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Am J Public Health. Author manuscript; available in PMC 2013 December 02.

Published in final edited form as:
Am J Public Health. 2013 December ; 103(0 2): . doi:10.2105/AJPH.2013.301309.

Elderly Homeless Veterans in Los Angeles: Chronicity and precipitants of homelessness

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Abstract

We interviewed 33 chronically and 26 acutely homeless veterans aged 65 and over about their health and mental health, education and employment experience, social support, service needs and other precipitants of homelessness. Chronically homeless elderly veterans were more likely to have lower levels of education, had greater numbers and longer durations of prior homelessness, fewer social contacts providing instrumental support, and were more likely to report financial barriers to procuring housing. In response to open-ended questioning, elderly homeless veterans revealed how health and substance use issues interacted with loss of social support and eviction. The results suggest the importance of healthcare access and substance disorder treatment among elderly veterans and informs service delivery. Further research with larger samples is needed to confirm the characteristics and needs of the elderly homeless veteran population.

Keywords

elderly homeless veterans; homeless chronicity; precipitants of homelessness

Introduction

In 2007, the U.S. Departments of Housing and Urban Development and of Veterans Affairs conducted the first comprehensive census of homeless people and found that a disproportionate number of the homeless population were veterans.[1] The population of veterans overall has been aging: Veterans over the age of 65 accounted for 38% of the total veteran population in 1999 and the most current estimate projected this would rise to 42% in 2011.[2] Elderly veterans are approximately twice as likely to be homeless as elderly civilians: Thirty-nine percent of homeless veterans were 51–61 years of age and 9% of homeless veterans were 62 years or older (compared to 19% and 4% respectively for same-aged groups of homeless non-veterans).[1]

Researchers have proposed a cumulative risk model composed of risk and protective factors to explain homelessness among elderly people.[3–6] Risk can include life events (death of spouse, marital breakdown, exiting employment, evictions), problem conditions (mental illness or medical conditions), and internal/external factors (minority status, higher levels of

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Author Contributions: C. van den Berk and J. McGuire concieved study. J. McGuire supervised the study and supplied dataset. C. van den Berk completed the analyses and led the writing.

Human Participation Protection Statement: The study procedures, including informed consent, were approved by the Institutional Review Board of the VA Medical Center providing the funding for the services (IRB# MCGUIRE0013).

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disruptive events during childhood, including parental incarceration or a history of substance abuse).[4;7;8] Multiple risk factors increase the likelihood of negative outcomes, including substance abuse and increased mental health problems.[9] To date, there has been little research on the relationship between such risk factors and their impact upon the trajectory of homelessness for either elderly homeless and scant attention to elderly veteran homeless.[10] Relatedly, in recent years, risk for chronic homelessness is a major concern in the literature on homelessness. Chronically homeless individuals have been found to be more likely to have more severe mental health, physical and substance abuse issues.[11–13] Little research has been done on chronic homelessness among the elderly[14] with no attention to homeless elderly veterans.

Research that does exist finds that - in comparison to non-elderly homeless - homeless elderly people have been found to experience a wider, more intense array of medical, psychological and social problems,[15] cognitive impairments and dementia,[15] greater sensitivity to the effects of alcohol and drug use, [16] dramatically lower rates of being married,[17] and weaker social ties.[18] These issues can affect elderly peoples' ability to make housing decisions and/or can increase the likelihood of eviction or abandonment by family or other support persons.[19] Other research suggests that length of time the elderly are homeless has been found to vary in relation to the timing of events during different life stages, for example, disruptive events (foster care, parental separation or incarceration, etc.) during childhood, impact of limited education, health and substance abuse problems during middle-aged upon occupational functioning, and significant loss in older age.[7]

For veterans across all age groups, a large body of research that has compared the characteristics of homeless veterans to non-veteran homeless people indicates that profiles of homeless veterans contrasts those of elderly homeless: Homeless veterans are slightly more likely Caucasian, are better educated, are more likely to have a history of marriage (as well as divorce), and are more likely to have serious alcohol problems than drug problems.[1; 7; 13;20] The cumulative risk model has also been applied to homeless veterans and has shown that additional risk factors such as combat exposure, wartime trauma and post-traumatic stress disorder increase vulnerability to homelessness.[21]

Cohen (1999) has concluded that older homeless people are "invisible" to researchers, policy-makers, and the public at large.[3] To provide visibility to elderly homeless veterans as a significant homeless elderly population and to contribute to the understanding of homeless chronicity in this group, we conducted interviews with a sample of elderly homeless veterans receiving transitional housing services during 2003–2005. Given the specific vulnerabilities of veterans, the study had two goals in examining issues relevant to homelessness for this sample. The first was to examine their characteristics, comparing those who were chronically homeless with those who were acutely homeless. The second goal was to better understand what precipitated homelessness through the veterans' own narratives compared to structured questioning across a broad range of potentially precipitating factors.

Methods

Recruitment of participants for the study was conducted at two VA-funded specialized transitional living programs for homeless elderly veterans located in Los Angeles, California. Veterans can receive services in these programs for up to 2 years. In order to be eligible for the study, veterans had to be homeless at program entry and at least 65 years of age.

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Staff from these programs identified veterans and determined their interest in participating in study. Graduate social work research interviewers screened participants with a short series of questions designed to ensure that the participant was able to understand and to provide informed consent for the study. The study procedures, including informed consent, were approved by the Institutional Review Board of the VA Medical Center providing the funding for the services (IRB# MCGUIRE0013).

Measures

Variables measured – including those identified in Cohen's 1999 framework – included sociodemographic characteristics, combat status, disruptive events during youth, social support, criminal history, health and mental health status, service needs, barriers to housing, and factors leading to homelessness.

Chronic homelessness status was identified using the Housing and Urban Development (HUD) definition of chronic homelessness: Continuous homelessness for a year or more or four or more episodes of homelessness over the past 3 years, accompanied by a disabling condition.[34] All veterans in the study reported a disabling medical or psychiatric condition defined as a serious medical condition or psychiatric diagnosis, so chronicity was differentiated by homeless history.

Socio-demographic characteristics measured include age, race/ethnicity, marital status, years of education completed, and income in the past 30 days. As an indicator of combat status, veterans were asked how many months they had spent in a warzone.

Other social status measures included troubles in childhood, criminal history, and social support. Disruptive childhood events, measured as historical stressors, was calculated as a sum across 11 events, including for example, living in foster care, physical abuse or parental estrangement[22;23] We assessed criminal history through number of arrests and number of months of lifetime incarceration.

The Lubben Social Network scale assessed instrumental and emotional social support among family and social support among neighbors or friends.[24] In addition, a general social network measure assessed the number of relatives, friends and acquaintances the respondent has in the Los Angeles area.

The veteran's physical health status was assessed by asking whether he had ever been told by a doctor or nurse practitioner that he had any of 22 serious health problems such as high blood pressure, hypertension and Hepatitis A.[25] A summary score of the number of chronic and acute conditions identified comprised the current health status score.

For mental health status, veterans were asked whether a doctor had ever given the veteran a psychiatric diagnosis of schizophrenia, PTSD, depression, bipolar disorder or other serious emotional problem. Past and present alcohol and illicit drug use problems were assessed by asking the questions: "Do you have a problem with alcohol or drug dependency now?" and "Have you had a problem with alcohol or drug dependency in the past?" Interviewers also assessed for cognitive impairment using the mini-mental state examination (MMSE), a brief 30 point questionnaire testing arithmetic, memory and orientation functions.[26]

Service needs scores were derived by first asking respondents to pick services they currently needed (including those services currently being received) from a list of services. The services identified as needed were then collapsed into 7 categories and reported within the following categories of need: (1) mental health services, (2) health services, (3) substance

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abuse services, (4), financial services, (5) housing services, (6) case management services and (7) nursing services.

Barriers to becoming re-housed and the veteran's explanation of current homeless status were assessed through a series of questions. Veterans were asked what was preventing them from living in permanent housing. Responses to this open-ended question were collapsed into the following categories: (1) financial problems, (2) record of institutionalization in prison (or psychiatric hospital), (3) eviction record, (4) health problems, (5) not interested in permanent housing, and (6) other.

Precipitants of homelessness were assessed using observation, open-ended and structured questions. Veterans' responses to open-ended questioning ("How did you first end up in the program?") specifically referenced the homelessness episode, prior to program entry, provided veterans' perceptions of entry into homelessness. The responses to open-ended questions were transcribed, along with observational notes about each respondent and examined for patterns using Atlas ti. Initial thematic analysis revealed 7 different types of factors leading to homelessness. The first author coded responses and observations into 7 categories of veteran-explained reasons for becoming homeless: (1) financial, (2) landlord, (3) health, (4) personal crisis, (5) social support, (6) substance abuse and (7) mental health. Further thematic analysis provided a deeper understanding of how the categories interacted.

Structured responses explaining the onset of homelessness were queried later in the interview, when veterans responded to a series of structured queries preceded by, "Now I am going to ask you about some reasons that people become homeless. Which of the following led you to become homeless most recently?" Eighteen possible reasons were queried. To provide comparison to the open-ended question responses, these were also coded into the same 7 categories above.

Analyses

We compared characteristics of chronic and acutely homeless veterans using chi-square for categorical variables and t-tests for continuous variables. Chi-square tests (Fisher's exact test where appropriate) were then used to compare the frequency of structured and unstructured responses within each category; paired t-tests were used to examine differences in the total number of precipitants across unstructured and structured responses.

Results

Chronic vs. Acute Homelessness among Elderly Veterans

Table 1 reports the sociodemographic characteristics of the homeless elderly veterans. A little over half (56%) of the veterans were chronically homeless at admission. Veterans in both chronic and acute groups were on average 74 years of age. Black veterans made up the highest percentage of the sample of respondents, 42%, but there were no differences in race between the chronically and acutely homeless. Similarly, there were no differences in marital status. The percentage married, 5% across the two groups, is similar to that of other homeless populations.[17] For the overall sample, the percentage without a high school diploma was lower than national averages for elderly aged 65 and older (27% for elderly veteran homeless compared to 35% of the general population).[33] Acutely homeless veterans were more likely to have more years of education than chronically homeless. Most of the veterans in the sample had served in the World War II through post-Korean/pre-Vietnam eras. Average warzone exposure was slightly over 6 months, with no differences between the two groups.

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With regard to background, the two groups had an average of three disruptive childhood events or stressors, with no difference in the summary scores between the two groups. The most frequently experienced events prior to age 18 included loss of one or both parents before age 18 (52%), family income low enough that sometimes it was not possible to meet monthly expenses (42%) and having had friends in trouble with law or school authorities (29%) (data not shown). The two groups did differ significantly in homelessness history: On average, chronically homeless veterans had three times the number of homelessness episodes and five and one-half more years of total time homeless than the acute group. Both groups had histories of substantial numbers of arrests and time incarcerated, but differences between the two groups were not significant.

Current parole/probation status indicated no difference in monitoring by the criminal justice system. Current income from all sources also identified no differences: Both chronic and acutely homeless veterans earned approximately $1000 a month. While size of social networks was similar, acutely homeless veterans had a larger social support system to rely upon for ‘instrumental’ help and a trend toward a larger emotional support system.

Physical and mental health variables reveal a range of clinical problems, but no significant differences between the two groups. The groups did not differ in cognitive impairment as measured by MMSE score. The sample MMSE scores were similar to scores (27 ± 1.5) of seniors of the same age and education.[27]

For service needs among the overall sample, housing was reported as the top need for all veterans, followed by needs for health, financial, and case management services. Although service needs were equivalent, chronically homeless veterans were more likely to report financial barriers to being re-housed.

Qualitative Analysis of Precipitants Leading to Homelessness for Chronically and Acutely Homeless Elderly Veterans

Three quarters of the sample (N=44) answered the open-ended question on factors relating to their homelessness. As seen in Table 2, veterans identified a range of homelessness precipitants in their responses to the structured and unstructured questions. There were no significant differences between responses in structured and unstructured questioning within each of the precipitant categories but respondents did offer more precipitants to homelessness when given structured responses. However, the average number of precipitating factors within structured and unstructured response categories did not differ between the chronically and acutely homeless groups (data not shown).

The narratives from unstructured responses of the veterans (names are fictitious) provide helpful details about how these precipitants leading to homelessness interact with each other. Richard and Jameson provided typical answers for respondents listing loss of social support as a reason for homelessness in open-ended questions. It was common that respondents answered that they became homeless after leaving (or being evicted from) the home of a son or daughter. However, they generally seemed to do so willingly, seeing their substance abuse, health issues or mental health issues as a cause of additional burdens to their relatives. For example, Richard, an alcoholic who occasionally convinces his daughter to bring him into a sober living facility illustrated this by sadly commenting on the caretaking role reversal implicit in this arrangement.

Among those living on their own, health and substance use often interrelated with ability to keep housing and eviction. When eviction occurred, it often exacerbated health problems. Vincent was a seventy-four year old man who has been homeless since 1989. He explained that he first became homeless when his landlady sold the apartment building he was living

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in. This loss of housing because of eviction appeared to cause significant stress on the part of the respondents like Vincent. It was common that respondents had cardiovascular disease, a condition known to be a major cause of mortality among the homeless, which is exacerbated by stressful conditions associated with eviction.[35] Other more commonly reported ongoing problems made more difficult with eviction, included cancer, severe swelling of limbs and severe asthma.

Mental illness, an interrelating factor connected to all these precipitating events, often sat at the back of respondents mind and rarely came up during open-ended interviews. However, the relationship between the course of mental illness and homelessness is captured in the story of Phil who thought he would make a career out of being in the Air Force but was later disbanded for "speaking up" about the treatment of fellow African Americans in the South. Phil did not directly call himself mentally ill. Rather, he spoke about racially motivated violent incidences, including a black man being hung by the Ku Klux Klan, which have traumatized him and stayed with him his whole life. Throughout the interview he had a hard time controlling his emotions about these events. Although Phil had worked for about 15 years as an aircraft mechanic, he had also been admitted to psychiatric hospitals approximately 20 times. At 65 years of age he continues to emphasize work and wanting to work. His ability to work however, had been interrupted by paranoia and suspicion which made it difficult for him to maintain a stable job and housing.

The same thing happened with Jack who reported substance abuse and social support issues as the cause of his homelessness. Before the formal interview, Jack spoke about having encountered extreme trauma from being raped at gunpoint when he was young. His resulting PTSD had led to drug use which originally led him to go to the VA for assistance. At the time, Joe had been living on the streets or on the beach, in his car, or with his daughter or friend. He spoke about his substance use problems in relation to the legal system and social welfare policy. His experience seems to resonate with that of many homeless who have high arrest rates due to petty violations, which keep them homeless longer.[28] Joe had lost his social security while serving time to clear a warrant because current social security is suspended if an individual is admitted for more than 30 continuous days in jail or prison and can be reinstated only one month following the month (s)he is released.[31, 32]

Discussion

The narratives from veterans speak to the range of factors that are important to veterans in their accounts of onset of their homelessness. Roughly divided between chronically and acutely homeless veterans, this study of 59 homeless elderly veterans found substantial levels of physical, psychiatric, and social impairment across both groups. More similar than different, the only differences between veterans with relatively little homeless history and those who had been chronically homeless were that chronically homeless veterans were less educated and had less of a social network. Both groups identified financial barriers as the primary challenge to re-housing, and listed housing, health, and financial service needs for assistance to re-house in a city known for its high cost of housing. Detailed questioning identified a wider range of factors precipitating homelessness than were subjectively volunteered. Personal statements by veterans emphasized the personal importance of the loss of social support as a precipitant leading to homelessness.

It is surprising to find little difference between chronic and acute groups given the current emphasis in the literature on the importance of differences between these groups in homeless populations in general and in prioritizing services to those who are chronically homeless. An additionally noteworthy finding in the study was the lack of cognitive dysfunction of the veterans whose average age was 74. Both findings run counter to conceptual speculations

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regarding an older homeless population, and may indicate that older homeless people are generally more equivalent in disability burden regardless of homeless chronicity, yet may or may not necessarily be less cognitively impaired than non-homeless elderly populations of similar age.

Further, the study findings suggest that assessment of a range of factors or domains is needed to address risk factors and events leading to homelessness and that assessment should be conducted using open-ended questions in order to allow veterans to emphasize what they view as the most important causes of their homelessness. The importance of individualizing intervention once the range of pertinent issues is identified is underlined in this veteran's comments:

> "It just appears to me that they have a one size fits all mindset when it comes to handling veterans' problems. One size fits all. And this is absurd. I mean, people come into a place like this for various reasons. Either they're depressed because their marriage broke up, they're depressed about their financial situation, they're depressed about their medical situation…I know this from life's experiences here in Southern California and the Los Angeles area-unless you've got a lot of money, it isn't possible for the average person to find a really decent, safe place to live."

This veteran's comments resonate with housing issues raised among other elderly veterans in our sample, a group with significant health, mental health, legal, benefit-related issues, substance use and other conditions, and whose homelessness is often associated with loss of social support. This is a portrait that calls for supportive housing, one in which the strong peer support networks among veterans could play critical roles in constructive feedback as well as companionship, and instrumental assistance. Affordable housing programs, which provide services to the elderly, like HUD's Section 202 program, only make up 20% of affordable housing available to the elderly and only house approximately 300,000 out of the 3.8 million very low-income elderly.[29] If these low-income elderly are anything like our sample, many could be contenders for long term care but due to their economic status, cost containment strategies on the part of states (which limit functional eligibility and create long term care waiting lists), they often are only considered for "housing first" supportive housing which often focuses services on populations who are much younger.[30]

There are long term housing options for veterans who have sufficient income to live in a house or apartment, veterans who have sufficient income to live in a board and care home, or for veterans who are disabled enough to require nursing or other long term care. The two prominent options that exist for veterans not in these circumstances are the HUD-Veterans Affairs Supportive Housing (HUD-VASH) housing voucher+case management program specifically designed for veterans and a newly implemented strategy for "permanent housing in place" funded by VA's Grant & Per Diem program (GPD). Both programs emphasize case management services and both have provisions for congregate living that is veteran-specific. How much access and with what outcomes elderly homeless veterans, particularly those who are not chronically homeless, obtain to these programs should be examined in the evaluation of these programs.

Which raises the study's most important limitations. The sample size was small, comprised solely of male veterans receiving transitional residential services, and was recruited via convenience sampling methods through a VA transitional housing program. Findings here are thus not generalizable to elderly homeless veterans (or non-veterans) across the homelessness spectrum. Future study on homeless elderly veterans and homeless elderly over the age of 65 should use larger and more diverse samples across a number of different sites and include objective measures of patient diagnoses (i.e. from patient medical records) to confirm or challenge findings here across larger elderly populations in the GPD and

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HUDVASH program. Further study of the population is also needed to identify the range of available income supports and access strategies needed to assist elderly homeless veterans to secure stable housing. Accurate assessment and appropriate services will be important in addressing this specific sub-population of homeless veterans to insure that the VA Secretary's goal of eliminating veteran homelessness is actually realized.

Acknowledgments

Manuscript preparation was funded by the National Institute of Drug Abuse Training Grant (tT32DA007313). The authors would like to acknowledge Molly Banks, MSW, who conducted the study interviews with expertise and patience, and the VA Greater Los Angeles Healthcare System Homeless Program for its support of the study project.

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Table 1

Homeless elderly veterans: Sociodemographic and health, characteristics, service needs, and housing barriers (N=59).

	Total sample N=59 (N or mean ± standard deviation)	Chronically homeless elderly veterans N=33 (N or mean ± standard deviation)	Acutely homeless elderly veterans N=26 (N or mean ± standard deviation)	p-value
Demographic:				
Age	74±5.8	74±5.7	74±6.0	ns
Sex (male)	100	100	100	ns
Race:				
Alaskan Native/Native American	2	3	0	
Black, not Hispanic	42	49	35	ns
Hispanic	7	3	12	
White, non- Hispanic	37	27	50	
Other	12	18	4	ns
Marital (married)	5	3	8	ns
Education:				
GED	27	32	19	ns
Years of education	13.0±2.4	12.5±2.1	13.8±2.6	.05
Military:				
Service era:				
Pre-WWII	2	0	2	
WWII	17	15	19	
Pre- Korean	12	12	12	
Korean	48	52	42	
Post- Korean/pre-Vietnam	46	42	50	
Vietnam	10	9	12	ns
Warzone exposure (months)	7.5±11.6	6.6±10.3	8.7±13.1	ns
Social:				
Disruptive Childhood Events:				
Disruptive events (childhood)	2.8±2.0	2.7±2.1	3.1±1.7	ns
Homelessness:				
Lifetime homelessness (times)	3.1±4.0	4.4±5.1	1.6±0.9	.008
Lifetime homelessness (years)	3.3±5.6	5.8±6.6	.3±0.2	.001
Criminal history/status:				
Lifetime arrests	6.1±9.5	6.4±9.4	5.8±9.8	ns
Lifetime months in jail/prison	25.0±84.7	16.9±39.4	37.6±123.2	ns
On parole/probation	11	13	9	ns
Income/employment				
Income (received past month)	$962±358	$936±316	$998±412	ns

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	Total sample N=59 (N or mean ± standard deviation)	Chronically homeless elderly veterans N=33 (N or mean ± standard deviation)	Acutely homeless elderly veterans N=26 (N or mean ± standard deviation)	p-value
Longest job (years)	15.8±12.3	14.0±10.0	18.3±14.7	ns
Social network/support:				
Close friends/relatives nearby (number)	5.7±8.2	5.2±8.9	6.5±7.3	ns
People could rely upon for instrumental support (number)	1.8±1.7	1.4±1.4	2.3±1.8	.05
People could rely upon for emotional support (number)	1.6±1.5	1.3±1.3	2.0±1.7	.09
Physical health:				
Serious health problems (number)	4.5±3.1	4.6±3.0	4.5±3.3	ns
Hypertension	60	56	65	ns
Chest infection/bronchitis	17	13	23	ns
Pneumonia	5	3	8	ns
Lung problem	22	22	23	ns
Hearing problem	33	34	31	ns
Ear, nose, throat problem	21	22	19	ns
Eye/vision problem	41	47	35	ns
Cancer	12	16	8	ns
Heart trouble	24	28	19	ns
Stroke problem	12	6	19	ns
Kidney/bladder trouble	24	28	19	ns
Arthritis/rheumatism	45	47	45	ns
HIV positive or AIDs	0	0	0	-
Hepatitis A, B, or C	12	13	12	ns
Diabetes	19	19	19	ns
Stomach/digestive disorder	24	25	23	ns
Anemia	12	9	15	ns
Pancreatitis	2	0	4	ns
Thyroid disease	2	3	0	ns
Skin disorders	16	13	19	ns
Seizures	5	6	4	ns
Back or neck problems	46	52	39	ns
Mental health:				
Serious psychiatric problem (number)	1.1±1.2	1.3±1.4	0.9±1,0	ns
Schizophrenia	7	6	8	ns
PTSD	14	16	13	ns
Bipolar disorder	13	9	17	ns
Depression	32	41	21	ns
Alcohol abuse	25	31	17	ns

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	Total sample N=59 (N or mean ± standard deviation)	**Chronically homeless elderly veterans N=33 (N or mean ± standard deviation)**	**Acutely homeless elderly veterans N=26 (N or mean ± standard deviation)**	**p-value**
Alcohol dependency	43	47	38	ns
Drug Abuse	23	28	17	ns
Drug dependency	41	50	29	ns
Mini-mental status exam (MMSE) score	26.5±3.0	26.3±2.8	26.9±3.4	ns
Service need:				
Mental health	38	44	30	ns
Health	95	100	87	ns
Substance abuse	22	28	13	ns
Financial	73	72	74	ns
Housing	100	100	100	ns
Case management	71	66	78	ns
Nursing	27	34	17	ns
Housing barriers:				
Financial	88	97	77	.04
Criminal or psychiatric Institutionalization record	16	16	16	ns
Eviction	19	15	23	ns
Health	20	18	23	ns
Don’t want to be housed	16	15	16	ns
Other	37	42	31	ns

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Table 2

Factors precipitating current homelessness episode: Unstructured vs. structured responses (N=44).

	Unstructured	Structured	p-value
Specific homelessness precipitants			
Financial	23%	77%	ns
Eviction	26%	42%	ns
Physical health	26%	33%	ns
Crisis	5%	2%	ns
Social support	37%	30%	ns
Substance abuse	33%	33%	ns
Mental health	7%	24%	ns
Legal/incarceration	11%	14%	ns
Average number of factors:	1.6 (±0.6)	2.5 (±0.6)	.001