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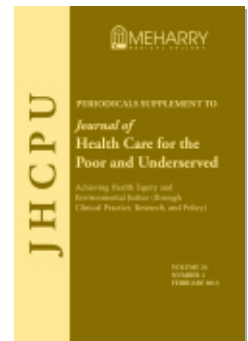
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Victor A. Molinari  
Lisa M. Brown  
Kathryn A. Frahm  
John A. Schinka

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## Perceptions of Homelessness in Older Homeless Veterans, VA Homeless Program Staff Liaisons, and Housing Intervention Providers

Victor A. Molinari, PhD  
Lisa M. Brown, PhD  
Kathryn A. Frahm, PhD  
John A. Schinka, PhD  
Roger Casey, PhD, LCSW

**Abstract:** **Purpose.** To understand the needs and challenges encountered by older homeless veterans. **Methods.** We conducted six focus groups of older veterans, two focus groups, and one semi-structured interview of VA staff liaisons, and two focus groups and one semi-structured interview of housing intervention providers. **Results.** Major themes for older veterans: 1) negative homelessness experience; 2) benefits of the structured transitional housing program; 3) importance of peer outreach; and 4) need for age-tailored job placement programs. Major themes for VA staff liaison/housing intervention providers: 1) belief that the transitional housing program has made a positive change; 2) need for individualized criteria to address the unique needs of veterans; 3) distinct differences between older and younger homeless veterans; 4) outreach services; 5) permanent housing issues; and 6) coordination of services. **Discussion.** Compared with younger veterans, older veterans have less social support, greater employment and health challenges, and, perhaps greater motivation to change.

*Key words:* Veterans, homelessness, older adults, providers, qualitative research.

Homelessness is prevalent in the United States, and triggers a distinctive set of challenges for older adults, especially those who are veterans. A 2009 U.S. Department of Housing and Urban Development point-in-time survey estimated that on a daily basis, over 634,000 people were either in a sheltered or unsheltered homeless state, and approximately 111,000 (17.5%) of these were chronically homeless.<sup>1</sup> Over 15% of the homeless are 51 years of age and older,<sup>2</sup> and the numbers of homeless over the age of 65 are expected to increase dramatically, doubling by 2050.<sup>3</sup> Among the homeless,

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*The first three authors are affiliated with the School of Aging Studies at the University of South Florida (USF) in Tampa [VAM, LMB, KAF]. JOHN SCHINKA is affiliated with the James A Haley VA Medical Center at USF. Roger Casey is affiliated with the VA's National Homeless Providers Grant and Per Diem Program in Tampa. Please address correspondence to Victor Molinari, PhD, ABPP; Professor, School of Aging Studies, University of South Florida, 13301 Bruce B. Downs Blvd., MHC#1320, Tampa, Florida 33612-3899; (813) 974-1960; vmolinari@usf.edu.*

older adults bear vulnerabilities that affect their health and adjustment. Older adults are more likely to experience death of, or separation from, loved ones; decreasing social networks and social support; and loss of independence due to illnesses such as stroke or dementia. Indeed, depression is the most common late-onset psychological disorder of older adults, with older men having the highest suicide rate of any age group.<sup>4,5</sup> Combined with the stressors resulting from homelessness, it is likely that many of these age-related vulnerabilities are compounded by homelessness.

In general, we do not know how aging vulnerabilities interact with known comorbidities in homelessness. Recent research documents some of the potential differences in characteristics and program outcomes between younger and older homeless adults. In a study conducted with a Pennsylvania sample, those who were homeless and older were more than three times more likely to report chronic medical problems, and more than two times more likely to be addicted to heroin than younger homeless adults.<sup>6</sup> These results are in part consistent with the finding of an earlier study that older homeless people complained of worse health than younger homeless adults.<sup>7</sup> However, the latter study found less lifetime drug abuse but more lifetime alcohol use among older adults than younger adults who were homeless. Using a public database (ACCESS), Gordon, Rosenheck, Zweig, and Rotem<sup>8</sup> found that on baseline older adults who were homeless had fewer mental health and substance abuse problems than young and middle-aged homeless adults. However, although all three age groups improved in housing, substance abuse, and psychiatric symptoms after intensive case management services, older adults improved less than young adults on psychiatric symptoms and substance abuse. In a prospective study of adults over the age of 60 living on the Boston streets and followed for four years, high medical morbidity and mortality were documented, with a significant proportion (23%) living on the streets for the duration of the study.<sup>9</sup> Even within the specialized mental health programs of the Veterans Affairs (VA) system, older homeless veterans with mental illness have been found to be at increased risk of mortality compared with non-homeless veterans with mental illness.<sup>10</sup>

Overall, the sparse research on homelessness among older adults suggests that older homeless people have unique medical, cognitive, psychiatric, and substance abuse comorbidities. Garibaldi, Conde-Martel, and O'Toole<sup>6</sup> suggested that the disease burden of the older homeless population was not being adequately identified and managed. Housing needs and health care services tailored to the needs of this group should be in place for optimal outcomes.<sup>9</sup>

Sub-groups of older adults bear further study to help understand pathways to homelessness; veterans are one such group. Veterans are over-represented in the homeless population, and constitute 15% of the homeless. On any given night, there are over 67,000 homeless veterans.<sup>11</sup> Compared with non-veteran homeless adults, homeless veterans are more likely to be older and male, and to have completed high school.<sup>12</sup> Thus far, although some problems and circumstances of older homeless adults have been identified, there has been no study of the systemic issues that must be addressed to enhance the provision of medical, psychiatric, and housing services to older homeless veterans. To increase the number of homeless veterans who complete housing intervention programs successfully and maintain their own residences, it is necessary to identify

and understand the factors that influence short- and long-term outcomes. A review of the literature suggests spotty attention to this matter. Early research identifying childhood antecedents of homelessness described differences between homeless veterans and non-veterans,<sup>13</sup> and examined barriers to use of services. Estimates of success rates for program completion of veterans enrolled in housing intervention programs hover around 50%, but how age affects program completion has been largely unexplored.<sup>14</sup>

To implement evidence-based planning and programming for older veterans, it is important to know more about how and why they first become homeless, if and how veteran status differs from older non-veteran homeless, and how aging affects the experience of homelessness among veterans. By using focus groups and semi-structured interviews to explore post-service and housing program experiences, the objectives of this study were to characterize the experience of older homeless veterans, to explore perceptions of homelessness in older veterans from varied viewpoints, to examine the factors associated with success in completing a transitional supportive housing program, and to identify approaches needed to ensure greater access to homelessness programs for older veterans. This information may be used to refine existing housing programs and to inform the development of new interventions to meet the particular needs of older homeless veterans. This research represents a contribution to the literature because there are no studies that yield data both about homelessness from the older homeless person's perspective and from those who provide services on a daily basis.

## Methods

**Assessment.** The authors developed a semi-structured, focus group interview that consisted of 15 to 20 items, depending on the version. Questions included demographic characteristics (i.e., age, time spent homeless, education, highest job level), perceptions of homelessness, reasons for homelessness, what programs were helpful in alleviating homelessness, whether the transitional supportive housing program (from which all veteran focus group participants received housing services for up to two years) was beneficial, barriers to using homelessness services, how the homelessness services could be promoted more effectively, and differences in service needs between younger and older homeless veterans. Probes were designed to elicit in-depth responses to these questions, especially the distinction between younger and older homeless veterans. Three versions of the interview were developed that explored the same areas but were tailored for each of the three groups: homeless veterans, Veterans Administration (VA) homeless program staff liaisons, and housing intervention providers. Veterans Administration Homeless Program Staff liaisons' duties include monitoring compliance, conducting inspections, and overseeing housing intervention providers and local transitional supportive housing services for the VA Grant Per Diem (GPD) program. Housing intervention providers were individuals who worked for the specific homeless site and coordinated services to the homeless. The questions and probes for the focus group and semi-structured interviews were exactly the same.

**Sample and setting.** Focus groups with homeless veterans and housing intervention providers were conducted at transitional supportive housing sites located in two

metropolitan (Gainesville, Tampa Bay) and one rural area (St. Cloud) in Florida. At each of these sites, two focus groups were conducted with homeless veterans, and one focus group or semi-structured interview was conducted with housing intervention providers. Two focus groups and one semi-structured interview were conducted with VA staff liaisons who were attending a national VA-sponsored meeting of homelessness VA program staff liaisons in the Tampa Bay area. All homeless veteran focus group participants were men aged 49 or over who were receiving transitional supportive housing from community-based housing intervention providers under the GPD program. The GPD program provides grants to staff liaisons to acquire and/or renovate housing facilities for veterans and also funds *per diem* to defray the cost of operations and supportive services. The program provides housing for an individual for a period of up to two years and is designed as a transitional program leading to permanent housing. Community housing arrangements differ in terms of the eligibility requirements for veteran program admission and the mix of offered services. Homeless veterans typically enter the program from the street or a shelter, but may move into GPD programs directly from a halfway house, other short-term housing situations, or prison.

**Procedure.** Prior to the start of study activities, this research was approved by the Institutional Review Board of the University of South Florida. The authors approached the housing intervention providers of three transitional supportive housing programs and asked for their help in scheduling and recruiting older veterans for the focus groups. Intervention providers were told that the VA wanted to go to the primary source to understand better the housing and service needs of older homeless veterans for future planning. Focus group size was limited to eight people at most, a size we deemed large enough to have a discussion, yet small enough for everyone to have an opportunity to speak. At one of the sites a semi-structured interview, not focus group, was conducted with the lone housing intervention manager available. The same approach was used with one of the VA staff liaisons who was available to participate in the study but not able to attend one of the two scheduled focus groups. The focus groups lasted between 75 to 90 minutes and the semi-structured interviews lasted approximately one hour. Homeless veterans were paid \$20 for their participation and provided with snacks and water during the focus group session. No payment was made to the VA staff liaisons or housing intervention providers. Three of the authors (VM, KF, LB) took turns as the lead facilitator. At least one of the other two authors co-facilitated and probed for additional details when it was deemed necessary. At the beginning of the focus groups and interviews, all participants were told that their sessions were to be audiotaped, their answers were to be kept confidential, and that individual responses (e.g., statements that were quoted) would be kept anonymous.

**Analyses.** After the audiotapes of the sessions were transcribed, four of the authors (VM, LB, KF, JS) read the transcripts, identified emergent themes, and noted common topics. Quotations that covered the same topic were compiled. In this way, important divisions within and across the data could be identified and agreed upon by the four researchers. One of the authors (VM) then wrote a summary of the recurring themes which the other authors reviewed to reach consensus. Wherever possible, *verbatim* quotations are provided in the text below to illustrate primary points made by the participants that reflect salient issues regarding homelessness.

## Results

**Homeless veterans' focus groups.** *Demographic characteristics.* Forty-five veterans participated in six focus groups (two each in St. Petersburg, St. Cloud, and Gainesville). Veterans ranged in ages from 49 to 72, with educations ranging from fifth grade and graduate level; highest job positions differed significantly as well, from handyman to corporate executive. Ethnic identities included White, African American, and Hispanic. Time spent being homeless prior to entry into the transitional supportive housing program ranged from immediate entry from prison to three years. One focus group member had spent a total of 25 years being homeless, but for a number of focus group members the current episode of homelessness was their first.

*Themes.* Four themes emerged from an analysis of the transcripts from the veterans' focus groups: 1) the very negative nature of homelessness; 2) benefits of the structured transitional housing program in providing the basic necessities of shelter and support; 3) peer outreach to assist homeless veterans who are ready to change; and 4) the need for age tailored employment training and job placement programs.

Homelessness. The veterans almost unanimously perceived homelessness as a humiliating and degrading experience. Veterans described struggling "to get your basic needs met," "scrounging, just trying to get by as best I can," and feeling "desperation," "humiliation," "despair," "a shocking feeling," "full of fear," and "turmoil." "What's tomorrow gonna bring? Why am I in this situation? How do I get out of it?" Several veterans indicated they would take fairly dramatic steps to avoid being homeless in the future: "My idea was I wasn't going to be homeless. I was either gonna die or, you know, fix it somehow but I didn't want to be homeless. It wasn't . . . an option."

Shelter, structure, support. Veterans almost unanimously agreed that the transitional supportive housing program offered shelter, structure, and welcomed support to get their lives back in order. All veterans indicated that they intended to make the most of their transitional housing experience and wanted a future that included stable, permanent housing. Many noted that to achieve their goal of permanent housing it helped to have an address, a place to bathe, and three meals a day; to obtain assistance with seeking employment; to have health care and dental needs met; and to get help resolving legal and financial problems. Perhaps most importantly, many indicated that living in transitional housing "instilled some self-worth back into my self-esteem." Only one person was negative about the transitional housing situation, saying that he often felt like he was in prison again and implied that the overly restrictive rules were disrespectful of veterans. However, for the most part, the veterans were complimentary of the VA transitional supportive housing program staff: "They listen to you and they help you with . . . your transition, your program. You set down and you work the program out with them;" "If you have a question you can walk in anytime and ask them what's going on."

Employment. The veterans almost unfailingly seemed grateful to the VA for the services they were receiving. Most felt that the best thing the VA could do was to get them a job so they could pay for housing on their own. Veterans mentioned not being competitive for employment because of the downturn in the economy or drug or health problems. The transitional homeless program served as a buffer to provide them a base of operations for food, clothing, shelter, computer access, and transportation (e.g.,

free bus passes) where they can use a “conscientious approach” to obtain retraining or education for a new job. Several veterans reported that this support allowed them to work on a steady basis because they were not always in a “day-to-day survival mode.” Tailored employment programs would be especially valuable for older veterans who said they experienced age discrimination. Otherwise, the transitional supportive housing program was considered a way to access VA services that would help them manage their financial and legal problems, receive needed health care services, and apply for VA benefits that would help marshal the resources they needed to secure permanent housing.

Outreach and access to services. It appeared the veterans reached the transitional supportive housing services mostly through select VA employees who alerted them to the program. As described by the veterans, this process seemed haphazard with veterans commenting that some VA employees were either rude (“He . . . got this rule book and threw it at me. Find a place!”), lacked knowledge of housing services, communicated poorly, or didn’t care. Others reported that employees took a special interest in them, leading to their entry into the program. One veteran noted: “Well you would need an advocate, somebody to actually get you through the door to start talking to somebody in the VA.” A number of veterans commented that the VA should publicize better these programs both at VA sites and to the general public. This group of veterans often mentioned that as they got older there was a greater need for coordinated medical care, which at times was the entrée into receiving VA homelessness services. (“You don’t want to be out there dealing with the pains and the exhaustion and the heat and trying to walk and carry stuff and finding a place to sleep.”) To reach all older homeless veterans, some veterans recommended broadening the VA criteria for entry into some of the structured housing programs, as some sites exclusively admitted only those with substance abuse problems.

Several veterans acknowledged that outreach efforts would not work unless the veteran was ready to change. Peer outreach was considered advantageous as former homeless veterans understand the plight of those who are currently homeless and are in the best position to provide credible guidance about accessing and using VA services. A few of the veterans also suggested that there were periods in their lives when they viewed living on the streets as a challenge to be met, and now their frequently co-occurring substance abuse, psychiatric, and criminal histories kept them from stable housing. Other veterans noted that substance abuse and psychiatric problems had to be addressed by homeless veterans for them to make the most effective use of the VA housing program.

**VA staff liaisons and housing intervention providers’ focus groups and interviews.**

*Demographic characteristics.* Two focus groups and one semi-structured interview of VA staff liaisons (n=14) were conducted. There were five VA staff liaisons in one group, eight in a second group, and one provider was interviewed in a third session. All the VA staff liaisons had spent at least one year at their current VA jobs, and most had spent more than five years working with homeless people. All had master’s of social work (MSW) degrees and met licensing requirements for their state of practice. The professional title of most of the VA staff liaisons was *Grant Per Diem Liaison*. Two focus groups and one semi-structured interview of housing intervention providers (n=10)

were conducted. There were five housing intervention providers in the St. Cloud focus group, four housing intervention providers in the Tampa focus group, and one housing manager interviewed in Gainesville. The housing intervention providers varied widely in how long they had been employed in their current position. One had just started in the position three weeks earlier, while another had founded the transitional supportive housing program facility 18 years ago. However, they had a range of two to 28 years' experience serving the homeless population. Their job titles encompassed director of case management services, counselor, case manager, Chief Executive Officer, substance abuse counselor, contractor and health service manager.

*Themes.* Six major themes emerged from an analysis of the transcripts of the VA staff liaisons and housing intervention providers: 1) their strong belief that the transitional housing program has made a difference in the lives of veterans; 2) individualized criteria to address the unique needs of veterans; 3) the sharp differences between older and younger homeless veterans in terms of less social support, greater employment challenges, more significant health care needs, and motivation to change; 4) outreach services; 5) permanent housing issues; and 6) coordination of services.

*Role of the transitional housing program.* Staff liaisons and housing intervention providers seemed sensitive to the needs of the homeless veterans and appeared to be empathetic and very concerned for their welfare. They believed the homeless population was a "misunderstood" group. All felt that the VA transitional supportive housing program gave them "a little bit of dignity," a "spark of hope," "something meaningful to do" as it "empowered them," built up their social supports, made them feel valued, "provided an opportunity to develop skills and tools that they need to be independent," and especially offered a place where they were greeted, welcomed, and able "to feel like a human being" because people know their names.

*Meeting the needs of all homeless veterans.* It was consistently expressed that the VA should do a better job clarifying the criteria for eligibility for services at a national level. The VA system at times communicated poorly, especially when rapid changes in program criteria occur. Indeed, a "sense of hopelessness, helplessness" is created in veterans when one veteran is entitled to a benefit, but another is not. It is important for housing intervention providers, VA staff liaisons, and veterans to know the programs that are, and will be in place, so that they can plan ahead and coordinate a treatment plan.

However, most VA staff liaisons and housing intervention providers viewed problems more from a systemic, financial perspective than an individual employee lens, and decried all the required paperwork, rules of admission, and waiting lists. One housing manager noted, "Everybody's locked into the siloed bureaucracy of 'You know this is my office.'" Housing intervention providers sometimes function as advocates to negotiate the VA system of care, and both staff liaisons and housing intervention providers stated that they also would like a bigger role in making decisions.

*Older versus younger homeless veterans.* SOCIAL SUPPORT AND NETWORKS. Both groups felt that older veterans were different from younger veterans in that their long histories of homelessness frequently included "burning bridges with their family . . . now they want to rebuild that relationship." One housing manager stated, "I think they feel very alone." Another mentioned, "The age of 50 is a big trigger, actually for vets coming in." Veterans Administration services allow them time to re-connect with others,



even family members who have been alienated for a long time. The same sentiment was voiced by several of the veteran focus group participants.

**EMPLOYMENT NEEDS.** Consistently across groups it was agreed that with medical problems, functional impairments, cognitive issues, patchy work histories, age discrimination, less education, less acceptance of psychiatric treatment, little tech-savvyness, and out-of-date job skills, older homeless veterans are more likely to need compensated work programs, vocational re-tooling, or in certain cases perhaps even recognition that their work careers are over and that they therefore need the safety net of VA benefits and pensions to which they are entitled.

**MEDICAL, PSYCHIATRIC, AND DENTAL NEEDS.** Veterans Administration staff liaisons and housing intervention providers recognized that the needs of older homeless veterans were different from those of younger veterans. The onset of major medical and dental problems appears frequently to prompt a re-assessment of the veteran's life situation and an acceptance of help to find a way out of his predicament. Dental, pulmonology, endocrinology, orthopedic, cardiac, oncology, optometry, audiology, and podiatry needs were specifically cited as medical needs, and "PTSD, anger issues, anxiety, and sleep issues" were specifically cited as mental health needs. Medical appointments at the VA often trigger social work consultations and referrals to homelessness services, so it appears imperative to generate additional ways for homeless veterans to be informed of how to access services. Older veterans need a professional health care workforce that coordinates medical management on a routine basis. Geriatric Evaluation Units staffed by trained geriatric healthcare professionals may be more inviting to older homeless veterans than generalists, as well as better prepared to tailor services to meet older veterans' needs. The older veterans need a place where they don't feel stigmatized for their emotional problems (e.g., Vet Center) and are encouraged to seek proper mental health care and ongoing therapy for psychological issues. Consistent with these thoughts, the staff members noted that, although most of the veterans they worked with were in their 50s, their difficult lives took tolls on their well-being, and they appeared significantly older than their chronological age. One of the focus group participants also thought that they tended to isolate themselves when they were with younger veterans, and they did best with their own age group.

**MOTIVATION FOR CHANGE.** On the positive side, it was felt by some (but not all) that, unlike younger veterans, many of the older veterans were more motivated to make a change, accepted their dire conditions, and were less likely to deny harsh facts by claiming that their situation was a temporary phase that could be easily resolved with a little more time and family assistance. They therefore were more easily "maintained" in the homelessness programs. However, one housing manager dissented and felt that older veterans "won't budge one iota to do something different to make their situation better."

**Outreach to homeless veterans.** Another issue that VA staff liaisons and housing intervention providers agreed upon was that the VA could do a better job of publicizing their services in areas where homeless people congregated. ("A lot of times veterans don't know that they are eligible for health care benefits if they hadn't already been in it.") One liaison noted that veterans feel a sense of belonging when they are around other veterans. Twenty-four hour hotlines and public service announcements were viewed

as helpful. “We have to find them first,” noted one housing manager, gain rapport, and “show [them] something that’s going to better my life.” Homeless veterans need to know where the “soup kitchens and homeless shelters are,” and “have the services located in all different areas of the country.” Veterans Administration Outreach staff would be one way to spread the word. Perhaps they could help coordinate services such as transportation and medical visits by taking on a case manager role so that homeless people could do one-stop shopping— a “complete homeless center” with links to agencies such as Housing and Urban Development (HUD). For example, the VA’s Homeless Patient Aligned Care Teams program and Project CHALENG use a coordinated approach to integrate clinical care with local community resources to enhance access to and delivery of needed medical, social, and housing services.<sup>11</sup> However, both liaison and housing intervention providers recognized that the expansion of the VA *per diem*, vocational services, and housing programs would require more financial commitments at a time when many federal government programs were contracting due to budgetary constraints. They seemed heartened by the VA’s goal to wipe out homelessness in veterans in five years, but wondered out loud how this could be accomplished given the extent of the problem and the current state of service provision.

Permanent housing. While there was generally very positive support among the VA staff liaisons and housing intervention providers for the transitional supportive house program, as reflected by comments such as, “I think transitional housing services provides the veterans an opportunity to develop skills and tools that they need to be independent,” there was also some expression of concern for the potential negative consequences of veterans remaining in transitional housing for long periods of time, believing they may qualify for other programs. (“That’s a big barrier for us because a lot of our clients are now coming in with the idea that once they leave they can apply . . . then they have somewhere to go.”) Additionally, housing intervention providers noted, “There are so many rules, so much bureaucracy, so much overview . . . we’re kind of left stuck.”

Coordination of services. Another issue the VA staff liaisons brought up was the need for better coordination and communication with housing intervention providers. The VA staff liaisons also were concerned about the lack of training and education of some of the housing intervention providers, especially regarding homelessness. A related issue was that VA staff liaisons felt that it made a real difference to have individuals with professional backgrounds involved in homeless care. Finally, they thought that sometimes people received grants to provide homelessness services because they were good grant-writers, not good service providers. One issue that the housing intervention providers uniquely brought up is that the VA staff liaisons sometimes “tend to get overloaded” and have too much on their plates to be completely effective.

## Discussion

Transcripts of the focus groups of homeless veterans, VA homeless program staff liaisons, and service housing intervention providers reveal substantial agreement about the problem of homelessness in veterans and how to address this complex issue. All

agreed that homelessness was a dehumanizing condition that called for a respectful response from VA staff liaisons and housing intervention providers honoring the veterans' prior service to their country. Consistently with the recent work on homeless veterans conducted by Tsai, Kaspro, and Rosenheck,<sup>15</sup> the veterans appeared to be deeply appreciative of what the VA was doing for them, frequently emphasizing that they did not want to appear ungrateful, but that they really needed a jobs program to put them back to work immediately, and in the absence of employment, some time to coordinate their service needs via the transitional supportive housing program. The transitional housing program allows them occasion to pause, reflect on their situation, and get the help that they need to secure permanent housing *via* treatment of acute and chronic medical/dental difficulties, management of substance abuse and psychiatric problems, provision of vocational rehabilitation services, and referral for homeless services and benefits.

There are sharp differences between older and younger homeless veterans. The older veterans have less social support, greater employment challenges, more significant health care needs, and perhaps more motivation to change. Given their frequently brittle health care status, it appears that access to homeless programs for older adults could be enhanced by using media outlets that promote the connection between homeless programs and VA clinics/hospitals that treat geriatric health care needs, by alerting medical social workers to the needs of homeless veterans for housing accommodations, and by enlisting older veterans to conduct peer outreach in homeless shelters touting the benefits of VA homelessness programs.

This study had a number of limitations. One, the small number of focus groups in only three Florida cities reduces the generalizability of the findings. Two, the homeless veteran focus group participants were the lucky ones, in the sense that they had successfully navigated the VA system to use program services. It is unknown if other homeless veterans who did not meet the transitional supportive housing program criteria, or had not yet accepted or obtained services and remained homeless, would have different views about homelessness and VA services. Indeed, veterans, VA staff liaisons, and housing intervention providers may have felt an implicit pressure to emphasize positive experiences in their responses to questions for fear that a negative evaluation might place the transitional housing program in jeopardy. Three, a qualitative analysis of the data, by definition, is subjective and may have been biased by the authors' own viewpoints of the benefits of the transitional housing program. The authors had a contract with the VA to conduct this research, and it is unclear how this might translate into a more positive interpretation of the results. To counteract this, the authors tried as much as possible to supplement their impressions with direct quotations from participants. Finally, specific issues of criminal backgrounds, substance abuse, older veterans with young children, PTSD victims, frail elders, and gender were not given the attention they deserved in our interviews due to time constraints.

In conclusion, the veterans, staff liaisons, and housing intervention providers were in general very positive towards the VA homelessness and social services care programs. However, they agreed that to eliminate homelessness a greater number of these programs must be made available and accessible to the many older veterans who remain homeless. To this worthy end, the focus group and interview respondents stressed that

the VA must continue to increase funding for the GPD and transitional supportive housing programs; refine, promote and enhance access to services; conduct effective outreach; broaden eligibility; and coordinate homelessness services more efficiently. The study findings have been conveyed to the VA Central Office to help guide homelessness policy. It is heartening to note that the VA continues to expand the breadth and scope of homeless veterans programs *via* a variety of coordinated initiatives addressing health (e.g., VA's Health Care for Homeless Veterans Program) and dental care (e.g., Homeless Veterans Dental Program), employment opportunities (e.g., Compensated Work Therapy), and social support (e.g., Supportive Services for Veteran Families).<sup>11</sup> Evaluations of these programs should be conducted in the short- and long-term to determine if they yield the necessary customization of services tailored to older adults and to the changing needs of the homeless veteran population to improve medical, psychiatric, social, and housing outcomes.

## Acknowledgments

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