I was a child. Breeding tropical fish on my own. Taking some fish of this species and breeding them with another species, mixing up the breeds, it's a lot of fun. (I15, Male, 68)

Again, this theme was also reflected in staff interviews ($n = 3, 8$ refs), where, for example, one staff member envisioned a social participation approach for OPEH:

Hmm ... If we don't consider resources and cost? I am allowed to think wildly? Ha-ha. I was thinking about having a center that is actually [run] by them [OPEH]. It could be a resource center for the homeless. Because through their experiences, they know what they actually need. I also think that it depends on what THEY want to do, maybe starting some activities that they can manage. For example, one member is originally from Thailand who likes to cook, maybe she can open Thai food workshops for the public to participate in, how about that? I think in addition to providing resources, it can be providing jobs. Is there the space to let them demonstrate their own strengths? (S2)

Facilitator Theme Three: Incentives as Catalysts ($n = 31, 93$ refs)

Participants indicated that incentives were a key factor driving their engagement in activities ($n = 31, 93$ references). For instance, when asked how he initially knew about the NGO center for activities, one participant shared that it was due to incentives: "Other homeless friends told me I could get meals here, so I signed up and came here. They also have some gifts, which are more attractive. It's important that we can get meals, thanks to them." (I32, Male, 69).

Interestingly, one NGO encouraged the OPEH to participate in activities at the centers by offering to waive their rent for temporary housing/hostel accommodations, which participants said motivated their engagement, as one participant opined:

They told me that to live in the dormitory I need to attend their activities at least three times a week and I can get lunch and dinner from here. Ping Pong, workout, etc. It's compulsory. At first, I wasn't that happy ... but for the dormitory, I had to. Yes, but later I found that I was benefitting from it. (I38, Male, 59)

This theme was also noted by two service providers ($n = 2$, 6 refs). For instance, one explained why OPEH joined their running program, saying:

Actually, if you ask me, the meal is the main incentive. Honestly, if you look at their [OPEH] level, they have never exercised, so the incentive of exercise itself is not significant for them, but when we introduced the meal, more people participated. Of course, there may be some people who purely come for the meal, but relatively, they all participate. I think, from our perspective, we have won them over, because ultimately, they don't just come for the meal anymore, we hope to have some kind of change in this group. I think that's the original intention. We want them to try first and then gradually realize the benefits of exercise. We want to develop in this direction. (S6)

Discussion

Homelessness is one of the most severe forms of social exclusion, and engaging OPEH in social activities can be a crucial first step toward fostering their social inclusion and facilitating their (re)integration into the community. Such participation could both provide pathways out of homelessness and have implications for its prevention. This study examined what helps and hinders social participation among OPEH in Hong Kong, and explored how the relationships between those factors could inform strategies for improving their social engagement. Constructivist Grounded Theory was employed to collect and analyze data, facilitating the development of a theory of social participation for OPEH in Hong Kong. The resulting theoretical framework, illustrated in Figure 1, can aid practitioners and policymakers in enhancing the social participation of older people experiencing homelessness. What are the practical implications of this framework? First, it highlights how face-saving—a salient construct in Chinese culture, particularly among older generations

(Kong et al., 2020)—influences how OPEH engage with services and social activities. An understanding of this cultural construct is therefore crucial for designing approaches that promote social participation by this population. Notably, the findings indicate that despite the availability of supportive services and programs, OPEH might choose to save face rather than use supports and services that could be seen as losing face. This insight helps explain why OPEH may be reluctant to use mainstream services, such as the senior centers in Hong Kong that are extensively available across the city’s 18 districts (Social Welfare Department Hong Kong SAR, 2023), and instead prefer to engage with homeless service providers and churches, which they perceive as less stigmatizing.

Therefore, to help OPEH (re)integrate into the community, services should create bridges between current support systems (e.g., homeless service providers and churches) and mainstream services (e.g., senior and community centers). Such bridges can enhance the competencies and training of mainstream service entities to ensure their inclusivity, accessibility, and protection of face-saving, thereby reducing stigma for OPEH. Furthermore, this key barrier aligns with two of the key facilitators—volunteerism, and hidden dreams and talents. Leveraging these factors will allow for shaping social participation in a way that highlights the strengths of OPEH and emphasizes their potential as contributors to society, thus supporting their face-saving and enhancing their engagement.

Second, this framework reveals another crucial need—while mainstream services need to become more inclusive of OPEH, homeless service providers also need to strengthen their expertise in aging issues. The findings reveal that age-related challenges, such as cognitive decline and hearing impairment, create significant barriers to participation. Therefore, both types of services must adapt: mainstream centers need to reduce stigma, while homeless services must become more age-friendly. Moreover, the challenge of developing age-friendly services and programs for homeless populations is not unique to

Hong Kong, as this study has revealed, but represents a worldwide need to address this expanding population. A key priority should be building the gerontological competencies of homeless service providers (Weldrick et al., 2024).

Third, it is unsurprising that the theoretical framework aligns with much of the existing literature pointing to mental health issues as a key barrier to services, social participation, and homelessness exits (Kerman et al., 2019). However, the findings also elucidate an area of mental health that may be critical to explore further, when contemplating how to enhance social participation of OPEH—the role of trauma in shaping that participation. In a systematic review and meta-analysis examining the prevalence of PTSD among homeless individuals, Ayano et al. (2020) analyzed data from 19 studies involving 20,364 participants across seven countries and found that the pooled estimate of PTSD prevalence was 27.38%, which is significantly higher than that observed in general population studies. For comparison, Goldstein et al. (2016) reported a lifetime prevalence of PTSD of 6.1% in a nationally representative study in the U.S., and Xi et al. (2017) found a prevalence of only 0.3% in Beijing, China. Trauma can precipitate homelessness; for instance, recall that one participant recounted how her brother’s suicide catalyzed her own spiral into homelessness. Moreover, the experience of becoming homeless can itself constitute trauma. Therefore, a deeper exploration of how trauma affects older adults is crucial, particularly regarding trauma’s cumulative impact over a lifetime and the underexamined phenomenon of late-life trauma (Kusmaul & Anderson, 2017).

Specifically, this finding underscores the need for trauma-informed care (TIC) in designing services and activities for OPEH. The principles of TIC, such as ensuring physical and emotional safety, maintaining transparency, offering choices, and fostering collaboration, focus on empowering clients by recognizing and utilizing their strengths in the healing process (Harris & Fallot, 2001). Importantly, trauma-informed care does not necessarily

involve discussing the trauma itself or delving into the details of traumatic experiences—the focus is on providing services and support in a way that is mindful of and sensitive to the trauma that individuals may have experienced, without requiring them to disclose or discuss their traumatic experiences. Indeed, social participation activities can integrate elements of arts-based and body-centered classes, such as dance and yoga, which are alternative, healing-focused approaches (Van der Kolk, 2014). Furthermore, these alternatives may actually be more accessible to cultures and generations such as the participants in this study, where face-saving plays a key role, and traditional talk therapy may not resonate or be socioculturally acceptable to such participants with trauma.

The study's framework emphasizes that key barriers to participation, such as mental health issues, cultural practices such as face-saving, and age-related declines (e.g., hearing, vision impairments, chronic pain, cognitive decline), are often “invisible,” yet they significantly hinder social engagement and thus need to be more prominent in assessments and support strategies. Furthermore, the framework categorizes these barriers into biological, psychological, and sociocultural factors, thus advocating for a bio-psycho-social approach (Engel, 1977) that identifies and addresses them intersectionally, to enhance social participation for older people experiencing homelessness.

Another way for this theoretical framework to inform practice can be through its facilitators—specifically, the two key themes of hidden dreams and talents, and volunteerism—which emphasize the need for strengths-based activities and approaches that identify and leverage the unique talents and interests of OPEH. By involving these individuals in the co-creation and leadership of activities tailored to their skills and past interests, and adapting physical activities to be age-appropriate, more meaningful engagement can be fostered. This strengths-based approach should not only enhance their mental well-being but also facilitate their more effective (re)integration into the community. Such

strengths-based programming can also address the third key barrier, face-saving, by incorporating practices that uphold this important cultural construct.

Last, and quite practically, the study's framework identifies the important role of incentives in enhancing the social participation of OPEH. Many participants reported that initial motivators, such as free meals and supermarket vouchers, were the main reasons they participated, but over time these were no longer the sole reasons. This theme would appear to contrast with the key theme of face-saving, which typically discourages accepting handouts—but individuals might instead view receiving such assistance as a reward for participation or as part of a mutual exchange, thus preserving their dignity. Furthermore, if this practice becomes normalized within their community or peer group, they may consequently experience less stigma or loss of face. This motivator theme emphasizes a practical enhancement to supportive approaches aimed at engaging OPEH through offering incentives presented as recognition of participants' time and contribution, not as charitable handouts. Delivered particularly as a reward or part of a mutual exchange, incentives could be vital for OPEH, who often face employment challenges due to age-related decline and ageism in the workplace, and who often need support for basic necessities.

Conclusions

This study's findings should be interpreted in light of two key limitations. First, the sample was predominantly male (75%), despite efforts to recruit additional females in later cycles—perhaps because of the higher likelihood of females being “hidden homeless” (Wong et al., 2016). Thus, although female voices were represented in each theme, further examination of gender-based perspectives on social participation is still required.

The second key limitation to interpreting the findings was that they are specific to the unique sociocultural, political, economic, and welfare context of Hong Kong. Whereas this study enriches the literature by adding insights from a geographic context that is largely

distinct from that of North America, that specificity also constrains its broader applicability. Still, the findings can be valuable to an international audience—the number of OPEH is increasing globally, including in Hong Kong, thus calling for innovative solutions and prevention strategies. At first glance, social participation might warrant a secondary focus in support services for OPEH, considered after securing their stable housing and employment. However, it is argued that social participation is an underexplored and underrated factor that is vital for exiting and remaining out of homelessness and could well be the initial step in reintegrating back into society.

This study, by drawing on the voices, lived experiences, and perspectives of OPEH themselves and their service providers, developed a theory for supporting their social participation. Although specific to Hong Kong, the findings are relevant for practitioners and policymakers across contexts and provide a starting point for working with culturally diverse populations. The theoretical framework emphasizes the importance of sociocultural values in understanding social participation and offers an alternative, socioculturally grounded and strength-based approach to designing, implementing, and evaluating programs and services for OPEH. For policymakers, this study underscores the importance of integrating social participation into policies and services for OPEH and advocates for recognizing social participation as an essential service rather than an optional or secondary consideration.

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Table 1

Demographic Characteristics of the OPEH Participants

Category	Participants (N = 44)
Gender	
Females	11
Males	33
Age (in years)	
50 – 59	13
60 – 64	10
65 – 69	10
70 – 74	10
75+	1
Homelessness status	
Chronic	34
Newly (Never been homeless or homeless less than 12 months)	10
Educational level	
No education	9
Primary	13
Secondary	15

High school diploma	2
Bachelor's degree	2
Preferred not to say	3
Employment status	
Full-time employment	5
Part-time employment	7
Self-employed (Freelance)	1
Informal work	6
Unemployed	25

Figure 1

A Socioculturally Informed Theoretical Framework for Enhancing Social Participation Among Chinese Older People Experiencing Homelessness in Hong Kong

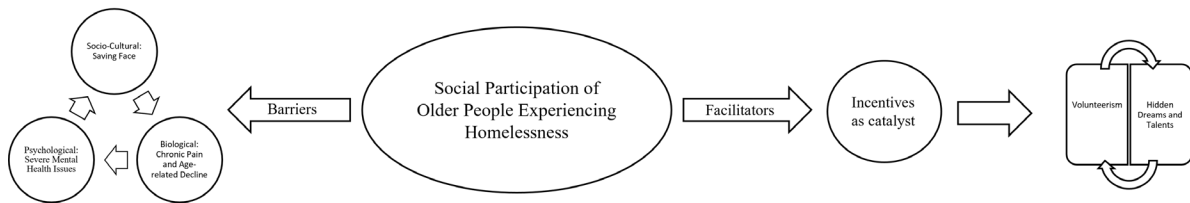


Figure 1 [Alt Text]

A Process Graphic: On The Right, An Arrow Leads From Social Participation of OPEH to Incentives as Catalysts. From Which Another Arrow Points To Intertwined Volunteerism And Hidden Talents. On The Left, An Arrow Points from Social Participation of OPEH To A Cycle Linking Saving Face, Chronic Pain and Age-Related Decline, And Severe Mental Health Issues.

List of Figures

Figure 1: *A Socioculturally Informed Theoretical Framework for Enhancing Social Participation Among Chinese OPEH in Hong Kong*

Figure 1 Alt Text: *A Process Graphic: On The Right, An Arrow Leads From Incentives To Intertwined Volunteerism And Hidden Talents. On The Left, An Arrow*

Points To A Cycle Linking Saving Face, Chronic Pain, Age-Related Decline, And Severe Mental Health Issues.