HOMELESS PREDICTORS IN THE OLDER ADULT POPULATION

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This secondary research study uses data from two convenience samples of homeless persons in Central Arkansas collected during 2004 and 2011 Point in Time Counts. The prevalence of predictors of homelessness are compared across years, and also compared by age (<50 and ≥ 50) controlling for year of survey. The number of older adults increased significantly between 2004 and 2011 surveys, and reporting serious mental illness and veteran status significantly decreased from 2004 to 2011.

Age differences were noted in 2004 with older adults more likely to report serious mental illness in comparison to younger adults. Older adults were also more likely to report veteran status in comparison to younger adults during both the 2004 and 2011 surveys. The predictors of homelessness -- including serious health problems, substance abuse, race, age, and developmental disabilities-- remained fairly consistent from 2004 to 2011 and across “age groups”.

In addition to Point in Time data, qualitative surveys and interviews of providers were performed for their observations of the older homeless population. Providers indicated their belief that the older homeless population is increasing. Providers suggested possible challenges and reasons for the increase among older adults who are homeless. In central Arkansas, service providers feel the current economy, programs, and agencies that provide homeless services and funding sources are adequate at this time as evidenced by no increase in numbers. Due to new funding, improvement has occurred with the veteran population through VA programs. Even though this research did not find any change in gender, the providers feel that for future
homeless, trends in gender (women in poverty), as well as older adults becoming homeless for the first time, should be watched in addition to other predictive factors such as the economy, increase in substance abuse, and physical and mental health concerns.
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By

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This research is dedicated to homeless older adults who need our care and support. The data for this paper is from homeless surveys taken from 2004 and 2011 homeless counts in Pulaski and surrounding areas of Central Arkansas. I would like to thank and gratefully acknowledge Dr. Carolyn L. Turturro, colleague and mentor, for giving me the opportunity to participate in the homeless counts and her willingness to share data for my dissertation research. I would also like to thank my friend and colleague Dr. Bonnie Curington for all of her support and friendship.
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CHAPTER 1
INTRODUCTION

The National Coalition for the Homeless Report (2007) cites statistical data on the homeless elderly, noting this population cohort is increasing. Past data reported that the number of homeless persons aged 65 and older was 9.9 % of the national census (2005 American Community Survey, US Census). This rate is growing as the number of older Americans is increasing as well as rates of older Americans living in poverty. One of the major contributing factors is increased numbers of older adults who are at risk of losing sustainable housing due to the availability of affordable housing options.

The National Alliance to End Homelessness cites city studies in San Francisco, New York, Boston, and Chicago (2004), where the number of elderly homeless has increased in comparison to population studies from 1990-2003. San Francisco reported an increase from 11.2% to 32.2% as compared to their homeless studies in 1990-94 and 2000-2002 respectively. New York City reported chronic homeless aging from persons 28 to 42 years of age from 1987-2005. The city of Boston (Boston Housing Authority, 2007) found that homelessness among the 55 and older population increased from 8% to 14% from 1999-2003. Chicago’s Alliance to End Homelessness also found an increase in the number of homeless among adults 50-64. These studies reveal that there is an upward trend in the number of elderly homeless that is likely to continue.

This study examines the relationships between homeless age groups, adults aged 50 and older, in comparison to groups of those aged 18-49 in order to determine contrasting and collaborative factors in the homeless population.

Specific points of comparison and contrast include physical and mental health
issues, as well as veteran status, substance abuse, developmental disability, HIV/AIDS status and the length of time any person is homeless.

The Point in Time Counts for 2004 and 2011 were taken in both sheltered and unsheltered areas of Central Arkansas (Pulaski, Lonoke, Saline, and Faulkner counties), conducted by Central Arkansas Team Care for the Homeless (CATCH), students from University of Arkansas at Little Rock, Graduate School of Social Work, and local law enforcement from the Little Rock Police Department.

The National Alliance to End Homelessness (2010) reports that 643,063 people experience homelessness on any given night in the United States and 17% are considered chronically homeless. In addition, 238,110 are people in families and 12% of the homeless population identify themselves as veterans. For those agencies and programs that count and support the homeless populations, this number is expected to increase and will include higher numbers of those persons 50 and older, as well as an increase in veterans, those with physical and mental disabilities, and the chronic homeless.

Current Trends

Many older adults find they cannot sustain themselves and are losing their homes, which is leading to greater levels of homelessness in this population (US Census Bureau Report, 2008). The problems that arise with the age group of individuals 50 and older, as defined by Housing and Urban Development (HUD), are magnified due to age-related physical, mental, and cognitive issues. As our world population ages, homelessness within this age group will increase as well. Accurate numbers of
homeless who are 50 and older are difficult to obtain because older homeless adults may not use shelters as resources. They often “double up” with family. Doubling up is when an individual resides with family or friends because they have no permanent home.

This research looked at the data from the 2004 and 2011 HUD Point in Time Count. The annual Point in Time Counts by HUD is the basis for grant programs to homeless providers and programs, which provide services for the homeless in America. The Housing and Urban Development Point in Time survey data examined homelessness in the older adult population in comparison with younger adult homeless persons in the Central Arkansas area for 2004 and 2011.

In order to understand these findings, it is important to first explore the literature about homelessness and the older homeless adult, which serves as a brief introduction to the statistical research findings of both surveys in a critical context. The cause of homelessness can include: economic factors; mental, physical, and cognitive health issues; substance abuse problems and addiction; unemployment; and the lack of adequate retirement or pensions. Additional causal factors include family and relationship breakdown and the lack of adequate public assistance programs, especially for the older adult.

Problem Statement

The existing homeless are aging. Research shows that older adult populations tend to identify key factors that contribute to their homelessness. These factors include deinstitutionalization; suburbanization; high availability of illicit drugs; a lack of housing
opportunities; and minimal access to support services. This research looked at some of
the causes for these key factors including physical (including HIV/AIDS status) and
mental health issues; substance abuse; developmental disabilities and veteran status.

Statement of Purpose

The purpose of this research is to investigate homeless individuals and families
in order to identify the needs and potential needs for specialized services and support,
with a focus on homeless adults older than 50. The Housing and Urban Development
Point and Time Counts require each county in each state to conduct homeless surveys
to identify the current homeless populations. Counties in each state are required to
determine if those who report homelessness are: individuals, family, unaccompanied
youth under 18, are considered chronically homeless, have an identifiable disability, and
if they report being a veteran. The counts help policy makers and programs administer
funding requests and help keep Congress informed on the effectiveness of HUD’s
funded programs and policies, all addressing the goal to decrease the numbers of
homeless Americans.

The following questions were examined: What are the correlating factors that are
observed in the homeless population aged 50 and older compared to those homeless
18-49 years old, between the years 2004 to 2011? What current trends are being
observed by homeless population providers? Other questions were asked of homeless
providers in what they observed while serving the homeless of Central Arkansas.
Questions about types of services, the providers’ roles, and if they observed an
increase or decrease in the age of homeless participants and if so, if providers felt they
had services and programs to meet the older adult needs and if not, to recommend specialized services. Both quantitative data provided by homeless participants as well as qualitative data compiled from homeless providers assisted the research in causal factors of homelessness in both younger homeless (18-49) and those homeless aged 50 and older.

Significance

The significance of this research will be to examine causal factors such as lack of housing, mental and/or physical illness, substance abuse, developmental disability, veteran status, and HIV/AIDS status, as it differs between older and younger homeless individuals. Studies also show that the elderly homeless differ from younger homeless populations in their needs, incomes, families, and community characteristics. Their mental, physical and cognitive problems differ. The significance of input from homeless providers will address observations about who is accessing and receiving services and support and if providers see the need for specialized services and support for those older homeless adults, aged 50 and older.

Physical and Mental Health Significance

Physical, cognitive, and mental illness are individual factors that often play a role in elderly homelessness, because they may require special mental and physical health services, as well as developmental disabilities, which tend to increase with age. Age-related issues may necessitate additional community and family assistance to help older adults maintain health and housing through supportive programs or family care.
Personal issues such as substance abuse may precipitate homelessness with these other mental and physical health challenges.

In addition, older adults are more likely to suffer from cognitive impairments such as dementia, and often develop poor judgment, depression, and anxiety. These are difficult to address or treat as homeless older adults lack transportation, income for medical care, and may be mentally unable to recognize the need for treatment and support. The older adult, as opposed to younger homeless individuals, may have physical and mental health concerns that have been untreated for years including the harsh environment the homeless older adult faces in trying to survive.

Finances and Housing Significance

Housing options for the older homeless adult are limited as with the other homeless populations. In some cases, the older homeless persons may be placed in protective custody by law enforcement after being picked up for wandering in the street or having been seen as self-neglectful, or victimized either in shelters or on the streets. Some older adults may be placed in nursing facilities as an option for services and support as opposed to being on the streets.

Structural factors also contribute to elderly homelessness. The major structural factor is the economy, which puts the cost of medical care and housing at an all-time high with the changes in health care laws, inadequate social security, pensions, and savings also contributing to whether an older adult can maintain their health and housing. Many older homeless adults find they cannot maintain their former housing
due to limited income and the need to use what income they do receive for food and medical needs.

Chronic Homelessness

As our global population ages, so does the chronic homeless population. The chronic homeless must have a disabling condition (HUD definition), and this condition must contribute to homelessness (for a year or more, or for at least three episodes of homelessness in a four-year time span). These disabling conditions can be physical or mental. They can involve substance abuse or developmental disability. They can also be due to HIV/AIDS or inability to sustain housing. Furthermore, populations for example, such as veterans, make up 40 percent of the homeless male population (National Coalition for Homeless, 2009).

While there is little literature or national data on aging homelessness, HUD estimated that, in Arkansas, 2.4 percent of sheltered homeless adults were 62 and older (Annual Homelessness Assessment Report to Congress AHAR, April 2005). According to the AHAR report for 2008, that number increased to two point eight percent. While this represents a modest increase in the reported elderly homeless population, it did not represent those chronic elderly homeless who do not access shelters. In addition, many older homeless adults may not be counted due to “doubling up” with family or friend, or the count did not include rural homeless due to limited accessibility in counting the rural homeless populations.
Hypotheses

The following are operational hypotheses for this study:

• Older homeless persons are more likely to report serious physical health concerns and psychiatric problems, including disabilities, compared to younger homeless persons.

• There was a difference in chronic homelessness between younger and older homeless participants surveyed in 2004 and again in 2011.

• Have these factors associated with homelessness changed over time for older and younger homeless individuals?

• Older homeless persons are more likely to report drug or alcohol abuse than the younger homeless population.

• Older homeless persons and younger homeless persons are more likely not to report HIV/AIDS status due to stigma and/or discrimination from the diagnosis.

Theoretical Frameworks

Cohen and Felson’s (1979) framework for looking at the elderly homeless, developed in the 1970s, theorizes differential risks for victimization. This framework suggests that the risk of becoming a victim of crime results from the absence of supportive environments with police, neighbors, and if friends and family, as well as the presence of motivated offenders with a readily available crime target.

The elderly homeless are exposed to this risk of violence and crime. Many lack the physical or mental capacity to defend themselves on the streets and fear staying in shelters, because they may fall victim to younger homeless persons who view them as more vulnerable targets. The economics of poverty, unemployment, drug use, and lack of access to services and support are also important factors that place the elderly homeless at risk, particularly those in rural areas.
One theory that pertains to the phenomena of homeless elderly women is the feminization of poverty theory. Diana Pearce (1978) coined this term in the late 1970s to describe the increasing overrepresentation of women and children among the poor in the United States. Many older women do not have work histories, and do not currently perform paid work. This lessens their ability to realize social security through pension and retirement plans and may also limit earning histories, job skills, or education that may preclude them from getting higher paying jobs. The responsibility many women have for child and family care, which further reduces their opportunity in the paid workforce. As a result, women earn less than men in their lifetime. This discrepancy places women at a risk for poverty, and deep poverty, as they age. Older women who have stayed home to raise children and care for other relatives jeopardize their ability to maintain stable employment, which is felt in later years when they have inadequate social security or retirement benefits.

Disengagement theory in aging may also provide insights about the homeless elderly. The term disengagement comes from Cumming and Henry (1961), “Growing Old: The Process of Disengagement”. This theory postulates disengagement as an inevitable process in which the relationships between a person and other members of society are severed. Disengagement is observed when older adults retire. At this time, there is decreased interaction with the workforce and their co-workers. The retiree may no longer contribute to work or co-worker relationships. As people age, they experience greater distance from their previous cohort, and they develop new types of relationships with others who are aging. Older adults willingly withdraw from work, while society and work are withdrawing from them. This is a mutual exchange process where the
withdrawal is viewed as a natural occurrence of aging. This can lead to social isolation, depression, and feelings of worthlessness.

Definition of Terms

Homelessness is defined as having no place to live, having no options other than to live on the street, or having to “double up” with friends or family (National Coalition on Homelessness, 2008). For this research, the conceptual definition of homelessness is one of the main difficulties in defining what homelessness is. There is no widely accepted definition (Meert, Edgar & Doherty, 2004) of homelessness. Defining homelessness is more about understanding the causes of homelessness both social and cultural, as well as policy implications. The definitions used in this research are:

- Sheltered or emergency housing are facilities with minimal admission criteria for homelessness that allow short-term services, including beds and meals.

- Transitional housing is a temporary shelter with supportive services that enables homeless persons, whether individuals or those with a family, to live independently while moving to permanent housing and support within a two year timeframe.

- Permanent housing is housing where individuals or families may live for an indefinite period of time, with support services as needed.

Summary

As our world ages, the number of older adults age 50 and older at risk for homelessness will increase due to aging factors such as: decreased income, physical and mental health concerns, and the inability to remain independent in their own homes. Some of the risk factors for the length of time a person is homeless are; serious mental illness, physical illness, veteran status, substance abuse, HIV/AIDS, or developmental
disabilities. While these are concerns for all homeless persons, they may be exacerbated by age. In addition to risk factors, the state of our global economy is predicted to put older adults at risk for homelessness.

To explore these issues, this comparison study of HUD’s Point in Time surveys conducted in 2004 and 2011 attempts to identify some of the risk factors that are observed to determine the significance of age as it shapes homelessness. The research will look at correlating factors that may influence the comparison between age groups. Additionally, the research was enriched using qualitative interviews and surveys with local homeless providers to examine their observations of participants in the 2004 and 2011 Point in Time Counts and to report their observations about each cohort group in their use of services and support by providers.

Comments and reports included observations and recommendations about possible specialized services and support that are either in place or may be needed to address the needs of those homeless adults aged 50 and older. The HUD guidelines for the older homeless adult predict these factors will cause an increase in the number of older adults who are homeless, whether they are chronic or new to homelessness.
CHAPTER 2
REVIEW OF THE LITERATURE

A History of Homelessness in Arkansas

Homeless data can be seen as early as 1640, when homeless issues were reported in bigger cities on the west coast and in the thirteen colonies (Cook, 2010). In the 19th century, images and reports of homelessness from areas with high rates of poverty in large east coast cities, such as skid row and the Bowery, were attributed to individuals who were alcoholics and undesirables. Smaller rural areas called their homeless populations “hobos,” since many of the poor and destitute lived near train tracks.

From 1892 until the first recognized counts for homeless persons began in the 1970s, homelessness in Arkansas was reported as a result of natural or manmade disaster (Homeless in the United States and the McKinney-Vento Act of 1987). The National Homeless Count Timeline’s Arkansas-specific data begins in 1892 with news of rain damage to cotton crops in the Arkansas Valley, which resulted in farmers and others becoming homeless. Similar reports of natural disasters from floods, fires, and storms were reported from 1892 until the 1970s, when more detailed counts took place. These later counts attributed inadequate housing or a lack of housing to the economy and unemployment rates. The counts, which came later, dealt with the economy as in “lay-offs” from factory work, mental health including Post Traumatic Stress Disorder (PTSD) from our service men and women, and substance abuse, family issues as divorce, domestic abuse, and medical issues like HIV/AIDS.
The idea that homelessness was caused by laziness or unwillingness to work was the main theme in earlier times. The Community Action Program of Central Arkansas was one of the first agencies to provide temporary help, paying for motel/hotel rooms for clients for two weeks to get them on their feet. Shirley Lea (Arkansas Democrat-Gazette, 8-13-1989) reported that most of the homeless they assisted were not “drunks or drug addicts or crazy,” but simply wanted to work to support their families.

Homelessness was not an urgent concern in Arkansas historically, because homeless persons in the news were most often referred to as “drifters.” As the literature on homelessness in Central Arkansas illustrates, not all people living in Arkansas have a positive attitude or understanding towards the homeless. Some of the local populations believe that those who are homeless do not deserve to live among the “hard working” folks of Arkansas (Herrick & Stuart, 2005).

This attitude has led to hate crimes against homeless people in the state in recent years. According to the U.S. Department of Housing and Urban Development, 2009 Annual Homeless Assessment Report cites from 1999-2009, eleven attacks against homeless were reported, resulting in five deaths (“Point-in-Time Estimates from January 2009 of Homeless Population by State”).

In Arkansas, the Democrat Gazette filed this report: “September 27: Homeless man Anthony Patterson, 50, was found beaten, bloodied and dead on Main St. of the upscale Argenta section of North Little Rock. Police followed a trail of blood to the house of Donald Scott Grace, 50, and found him with blood still on his clothes and the
bloody bat in the foyer. Reported by Patty Lindemann, of Hunger Free Arkansas, Grace was arrested and charged with pre-meditated murder” (North Little Rock, 2010).

Homeless Counts Begin in Arkansas

The first official homeless count was conducted by the Arkansas Coalition of Care (ARCOC) in February 2004. The city of Little Rock and the Arkansas Homeless Coalition requested assistance from local governments to conduct homeless surveys in camps. This was a combined effort to count the homeless in shelters, feeding programs, and alcohol and drug treatment programs, as well as previously unaccounted homeless persons who were living in the camps surrounding the city. The number of homeless people in rural areas of Arkansas was found to be greater than in central and major cities, where it was thought that the situation was better controlled by local authorities.

In 2005, the south was dealt a devastating blow with Hurricanes Rita and Katrina. People who had homes became victims of this natural disaster. Many were forced to evacuate to surrounding states, including Arkansas. This resulted in a dramatic increase in the homeless population, with numbers almost tripling. Over 16,000 persons were counted as homeless, with 11,000 reported as evacuees. By 2007, the homeless count dropped back down to 3,800.

Arkansas' homeless population has fluctuated since the first full count of the homeless in shelters, feeding programs, mental health services, and rural camps in 2005, when service providers counted 5,626 homeless people. A count in January 2006 reflected an influx of Hurricane Katrina refugees, putting the state's homeless population at 16,665. The number dropped to 3,386 in January 2007, after most of the refugees
found permanent housing. Notably, the 2009 Count of homelessness in Central Arkansas, by the University of Arkansas Community and Family Institute, reported an increase in homeless shelters in Arkansas, despite a recent federal report that stated there were fewer homeless in the state and nation.

The 2009 Annual Homeless Assessment released to Congress by the U.S. Department of Housing and Urban Development stated that Arkansas had 2,852 homeless in 2009, down from 3,255 in 2008 and from 3,386 in 2007. Numbers may have decreased due to more services and housing that was provided for Rita and Katrina hurricane victims. It is possible that the numbers of homeless persons who may have been in Arkansas, before the influx of hurricane refuges, received services and support, that would not otherwise available to them as homeless persons.

The 2011 Homeless Count was conducted on January 25, by the Central Arkansas Team Care for the Homeless (CATCH), UALR Social Work Students, and community volunteers. The count in this year was 1,276 persons reported being homeless in the Central Arkansas area. The statewide count and those agencies reporting put the number of homeless persons at 2,762. The count for Central Arkansas (which included Pulaski, Lonoke, Prairie, and Saline counties) found that 149 fewer persons reported being homeless in 2011 than in 2009 (Netterstrom, 2011).

Although the Central Arkansas count has declined, reports from the Homeless Assessment Report to Congress showed a 1.1% increase since 2010, from 643,067 to 649,917 in the 2011 national count (HUD 2011). With the help of different services and shelters in Arkansas, the number of homeless people in the streets decreased in the next few years, even though the number of homeless shelters increased. The 2009
count by the University of Arkansas Community and Family Institute and the Arkansas Homeless Coalition reported this increase by using a point in time survey in Central Arkansas. This increase came despite federal reports that the number of homeless in the state and in America had decreased.

The government responded to this survey by suggesting a greater number of homeless in the state were able to access overnight shelters (McNamara 2008). His report stated that “emergency shelters provided indoor places where homeless people [could] sleep and often have a meal, take a shower and tend to other of life’s most basic necessities.”

Homeless shelters, however, are not considered the solution to the problems associated with homelessness in Arkansas and the US in the new millennium. According to the report *Homelessness: A National Perspective*, shelters help homeless people to find physical security and meet their physiological needs (Ladner, 1992). However, many in society think the existence of overnight shelters will not help people to recover from the causes of homelessness and their struggles with existing problems. They think if the homeless know that they can always find food and other necessities in shelters, they are not motivated to work. This goes back to the earlier view that the homeless person is lazy and is not deserving of help.

The primary factors for homelessness in Arkansas today are the housing crisis and poverty as well as need for additional supportive services. These services needs include “substance abuse treatment and mental illness stabilization through medication, vocational training, etc.” (Homelessness in Arkansas, 2008). According to the National Coalition of Homeless in Little Rock (2010), there is a 2% increase in the homeless
population in Arkansas every year. Homelessness in the state of Arkansas has become a major social and political issue.

**Homeless Trends**

Traditionally, older adults have moved in with families when they could no longer afford or were no longer able to live alone. Those without family support were, often times, placed in long-term care facilities regardless of ability or desire to remain independent. Those who cannot afford the collateral costs of utilities, food, and/or medicines often become a population of older adults who, without support, may find themselves homeless.

A study by Hahn et al. (2006) examined trends in homelessness in San Francisco over a 14-year period, with the original goal of reporting the rate of substance abuse and health problems associated with being homeless. The study tracked the age of the recipients and how long they had been homeless, as well as self-reported chronic conditions, hospital and emergency room use, and any history of substance abuse.

The authors conducted a serial cross-sectional study of 3,534 homeless adults from the San Francisco area. They examined data in waves, from 1990-1994, 1996-1998, 1999-2000, and 2003. Hahn and Kushel found the median age over time increased from age 37 to 46, a rate of 0.66 years per calendar year. The most recent wave (2003) found that one-third of the homeless population surveyed were 50 or older (Hahn et al., 2006). The study reported an increase in hospital admissions, emergency room visits, and chronic health conditions within the homeless population 50 and older.
The data revealed that between 2.3 and 3.5 million Americans became homeless every year from 1990 through 2006 wave studies. Compared to the homeless populations of the 1950s and 1960s, Hahn et al. found that today’s homeless population is poorer, suffers from worse health conditions, and less likely to find shelter or indoor living. Hahn also found an increase in substance abusers and minorities included with increased age.

The National Alliance to End Homelessness Report (April, 2010) supports the concerns of Hahn’s studies on homelessness and the impact of aging on future homelessness. Sermons and Henry (2010) also report on the impending crisis of increasing numbers of homeless. Their work aligns with Hahn and others about the trend in aging homelessness. Researchers in the field of aging agree that the Baby Boomers turning 65, and the numbers of older adults who report being homeless increasing, suggest this trend will continue to increase dramatically. The results of global aging have serious implications for providers of homeless services, and will impact policies and goals of preventing poverty and homelessness among the elderly through state and local social welfare programs.

The September 2009 fact sheet entitled “Homelessness among Elderly Persons” (National Coalition for the Homeless) reported the number of homeless persons aged 65 and older is 9.7% of the national census of total homelessness. This rate is growing because the number of older Americans who are living in poverty is growing.

Poverty

The National Center for Law and Economic Justice (2010) reported poverty
reached its highest point in 16 years. In 2010, almost 20.5 million Americans, or 6.7% of the population, lived in deep poverty. The American Community Survey (2008) reported on the number of elderly persons in deep poverty, citing this population at about 969,925, or 2.6% of the elder population as a whole. This projection is alarming because, as the general population ages, the rates of deep poverty for the elderly will increase, thus increasing those elderly who are at risk for homelessness and those who are chronically homeless.

The American Community Survey concluded that although many older homeless persons have a steady income, whether from social security (SS), social security income (SSI), government benefits, military benefits, or private pensions, it is limited and, at times, lower than the average rental cost. Due to their limited income, often they are unable to maintain a residency due to costs for upkeep and utilities. Many older adults find they may need to “downsize” from family homes to smaller residences in order to remain both physically and financially independent. Finding affordable housing that meets disability needs without being institutionalized is difficult for those disabled older adults who also want or need housing.

The U.S. Census Bureau’s Consumer Income Report Document (2007) describes the statistics and traits of poverty in the U.S. for 2005 to include elderly persons who become homeless or near homeless because of economic instability. News, television, and advertising agencies often depict the elderly as retirees having fun in their golden years, when the truth is that many elderly are dependent on their social security and pensions to sustain them. Although the media project these elderly images, neither of these income sources provides a lavish, or even comfortable, lifestyle

Economic Factors

Elderly persons may be forced into homelessness by economics or by a decreasing ability to maintain housing. According to the Social Security Administration (2009), the current maximum monthly SSI benefits are $674 for an eligible individual and $1,011 for an individual with spouse. For 2010, there was no cost of living allowance, so there was no increase in SSI payment amounts. If an elderly person retires at 65 they will receive the maximum in Social Security benefits, but if an elderly person retires before 65, the social security is decreased. Although up to 96% of American workers are covered by Social Security (Social Security Administration, 2009), including non-working spouses, this may not be enough for them to maintain themselves in their communities. For this reason, risk of homelessness for the older adult is increased. In the current research report by the National Alliance to End Homelessness (Jan 2012), The State of Homelessness in America, reports the state of Arkansas homeless population decreased by 20.6%, but the NAEH feels that the counts in Arkansas, as well as the United States, have lagged behind due to current economic downturns and decreasing funding for homeless programs.

The report by McNamara (2008) stated that due to the Department of Veterans Affairs (VA), nearly 200,000 veterans of various wars are presently homeless. According to the National Survey of Homeless Assistance Providers and Clients
(NSHAPC) conducted in 1999, “23% of all the homeless and 33% of homeless men are veterans out of a total veteran presence in the general population of only 12.7%” (p. 65). In 2006 the American government implemented a great number of policies to help deal with the problem of homelessness among veterans, including the Homelessness Veterans Assistance Act, Homes for Heroes Act, and so on.

The National Coalition for the Homeless (2006) provides an example of how the lack of affordable housing is a major issue causing homelessness. The Boston Housing Authority reported a 37 percent increase of elderly households facing severe housing cost burden since their 1990 Census (Designated Housing Plan, 2007). Furthermore, the plan based on the 2000 Census in Boston identified 7,893 elderly renter and owner households of low income that had severe housing cost burdens. Housing cost burdens are defined as fifty percent of a household’s income designated for housing costs. The Boston Census projected data for the population 60 and over predicts an increase of 30% by 2020. The need for additional, affordable housing will increase as well.

The Homeless Over 50: The Graying of Chicago’s Homeless Population reports key findings about some of the causes of homelessness in older Chicagoans (Chicago Alliance to End Homelessness Report, 2007). The report included 1,324 elderly homeless persons who were randomly selected from 33 social service sites and programs, 55 homeless service agencies, and 20 other advocates or government staff members who work with the homeless population of Chicago to identify causal circumstances for older homeless adults.

The study identified five circumstances or effects for persons 50 and older. Circumstances included: chronic physical, mental, and cognitive health problems,
decreased likelihood for Social Security eligibility, pension, or retirement benefits, less support from family, age discrimination with opportunity to work, precarious employment; and precarious housing. These circumstances were found to predict who is or will be homeless in this age group.

Elderly people generally have less income because of retirement, which means that they also have less money for the necessities of life. In addition, the burdens of health costs are increasing, in addition to the rising costs of utilities and food. Elderly homeless have an additional burden as health concerns and physical frailties make them more vulnerable to being victimized. Many elderly have meager social security or pension benefits that make sustaining housing impossible, especially when food, medicine, utilities, and transportation are added to the cost of mortgage payments or rent. In addition to rent or a mortgage, the economic marginality of the elderly can make keeping up with house repairs, electric bills, and necessities like gas bills impossible.

Physical and cognitive disabilities are certainly contributing factors for elderly who become homeless. Many elderly fall victim to fraud and economic abuse due to disabilities and frailties that occur as they age. Economic marginality also results from a lack of adequate resources for the elderly due to low social security or pensions. This leads to high rates of poverty (Bingham et al., 1987; Robertson et al, 1992). Individual factors such as the cost of housing and the affordability of housing maintenance play a significant role in homelessness among the elderly as well.

Empirical research conducted on homelessness among the elderly is limited in comparison to research about the total homeless population (HEARTH, 2007). As a
result, this study looks at the factors associated with homelessness in older adults, aged 50 and over. The existing research indicates the elderly homeless represent a special population whose needs are greater than the needs of the general population. The elderly who are in poverty, with unavailability of housing, are at greater risk for homelessness than their cohorts who are able to sustain themselves economically.

Policy Issues

Current policy on homelessness caters to the elderly to some degree. Federal housing programs, for example, have been helpful in reducing homelessness in the elderly for those who have Social Security or Supplemental Security income. Affordability is the main issue, though, and this has not been adequately addressed. There is a significant waiting list for affordable or subsidized housing for all populations. The elderly are often faced with the decision between housing, medication, or food.

The US Census American Housing Survey (2007) reports that over 8.7 million elderly households experience housing cost burden. As mentioned previously, cost burden is defined as a housing cost that exceeds 50% of a household’s total income; the issue of affordability is central to elderly homelessness. The American Housing survey also reports only 6% of public housing was used by the elderly homeless for subsidized housing. This percentage represents 1.3 million households in the US.

Cohen (2010) recommends greater advocacy to achieve a higher level of outreach, not only to advocate for chronic homeless older persons but to also help those suffering from severe and life-threatening conditions that are prevalent among the older homeless, such as mental illness.
The National Alliance to End Homelessness (2010), reported with the current economy, the picture of homelessness in America is disquieting. The NAEH encourages Congress, as well as local and state authorities, to look at their state institutions, including foster care, incarceration, and health care facilities, as contributors to homelessness. The need to examine discharge policies may have a lasting effect on the growing numbers of homelessness. The National Alliance is also suggesting that each county and state examine federal resources, which are becoming scarce, to maximize their use for best outcomes and impact on the existing homeless programs and agencies already in place.

Chronic Homelessness and New Homelessness in the Elderly

Chronic homelessness is defined by HUD as a person who is “an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more OR has had at least four (4) episodes of homelessness in the past (3) years.” HUD’s definition of disabling condition/s is “a diagnosable substance use disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions.”

HUD’s annual homelessness assessment report (AHAR) to Congress estimated 2.4% of sheltered homeless individuals were age 62 and older. The AHAR report for 2008 reported this has increased from 2.4% to 2.8%. While this represents a modest increase in the reported elderly homeless population, the chronic elderly homeless who do not access shelters were not included. The article “Aging on the Streets” (Health
Clinicians’ Network. 2008), shows that many chronic elderly homeless do not access shelters, citing personal risks, such as victimization by younger shelter users, and chronic health concerns that may put them at risk while staying in a shelter (Healing Hands publication, 2008).

Research also suggests that chronic elderly homeless persons are also difficult to house or place (O’Connell, 2005). Access to care and support is also difficult to provide. The study by O’Connell reported that of 30 elderly homeless in Boston, 30% died, 20% were placed in nursing facilities, 17% were able to obtain housing, and 23% remained homeless. Overall, O’Connell concluded elderly homeless persons posed significant challenges in accessing housing, health care, and social services, resulting in higher mortality rates than younger homeless cohorts.

According to an article by the California National Organization for Women (2010), there are “serious implications” for those who provide homeless services in terms of the increasing age of the population. These organizations are primarily concerned with preventing poverty and homelessness among the elderly, one of the most vulnerable populations. Current welfare safeguards and systems, (such as Social Security, Medicare, Medicaid, pensions and Veterans Association), are largely inadequate or ill-prepared to handle the extent of the problem.

Elderly homeless women as a subgroup need special recognition and require special attention. The July 1991 article “The Elderly ‘New Homeless:’ An Emerging Population at Risk” (Kutza and Keigher, 1991) reported 283 cases from private and public agencies in the Chicago area, indicating elderly women are becoming the largest group entering into homelessness. Elderly women are at high risk for experiencing
physical and mental health issues, and they are physically vulnerable, requiring protection from victimization. Their special physical limitations make living on the streets and in shelters a challenge.

The risk factors for long-term homelessness and new homelessness are varied. Susser, et al. (1991) reported long term homelessness due to poor parental instability and care resulting in out of home placement during childhood. Inadequate family or community support during adulthood was also a precipitating factor in long-term homelessness. In comparison, a longitudinal study of first time homeless single adults (Caton et al., 2005) demonstrated risk factors including substance abuse and mental illness.

In the study entitled ‘Three Nation Study of the Causes of Homelessness among Older People’ (Crane et al. 2005), the Committee to End Elder Homelessness conducted a study with 125 newly homeless elders using a cross-sectional design in the United States, United Kingdom, and Australia. This study was designed to understand the factors leading to elder homelessness, while gaining the international perspective of the participants. The policy reformations necessary to eradicate elder homelessness were determined to be the initiation of effective response programs and services to elderly homeless individuals. The study found that two-thirds of the subjects interviewed had never been homeless.

Causal factors leading up to homelessness indicate that previous housing had been sold or was in need of repair. Other factors were the loss or relationship, breakdown of a spouse or a caregiver, the decline of neighborhood conditions, physical or mental health care concerns, substance abuse and gambling addiction.
Health

Data on homelessness from the HEARTH study cites similar mental health factors as in past studies (HEARTH, 2009). The study in 2006 surveyed elderly residents of Hearth Housing in the Boston area to determine previous factors that “lead to homelessness and entry to Hearth Housing.” The study data showed 36% of homeless elderly had mental health issues; 30% with physical health problems 28% with relationship support problems from family and friends. Also, 14% of the study participants reported problems stemming from addictions and 11% reported evictions from current housing as their main factor leading to homelessness.

The study showed 9% suffered the loss of a supportive family member through relocation or death, and 6 percent experienced the loss of housing due to their residence being condemned or closed. Four percent reported either abuse or neglect, including self-neglect. These percentages equal over 100% of the elderly homeless surveyed, because many elderly reported multiple factors prior to homelessness.

The elderly homeless reported significant mental health issues and chronic psychiatric symptoms, and many had organic or alcohol-related dementia. Up to 45% of elderly, homeless women had confusion and paranoia compared with elderly, homeless men who reported 31% of the same symptoms and behaviors. These health issues are attributed to the unstable environment in which older homeless persons find themselves.

Examining other issues and concerns include medical problems for the older homeless as they tend to be chronic, because of lack of health care opportunities or support. 66% of the women surveyed from this population, and 74% of the men
surveyed, reported being in poor health. This was in direct contrast with the younger homeless population, which reported only 36% in fair to poor health (Roesnheck, R., Bassuk, E. & Salomon, A., 2001).

Lack of access to mental health and substance abuse programs is challenging for the homeless elder, because often the homeless person is at risk for depression and other mental illnesses. Mental illness and substance abuse are under-diagnosed and untreated in this population, which can lead to prolonged homelessness. Even when mental illness or substance abuse is diagnosed, many elderly are unable to pay for services, therapy, or medication that could otherwise stabilize them.

The article “Why Are There So Many Homeless People in America?” (Loy Williams, 2008), suggests addiction and mental illness are important factors. In his view, 25 percent of the homeless are drug or alcohol abusers and about 25 percent suffer from some other mental illness. Both groups lack access to programs. Herrick & Stuart (2005) believes that due to insufficient aid from local, state, and national governments that homeless persons are victims of poor planning.

In addition, mental and cognitive health issues contribute to elderly homelessness because such disabilities make the elderly particularly vulnerable to victimization involving fraud and economic abuse. Chronic, persistent mental illness can also be caused by the inability to afford medications, resulting in increased symptoms that make it difficult to function in society. Depression, psychosis, and cognitive impairment are all examples of mental illnesses common in the elderly.

According to the US Department of Housing and Urban Development (1998), of the 12.5 million persons in US households, elderly persons are identified as having the
most severe housing needs. The National Coalition for the Homeless Report (2006) cites the lack of affordability is a major issue causing homelessness. The census-projected data for the population 60 and older is estimated to increase by 30% in 2020 as Baby Boomers age, which means that the need for additional affordable housing will increase as well. Income marginality and affordable housing are not limited to specific areas in the US, but are widespread throughout the country.

Prevention and Treatment for Homelessness in Elderly

As Feilda et al. (2002) suggest, “Social networks were vital in supporting the health of older people living in sheltered housing.” According to Feilda, there is a clear need for service systems to prevent conditions that affect older persons who need support and protection. The study concludes elderly homelessness is increasing, and current support systems in health care and housing are inadequate to meet the needs of this population.

According to Rosenheck, Bassuk, and Salomon (2001), older homeless adults experience a variety of health and mental health problems, but they lack access to care because they have little or no money, do not have reliable transportation, and are regularly unable to pay for medications. In addition, many elder homeless adults have cognitive impairments that are exacerbated by the stress and anxiety of homelessness.

Many homeless senior citizens choose to live on the streets rather than in shelters because they fear becoming victimized by caregivers more than they fear other homeless people. Many elderly homeless do not trust service providers because they are afraid that if they seek help, they run the risk of losing their independence by
becoming institutionalized in long-term care or mental health facilities. Many researchers and professionals in the fields of aging and homelessness look for ways to improve homeless conditions while working to end homelessness.

Solutions to homelessness are aimed at targeting support systems such as housing to affect the elderly homeless. Prevention and treatment for elderly homelessness may be found in the approach at St. Mary’s Program in San Francisco. The program incorporates overall health and safety with psychosocial support, including stable housing, finances, mental health, sobriety, with self-determination and respect for autonomy. Opportunities and support for the elderly homeless to achieve meaning in their lives is the central focus of St. Mary’s Program. Support and service goals are developed to help the elderly sustain their mental health and sobriety. This approach shows how multidisciplinary services can be crucial in serving the homeless elderly with mental health and substance abuse problems.

Another solution for elder homelessness is addressing the problem at the root level. According to Cohen (2010), there is a significant lack of social networks among older homeless persons. These networks consist of staff members of supportive agencies who provide assistance beyond what family or friends are able to offer, since they provide professional aid. Networks that provide assistance, while important, are only a part of the support needed. The homeless elderly need to construct and maintain peer networks. This can have the dual effect of providing a sense of belonging as well as “safety in numbers.” Peer networks also foster a feeling of self-worth within the group. Furthermore, they disseminate important information regarding the availability of housing and other services.
Cohen (2010) suggests that little attention has been given to programs for homeless older persons at the service level. Abuse and crime against the elderly in shelters is a concern. Cohen recommends addressing this issue by increasing the number of age-segregated drop-in centers, as well as outreach programs. An example of this can be seen in the Veteran’s Association (VA) outreach programs. The VA has homeless drop-in centers in Little Rock and North Little Rock targeted at the homeless veteran. They can receive support and treatment, as well as education on housing, VA benefits, and programs that are aimed at getting them off the streets.

Summary

Homelessness in the elder population is growing. Causes are varied and include individual and personal factors such as physical, mental, or cognitive decline and chronic co-morbidities that come with aging. Financial factors that are related to work, lack of access to work, social security for those who “fall between the cracks,” and retirement benefits are additional causal factors. The inability to maintain work due to ageism in the workforce and bridge jobs such as “Wal-Mart Greeter” that pay minimum wage with no benefits also contribute, as does the economic situation of older women with little or no work history and poor savings.

Structural factors play a role too, such as maintaining or sustaining housing, lack of housing options for older adults, and competition for low-cost housing with other age groups. Those elderly who are chronically homeless lack access to supportive services and housing that could help them maintain a place to live. This is a new crisis in our
global homeless population. As the world ages, economies are struggling and housing is scarce.

In general, the most important factor in elderly homelessness is to integrate practical and theoretical research on the issue to understand all its challenges and opportunities. The focus for such research should be as wide, diverse, and multidisciplinary as possible, integrating the homeless spectrum to include all ages, as well as races and genders. This research and theory should also encompass a global view, because worldwide populations are aging including the United States.

Adequate housing and income support for the elderly will become increasingly important as our elder population explodes due to the Baby Boomers reaching older adulthood. At this time, the demand for affordable housing will become greater, while the options for housing may remain limited. Furthermore, homelessness among the elderly raises special concerns due to declining physical, mental, and financial functioning. Other risk factors identified for long term homelessness were educational level, marital status, past and current employment, and veteran status (Caton, 2000). These factors and the vulnerability of the elderly to victimization in shelters and on the streets present challenges for programs that support our homeless population.

Further research about this population is needed, and particularly data that compares this cohort to others. Estimates of homeless older adults are just estimates, as some older homeless adults do not stay in shelters, participate in soup kitchens, or enter supportive programs. We can only guess at the possible numbers of uncounted elderly homeless, but can predict, at the rate of our population aging, that the numbers will increase.
CHAPTER 3

METHODOLOGY

This research investigated younger and older age groups for homeless individuals in the Central Arkansas areas of Saline, Pulaski, Faulkner, and Lonoke counties for 2004 and 2011 Point in Time Homeless Counts. This population was selected for research in order to understand the factors associated with homelessness such as: physical health problems, mental health problems, substance abuse, chronicity as length of time homeless, veteran status, as well as HIV/AIDS status among the general homeless population. The main hypothesis for this research was to determine if age affects homelessness causal factors: physical health problems; mental health problems; substance abuse problems; developmental disabilities; veteran status; and HIV/AIDS status in cohort groups 18-49 and 50 and older homeless persons.

Research data investigated differences in age groups: those younger homeless 18-49 (<50) and those adults 50 and older. The frequencies of relationships between older homeless adults and younger homeless adults were compared for each year as well as within each year of the surveys studied. Additional data collected included demographic information on age, race, and gender, the latter of which was aggregated to protect confidentiality of participants. The design for this study was mixed; both qualitative and quantitative surveys were used to collect data.

Instrument

The Point in Time surveys used for data collection were originally developed for use in annual homeless counts for the U.S. Department of Housing and Urban
The surveys were used by homeless programs nationwide as a prerequisite for federal funding that provides housing and services within the community that serves homeless populations. The HUD surveys were taken in both sheltered and unsheltered areas of Central Arkansas during each count. The surveys were conducted by the Central Arkansas Team Care for the Homeless (CATCH), students from the University of Arkansas at Little Rock School of Social Work, and local law enforcement from the Little Rock Police Department (LRPD) and community volunteers.

The Point in Time surveys were conducted as face-to-face, self-reported interviews by the CATCH, student volunteers or community volunteers. Each participant was provided written information, informed consent, and a personal hygiene bag for their participation in the interview. Each survey (2004 and 2011) was approved by the Institutional Review Board (IRB) from the University of Arkansas at Little Rock.

In addition to face-to-face interviews with each participant, each facility or agency was asked to describe the type of beds available, and if any additional beds were marked for individuals or families with children. Another form was developed to address those homeless living in camps or who were unsheltered, noting the sites for these individuals and their basic demographics.

Information was also collected via interviews with some of the homeless providers who did not participate in the survey during the January 2011 count. This was completed in order to add qualitative data on older homeless adults and was taken from an outreach event for homeless persons that occurred during October 2011.

After the quantitative data was gathered and analyzed for 2004 and 2011, the researcher felt it was important to survey homeless providers for their observations to
enrich the quantitative and limited qualitative data already collected. The survey for the interview was an original design, consisting of nine questions including type of agency or program, position of the participant, observations on older homeless adults who receive support and services, trends and recommendations for special needs of the older homeless adult, and any comments the participant chose to include. The survey also asked what, if any, services may be needed or added to address the needs of homeless persons 50 and older. Research was done using Arkansas Democrat Gazette articles on homelessness dating from 1892 to 2012, and telephone and face-to-face interviews were conducted in September 2012 to current homeless providers for their observations about homelessness and aging.

The qualitative survey was conducted using Survey Monkey (Jan 2011) as well as telephone and face-to-face interviews to homeless providers. For these interviews, providers were asked to report their observations about the homeless population they served in 2004 and 2011 to see if they observed any differences in age of homeless clients seeking shelter and services. Telephone and face-to-face interviews were conducted in September of 2012 to add to the richness of qualitative data received via Survey Monkey.

Samples

The quantitative research samples consisted of homeless participants in the 2004 and 2011 Point in Time Counts for Central Arkansas. During the 2004 and 2011 counts, 10 of the 40 local homeless agencies that provide services and support requested UALR School of Social Work to assist in collecting count information using
the Point in Time Count Survey developed by HUD. In 2004, a total of 213 homeless persons participated. Of the total, 173 (81.2%) were aged 18-49 with 40 (18.8%) reporting age 50 or older. In the 2011 survey, a total of 258 participants were surveyed, with 136 (55.7%) reporting age 18-49 and 108 (44.3%) reported being 50 or older. The qualitative sample consisted of persons who worked in thirty homeless agencies or programs in the Central Arkansas areas of Pulaski, Lonoke, Faulkner, and Saline Counties with data collected using Survey Monkey via the Internet. The additional qualitative sample consisted of four local homeless providers and data taken from telephone and personal interviews.

Measures

For race, African American and Caucasian were reported as labels and those who answered Asian, Native American, Inuit, Hispanic, or “other” were reported as “other”. For purposes of analyses, persons reporting age as 18-49 represented younger homeless persons, while age 50 and older represented older homeless persons. A participant reporting physical health problems, mental health problems, developmental disability, veteran status, or HIV/AIDS status were analyzed and created to represent presence or absence of these characteristics. Chronicity was used to label length of time or how many times a participant was homeless within the past three years. For drug and alcohol use, this research used the label substance abuse in analyzing the data collected.
Data Collection

A Point in Time Count Survey (Appendix B) was taken to determine what services may be necessary to reduce or eliminate homelessness, and to detail the changes in population during economic stress. In 2004, students from University of Arkansas at Little Rock (UALR) Graduate School of Social Work and community volunteers conducted two assessments in the central Arkansas area following the Housing and Urban Development (HUD) survey guideline and criteria for homeless funding. Approval for the 2004 count was granted by UALR Institutional Review Board (IRB) on January 2004 and 2011. Informed consent to participate in the survey was presented and signed by each participant and those who participated received a copy.

The consent to participate in the homeless survey included the following:

1. The purpose of the study.
2. A description of procedures to be followed and duration of the survey.
3. The descriptions of any discomforts, inconveniences, or risks that could result from participation in the survey.
4. Description of confidentiality and the limits of assurance.
5. Anticipated benefits from participating in the survey.
6. Alternate procedures, including the participant’s right to choose the questions they would or would not want to answer.
7. Contact information for questions or concerns regarding the study and their participation in the survey.
8. The right to participate or not participate in the survey study.

Surveys for both 2004 and 2011 were administered via personal interview using the HUD Point in Time survey with additional questions developed by Dr. Carolyn L. Turturro of the UALR School of Social Work and Gerontology.
Shelter directors, program directors, soup kitchens, and participating homeless facilities were contacted prior to each survey to identify times for interviews that did not conflict with meals or programs. Each of the participating facilities made areas available for interviews to assure confidentiality. The interviewer explained the purpose of the survey and received informed consent prior to each interview. Interviews lasted approximately 15 minutes.

The first survey (January 2004) was conducted with participants staying in homeless shelters, soup kitchens, and other organizations that provide services for homeless persons. The second survey was conducted in January 2011 with surveyors visiting homeless persons staying in shelters at the end of that month.

Qualitative data collected from homeless providers was compiled and assessed for trends they observed during the survey counts and at the present time. The purpose of this survey was to investigate homeless resources that were available in the Central Arkansas area at the time of each survey. Additional questions focused on current and future trends in the numbers of homeless persons 50 and over in terms of what, if any, special services were in place or what providers felt should, or needed, to be available to assist them compared to the 18-49 or younger homeless population. Service providers’ survey was taken using Survey Monkey, an Internet survey program. Thirty homeless programs in Central Arkansas were emailed, requesting participation. The survey ran from July 2011 to December 2011 to ensure maximum participation. In addition to the Internet survey, personal interviews were conducted in September 2012 with four homeless providers for additional and current trends in homelessness.
Variables

The variables in this study are the causal factors of a homeless individual. In addition, the research looked at homeless providers to ask if changes in the older homeless adult population had occurred between the 2004 and 2011 in terms of the numbers and need for additional or special services.

The quantitative study surveyed causal factors, physical health problems, mental health problems, developmental disability, chronicity, substance abuse, and veteran or HIV/AIDS status of homeless individuals. Additionally, demographic data variables, age, race, gender, veteran and HIV/AIDS status and chronicity of homelessness were surveyed. Qualitative factors from homeless providers looked at observations for changes in the older homeless population between 2004 and 2011 participants in terms of the numbers and need for additional or special services. Qualitative variables of change observed by homeless providers were reported to determine the need for additional services or special services for the older homeless adults.

Data Analysis

The data sets used were the Point in Time counts taken in 2004 and 2011 in the Central Arkansas areas including Saline, Pulaski, Lonoke, and Faulkner counties. The Point in Time Survey data using SPSS was first cleaned with the following variables from each year: age, race, gender, serious health problems, mental health problems, substance abuse problems, veteran status, HIV/AIDS status, and whether a person was chronically homeless for both 2004 and 2011.
Chi square tests were employed in tests of association between the nominal variables and year of survey. A second cross tabulation analyses was completed to compare younger and older homeless individuals on all other variables, controlling for year of survey.

Multivariate logistic regression was employed to examine predictors of homelessness: age group, veteran status, health problems, and chronicity in relation to year of survey 2004 and 2011 (the dependent variable). An additional multivariate analysis for age (dependent variable) was run to differentiate younger: those participants 18 to 49 years of age compared to those survey participants aged 50 and older.

Summary

This chapter includes the methodology used to analyze both quantitative and qualitative data. For the quantitative research data, the main hypothesis was that the occurrence of causal factors of homelessness such as-- physical health problems, mental health problems, substance abuse, chronicity as length of time homeless, veteran status as well as HIV/AIDS status-- would differ between homeless persons 50 years old and older, and younger 18-49 years old. It was also hypothesized that differences between predictors would occur between the years 2004 and 2011. Analysis using chi square was used to determine if age was associated with predictors of homelessness in cohort groups 18-49 and 50 and older homeless persons. Chi square analysis was also used to investigate whether there were differences associated with the year of survey. Multivariate logistic regression of year (2004 and 2011) and age
(<50 in vs. >50) was employed to differentiate and assess predictors for homelessness and examine the strengths of the relationships among the predictor variables of age, chronicity, health, and veteran status.

For the qualitative research data, the survey and interviews of homeless providers looked at observations about homelessness in general and also homelessness in regards to individuals aged 50 and older in use of services and programs to see if any changes occurred in 2004 and 201, and if those changes suggest a change in services or development of specialized services for homeless adults aged 50 and older.
CHAPTER 4
ANALYSIS AND DISCUSSION OF RESULTS

Introduction

This chapter introduces the quantitative data used for this research. It first discusses data comparing years 2004 and 2011 and review predictors associated with homelessness. First a comparison of demographic data including age, race, and gender, then a comparison of disability predictors including serious health concerns, substance abuse, developmental disabilities, mental health concerns, and veteran status are reviewed.

This chapter also reviews the responses from service providers in the Central Arkansas area regarding the 2004 and 2011 including their observations and their beliefs about the current and future states of homelessness in Arkansas.

Comparisons of Homeless in 2004 and 2011

The quantitative data was first used to compare and contrast predictors associated with homelessness during 2004 and 2011. Comparison was also made between the age groups (under 50 and 50 plus) controlling for year of survey. The variables examined included sex, race, physical health, mental health issues, developmental disability, veteran status, substance abuse, and length of time or chronicity of homelessness.

Table 1 presents a comparison of the sociodemographic characteristics for 2004 and 2011 survey participants analyzed. For gender, there were no associations in proportions of male and female in the samples for years 2004 and 2011. It can be seen
that the majority of the two convenience samples was male for both 2004 and 2011, with no significant differences between years.

Table 1

Comparisons of Sociodemographic Variables from 2004 and 2011 Survey Participants

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2011</th>
<th>Chi Square</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=213</td>
<td>N=248</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>48 (22.6%)</td>
<td>55 (22.2%)</td>
<td>0.014</td>
</tr>
<tr>
<td>Male</td>
<td>164 (77.4%)</td>
<td>193 (77.8%)</td>
<td></td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black/African American</td>
<td>129 (61.4%)</td>
<td>138 (57.3%)</td>
<td>1.80</td>
</tr>
<tr>
<td>Caucasian</td>
<td>70 (33.3%)</td>
<td>86 (35.7%)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>11 (5.2%)</td>
<td>17 (7.1%)</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;50</td>
<td>173 (81.2%)</td>
<td>136 (55.7%)</td>
<td>33.7***</td>
</tr>
<tr>
<td>≥50</td>
<td>40 (18.8%)</td>
<td>108 (44.3%)</td>
<td></td>
</tr>
</tbody>
</table>

***p<.001

For race/ethnicity, approximately one-third of the sample reported being Caucasian in both years 2004 and 2011, while Black/African Americans were the reported majority. Of the total respondents in 2004, 61.4% reported being African American, White/Caucasian reported lower numbers at 33.3% of the total count, with “other” at 5.2%. Of the total of 248 homeless persons reported, race/ethnicity in 2011, Black or African American had the highest number at 57.3%. Percentages of reported race/ethnicity remained roughly the same in samples for 2004 and 2011.
A major finding in the data for age comparisons between 2004 and 2011 was noted. In 2004, 81.2% of participants in the survey identified themselves as fewer than 50 years old, but in the 011 survey only 55.7% of the participants identified themselves as less than 50 years old. For those 50 years of age and older, 18.8% reported in 2004 compared to 44.3% in 2011. This further supports our findings about the older population increasing while the younger population decreased. This was statistically significant at 33.726 chi square ($df =1$), $p<.001$.

Table 2 presents a comparison of disability characteristics between survey years 2004 and 2011. There were no significant findings for serious health problems, substance abuse problems, and developmental disabilities.

Table 2

<table>
<thead>
<tr>
<th></th>
<th>2004 N=213</th>
<th>2011 N= 248</th>
<th>Chi Square</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious Health Problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>72 (33.8%)</td>
<td>51 (20.9%)</td>
<td>0.509</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>97 (45.5%)</td>
<td>116 (47.5%)</td>
<td>0.006</td>
</tr>
<tr>
<td>Developmental Disabilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>27 (12.7%)</td>
<td>23 (9.3%)</td>
<td>1.371</td>
</tr>
<tr>
<td>Serious Mental Health Concerns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>83 (39.0%)</td>
<td>66 (26.7%)</td>
<td>7.83**</td>
</tr>
<tr>
<td>Veteran Status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>61 (28.6%)</td>
<td>45 (18.1%)</td>
<td>7.12**</td>
</tr>
</tbody>
</table>

**$p<.01$**

The report of serious mental health problems was found to be statistically associated with year of survey. The report of serious mental health problems was reported by 39.0% of participants in 2004 and 26.7% of participants in 2011. Chi square
7.83 \((df = 1)\) was significant at \(p < .01\). The last characteristic comparison was veteran status, which was also significantly associated with year. Veteran status was reported by 28.6% of homeless participants in 2004 and 18.1% in 2011, which was statistically significant \((\text{chi square} = 7.13 \,(df = 1), \, p < .01)\).

In summary, comparisons of disability characteristics from 2004 to 2011 data for serious health concerns, substance abuse, and developmental disabilities did not change. There was change that was statistically significant for serious mental health concerns and veteran status from one year (2004) to the other (2011).

Table 3

*Comparison of Homelessness Characteristics for 2004 and 2011 Survey Participants*

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2011</th>
<th>Chi Square</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(N=213)</td>
<td>(N=248)</td>
<td></td>
</tr>
<tr>
<td>Non-chronic</td>
<td>(n=90 ,(42.3%))</td>
<td>(147 ,(59.3%))</td>
<td>1.191</td>
</tr>
<tr>
<td>Chronic</td>
<td>(n=123 ,(57.7%))</td>
<td>(101 ,(40.7%))</td>
<td></td>
</tr>
</tbody>
</table>

Chronicity of homelessness was surveyed for both the 2004 and 2011 counts. Chronic homelessness was defined as number of months a person reporting being homeless in the past 12 months or in the past three years. Chronicity was not associated with year of survey.

Table 4 presents findings of homeless data in 2004 and 2011, and compares older with younger homeless adults, controlling for time. The predictors of serious health problems, chronicity of homelessness, developmental disabilities, serious mental illness, veteran status, substance abuse, HIV/AIDS, and their association with age group are investigated controlling for time.
Table 4 represents Descriptive Statistics for 2004 and 2011 by age group. Survey participants under the age of 50 compared to those who were 50 and older reported “yes” to serious health problems; was not significant.

Table 4

Descriptive Statistics by <50 and >50 Age-Groups Controlling for Year

<table>
<thead>
<tr>
<th></th>
<th>2004 N=173</th>
<th></th>
<th>2011 N=136</th>
<th></th>
<th>Chi Square</th>
<th>2011 N=108</th>
<th></th>
<th>Chi Square</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt;50</td>
<td>&gt;50</td>
<td>&lt;50</td>
<td>&gt;50</td>
<td></td>
<td>&lt;50</td>
<td>&gt;50</td>
<td></td>
</tr>
<tr>
<td>Number</td>
<td>N=173</td>
<td>N=40</td>
<td>N=136</td>
<td>N=108</td>
<td></td>
<td>N=136</td>
<td>N=108</td>
<td></td>
</tr>
<tr>
<td>Health Problems</td>
<td>56(32.4%)</td>
<td>16(18.8%)</td>
<td>41(17.6%)</td>
<td>27(25.0%)</td>
<td>.845</td>
<td>41(17.6%)</td>
<td>27(25.0%)</td>
<td>1.96</td>
</tr>
<tr>
<td>Chronicity</td>
<td>96(55.5%)</td>
<td>27(67.5%)</td>
<td>50(36.8%)</td>
<td>51(47.2%)</td>
<td>1.92</td>
<td>50(36.8%)</td>
<td>51(47.2%)</td>
<td>2.71+</td>
</tr>
<tr>
<td>Developmental Disabilities</td>
<td>22(12.7%)</td>
<td>5(12.5%)</td>
<td>16(11.8%)</td>
<td>7(6.5%)</td>
<td>.001</td>
<td>16(11.8%)</td>
<td>7(6.5%)</td>
<td>1.96</td>
</tr>
<tr>
<td>Mental Health</td>
<td>61(35.3%)</td>
<td>22(55.0%)</td>
<td>53(39.3%)</td>
<td>38(27.9%)</td>
<td>5.323*</td>
<td>53(39.3%)</td>
<td>38(27.9%)</td>
<td>.124</td>
</tr>
<tr>
<td>Veterans’ Status</td>
<td>45(26.0%)</td>
<td>16(40.0%)</td>
<td>17(12.5%)</td>
<td>28(25.9%)</td>
<td>3.11+</td>
<td>17(12.5%)</td>
<td>28(25.9%)</td>
<td>7.21**</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>97(45.7%)</td>
<td>18(45.0%)</td>
<td>65(47.8%)</td>
<td>51(47.2%)</td>
<td>0.006</td>
<td>65(47.8%)</td>
<td>51(47.2%)</td>
<td>.008</td>
</tr>
<tr>
<td>HIV/AiDS</td>
<td>4(2%)</td>
<td>0</td>
<td>1(0.7%)</td>
<td>0</td>
<td>.402</td>
<td>1(0.7%)</td>
<td>0</td>
<td>.361</td>
</tr>
</tbody>
</table>

+ p<.10, *p<.05, **p<.01, ***p<.001

For chronicity of homeless persons in 2004, 55.5% participants from the <50 group reported to being chronically homeless while 67.5% participants who were 50 or older reported “yes” to being chronically homeless. Reporting for groups in 2011, the <50 group had 50 participants at 36.8% and an increase in the 50 and older group at 47.2% reporting “yes” to chronic homelessness. This was a trend toward statistical significance at p < .10. There was no significance, however, with chi square controlling for year.

For developmental disability, it was hypothesized that older homeless persons were more likely to report a developmental disability than their younger homeless persons.
cohorts in 2004 and in 2011. Chi square analysis was not significant.

For serious mental health, it was hypothesized that older adults were more likely to report having serious mental illness than younger adults. In 2004, 35.3% of participants <50 reported a serious mental health problem compared to 55.0% of those 50 and older who reported yes to a serious mental health problem. There was a statistical significance at 5.323** $p < .05$ for 2004.

For the label, veteran status, the research hypothesized that older homeless persons were more likely to report veteran status than their younger counterparts. Veteran status was a question on the survey for both 2004 and 2011. Of the total count for 2004, 26.0% of the participants who were <50 reported being a veteran to 40.0% persons 50 and older who reported veteran status. This was reported in the difference between age cohorts for 2004 at 3.111+ ($p < .10$). For 2011, of the participants <50, 12.5% reported veteran status as compared to the participants 50 and older at 25.9%, with chi square significance at 7.214** (**$p < .01$) and chi square controlling for year being significant at 5.247*(*$p < .05$). There was a decrease in those participants who reported being a veteran from 2004 to 2011.

A question on the homeless survey asked each participant to report issues or concerns with substance abuse. The 2004 and 2011 homeless survey question about substance abuse was not significant for either 2004 or 2011 or combined year total. Chi square, controlling for years, was not significant.

The final hypothesis was that older homeless persons were more likely to report HIV/AIDS status more than the younger homeless population. The question about
HIV/AIDS status was reported by both cohort groups for 2004 and 2011 with a very small percentage of those who answered, the data was dropped from further analysis.

In summary, findings for Table 4, Descriptive Statistics for 2004 and 2011 by age groups, revealed no significant changes in serious health problems, substance abuse, and developmental disability. In chronicity, there was perhaps a small change between age groups in 2011, with 2.71 chi square value at p<.10. This could be due to the number of programs and funding available to veterans, as there was a significant decrease in the numbers of veterans in both age groups and in both 2004 and 2011. The data on HIV/AIDS status was considered small that results were not reported. This may be due to the stigma of HIV/AIDS for both age groups.

Multivariate Logistic Regression

Logistic regression was performed to assess the odds of risk factors' prevalence in year to year comparison and within age groups, younger homeless vs. older homeless (<50 vs. >50), for 2004 and 2011.

In the comparison of age groups, it was found that older adults were more likely to be veterans in comparison to younger homeless adults from 2001 as compared to 2004. The predictor variables of gender, mental health status, developmental disability, substance abuse, and race were not significant to the regression findings.

The homeless in 2011 were more than four times as likely as those in 2004 to be aged 50 years and older. The predictors of gender, health status, mental health status, developmental disability, substance abuse, and race were not found to be significant. Chronicity of homelessness was more likely to occur in 2011 in comparison to 2004.
Veteran status was almost two times less likely to occur in 2011 as compared to 2004.

Table 5

Logistic Regression with Age Groups: Younger (18-49) <50 and 50 and Older > 50 with Predictor Variables

<table>
<thead>
<tr>
<th>Predictors</th>
<th>Wald</th>
<th>Sig</th>
<th>Exp(B)</th>
<th>95%C.I.forExp(B) Lower</th>
<th>95%C.I.forExp(B) Upper</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>.082</td>
<td>.775</td>
<td>.927</td>
<td>.533</td>
<td>1.555</td>
</tr>
<tr>
<td>Chronic</td>
<td>12.825</td>
<td>.000</td>
<td>.469</td>
<td>.310</td>
<td>.710</td>
</tr>
<tr>
<td>Health</td>
<td>7.964</td>
<td>.005</td>
<td>.503</td>
<td>.312</td>
<td>.811</td>
</tr>
<tr>
<td>Mental Health</td>
<td>3.718</td>
<td>.054</td>
<td>.635</td>
<td>.400</td>
<td>1.008</td>
</tr>
<tr>
<td>Dev. Dis</td>
<td>.418</td>
<td>.518</td>
<td>1.252</td>
<td>.634</td>
<td>2.474</td>
</tr>
<tr>
<td>Veteran</td>
<td>10.367</td>
<td>.001</td>
<td>.430</td>
<td>.257</td>
<td>.719</td>
</tr>
<tr>
<td>Sub abuse</td>
<td>.008</td>
<td>.928</td>
<td>1.019</td>
<td>.678</td>
<td>1.530</td>
</tr>
<tr>
<td>Race</td>
<td>.322</td>
<td>.571</td>
<td>.879</td>
<td>.564</td>
<td>1.371</td>
</tr>
<tr>
<td>&lt;50 vs. &gt;50</td>
<td>39.492</td>
<td>.000</td>
<td>4.494</td>
<td>2.812</td>
<td>7.180</td>
</tr>
<tr>
<td>Constant</td>
<td>2.259</td>
<td>.133</td>
<td>2.155</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 6

Logistic Regression for 2011 vs. 2004 with Predictor Variables

<table>
<thead>
<tr>
<th>Predictors</th>
<th>Wald</th>
<th>Sig</th>
<th>Exp(B)</th>
<th>95%C.I.forExp(B) Lower</th>
<th>95%C.I.forExp(B) Upper</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>2.905</td>
<td>.088</td>
<td>1.654</td>
<td>.927</td>
<td>2.950</td>
</tr>
<tr>
<td>Chronic</td>
<td>5.012</td>
<td>.025</td>
<td>1.649</td>
<td>1.064</td>
<td>2.554</td>
</tr>
<tr>
<td>Health</td>
<td>3.010</td>
<td>.083</td>
<td>1.554</td>
<td>.944</td>
<td>2.557</td>
</tr>
<tr>
<td>Mental Health</td>
<td>1.975</td>
<td>.160</td>
<td>1.417</td>
<td>.872</td>
<td>2.304</td>
</tr>
<tr>
<td>Dev. Dis</td>
<td>2.672</td>
<td>.102</td>
<td>.533</td>
<td>.250</td>
<td>1.134</td>
</tr>
<tr>
<td>Veteran</td>
<td>5.781</td>
<td>.016</td>
<td>1.879</td>
<td>1.124</td>
<td>3.141</td>
</tr>
<tr>
<td>Sub abuse</td>
<td>.020</td>
<td>.886</td>
<td>.970</td>
<td>.635</td>
<td>1.481</td>
</tr>
<tr>
<td>Race</td>
<td>1.193</td>
<td>.275</td>
<td>1.301</td>
<td>.811</td>
<td>2.087</td>
</tr>
<tr>
<td>2011 vs. 2004</td>
<td>39.983</td>
<td>.000</td>
<td>4.699</td>
<td>2.909</td>
<td>7.592</td>
</tr>
<tr>
<td>Constant</td>
<td>26.621</td>
<td>.000</td>
<td>.038</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
In summary, the comparison of 2011 to 2004, it was found that homeless persons were more likely to be older and less likely to report being a veteran, chronically homeless, and having serious health problems. In the comparison between age groups, it was found that older adults were more likely to be veterans, chronically homeless in 2011 in comparison to younger homeless adults.

Qualitative Findings

For the qualitative data, a survey was posted via the Internet using Survey Monkey and followed up by “face-to-face” and telephone interviews. The Provider Survey was posted July 7th, 2011. Thirty participant organizations and programs were contacted and, of the seven participants who began the survey, six completed the survey in its entirety. An additional four providers were interviewed face-to-face and by telephone to add to the data. The providers were asked if older homeless persons used their services and if they thought specialized services were or would be needed to help those homeless who are aged 50 and older.

Descriptive Characteristics-Types of Homeless Providers included in the survey were reported as: emergency shelter programs, food pantry providers, soup kitchens, mental health care programs, and veteran’s homeless programs. Some of the listed categories for types of providers who had no response were: Permanent Housing Programs, programs accepting vouchers for temporary accommodation, or other for-profits, HIV/AIDS programs, or any Drop-in Program or Outreach programs in the area.

This additional study conducted a qualitative survey to look at those programs and services that work with the homeless. Questions were aimed at observations made
by staff and directors of these programs to ask if they noticed any changes in the age of
participants. One homeless provider stated:

I’ve been working with homeless persons for many years and that I believe there
will not only be more homeless, due to the current economic environment and
natural disaster occurrences such as Katrina, but more and more older folks who
will become down and out and will need our help.

The most common replies for what we, the government at both local, state, and
national levels could do to assist replied, “More money, more housing, more programs,
and more volunteers.”

Other providers commented on the need for specialized programs for those older adults
who have chronic substance abuse and mental health issues. Comments also included
women who are reporting being homeless in the veterans’ programs. A VA homeless
provider commented in a recent interview:

The VA, in particular, needs to have more than just housing for our older vets,
these guys need support for chronic health and mental health needs. Now, it’s
not just male vets, but females as well, they will all need help!
CHAPTER 5
CONCLUSION, DISCUSSION, RECOMMENDATIONS, LIMITATIONS

Conclusion

The research data analyzed was collected in 2004 and 2011 using the Housing and Urban Development (HUD), Point in Time Surveys, conducted in Central Arkansas. The data was aggregated and secondary analysis was used to scrutinize parts of the existing data to include possible predictors of homelessness, age, race, gender, physical and mental health, substance abuse, developmental disability, length of time homeless, HIV/AIDS status, as well as Veteran status. All of the measures surveyed were by self-report from homeless participants. This research examined the factors of homelessness within the age groups 18-49(<50) and 50 (>50) and older, looking at substance abuse, developmental disability, HIV/AIDS, and veteran status, as well as physical and mental health.

Both quantitative and qualitative data were collected to compare and contrast predictors associated with homelessness during 2004 and 2011. The quantitative data included HUD Point in Time Surveys taken in shelters, soup kitchens, and homeless camps in the counties of Pulaski, Faulkner, Lonoke, and Saline in central Arkansas. The qualitative data was taken via Internet survey and personal interviews with homeless providers in the same area.

The bivariate analysis revealed that percentages of race/ethnicity remained roughly the same in samples for 2004 and 2011. The year-to-year comparisons were significant for age, with the older homeless population increasing from 2004 to 2011. For gender, there were no associations in the portions of male and female in 2004 to
2011, but males were observed as the majority of the two convenience samples for both years.

In the bivariate analysis of Comparisons of Disability Characteristics from 2004 to 2011 there was statistical association for serious mental health problems and veteran status from year to year. The findings from data analyzed for 2004 and 2011 by age groups showed no significant associations for serious mental health problems, substance abuse, and developmental disability. There was a small change in chronicity observed with slight change in 2011.

From the findings of survey participants, the majority of both age groups in 2004 and in 2011 report HIV/AIDS status at 4 (2%) for 2004, (0.7%) in 2011. The research may be skewed as many homeless may feel the stigma of HIV/AIDS and do not report, period.

In the multivariate analysis for year-to-year, logistic regression revealed that homeless persons were significantly more likely to be older than younger persons in 2011 compared to 2004. Being a veteran, physical health problems, and chronicity were less likely in 2011 as compared to 2004. Multivariate logistic regression differentiating younger and older homeless adults in 2004 and 2011 revealed that older adults were more likely to be veterans, chronically homeless, and have data collected in 2011 as compared to 2004. Review of the qualitative data from interviews and surveys with homeless providers revealed the need for more funding, more services, and specialized services for the older adults. HIV/AIDS had very small numbers so statistical analysis produced very little findings and was omitted from further investigation.
Discussion

This research began with a review of the literature on the history of homelessness in Arkansas to help understand the cultural and political climate involving homelessness in the Central Arkansas area.

Homelessness and causes for homelessness, in general, were traditionally based on Victorian views of the period and many of the ideas on homelessness are still considered. The homeless were labeled as “lazy” and unwilling to work. In reviewing the literature, there are also theories that perhaps more appropriate for current causes or predictors of homelessness. Cohen and Felson (1979) argued that homeless persons are mostly victims due to their lack of shelter, work, or any social support. Felson’s theory of victimization suggests that the risks of becoming a victim of crime for older homeless adults are based on their vulnerability, lack of physical or mental capacity to defend themselves on the streets or in shelters, as well as being labeled as easy targets from motivated offenders.

In the research findings, the predictor variable “older adult” was labeled as those homeless participants age 50 and older. While gender was not statistically significant in the findings, the literature supports an increase not only in age, but gender. This may be considered a factor for older homeless women who are victims of poverty and deep poverty. In Diana Pearce’s 1978 theory of the “feminization of poverty,” older women are increasing among the poor in the United States. Many older women do not have work histories and do not currently perform paid work caring for family. This places women at a risk for poverty, which may result in homelessness.
Traditionally, older adults have moved in with families when they could no longer afford or were no longer physically or mentally capable of living independently. Those persons without family support were often placed in long-term care facilities regardless of their ability or desire to remain independent with assistance. Those who could not afford the collateral costs of utilities, food and medicines, or lacked access to services and support due to transportation issues, often create a population of older adults, without support, may find themselves homeless. The literature on homeless adults observed that the statistics regarding this subpopulation of older adults, aged 50 and older, is difficult to determine because these adults often double up with family.

Articles from the *Arkansas Democrat Gazette*, from 1892 until the first recognized counts for homeless persons began in the 1970s, examined homelessness in Arkansas. These articles and data recount the devastation of crop failures and natural disasters in Arkansas that resulted in dramatic increases in the homeless population during those times.

The total homeless population in Arkansas has fluctuated from lower numbers in statewide counts. Central Arkansas counts in 2004 and 2011 are samples taken from the full counts during those years. In 2004 the Central Arkansas count was 213 and 258 for 2011. But statewide counts were as high as 16,665, when Hurricane Katrina displaced many evacuees from Louisiana to Arkansas. From these events, one of the main themes observed throughout this research was the lack of shelter or housing as a priority concern in helping the homeless begin the process of improving their lives.

Homelessness in Arkansas has been a subject for cause and debate, dating back as early as 1892 to the homeless counts which took place in January, 2011. Many
homeless were overlooked; the communities referred to them as “drifters.” Shirley Lea (Arkansas Democrat Gazette, 1989) wrote that the homeless seen in Arkansas at that time were not “drunks or drug addicts or crazy,” but simply persons needing and wanting to work to support their families.

As the current literature on homelessness in Central Arkansas was reviewed, many articles cited hate crimes against homeless persons. In the Democrat Gazette article (Sept 27, 2010), a homeless man was found beaten and dead on Main Street in North Little Rock. This attitude has been seen across the country with the 2009 Annual Homeless Assessment Report (1999-2009), which noted eleven attacks against homeless persons, resulting in five deaths.

For this research on homelessness in the older population of Central Arkansas, the hypotheses tested asked if there will be differences in factors associated with homelessness for young and older persons over time in observed predictors: serious health problems, substance abuse, developmental disabilities, serious mental health problems, and veteran status. The findings of the data inform homeless programs about the makeup of homeless population at the time of each count and are useful in program development for the homeless of Central Arkansas.

Univariate analysis and multivariate regression analysis for year-to-year comparisons and age groups within each year revealed some associations. For age, older homeless persons increased from 2004 to 2011. This supports our observations and understanding about aging in that, as our world ages, the likelihood that older adults will be at risk for homelessness increases.
In Arkansas, the predictors of serious physical health, substance abuse, and those homeless who have a disability reported decreases from year to year. This decrease could be attributed to those disabled receiving medical aid from the government through Medicare and Medicaid programs, increased social services and support agencies, as well as the increased funding and programs for homeless veterans. As an example, in Central Arkansas, programs such as River City Ministries provided medical, mental, and dental care to the homeless.

In addition to support and services, the cities of Little Rock and North Little Rock partnered in the past ten years with the Veterans Administration and surrounding hospitals, churches, and volunteer organizations to support “stand down” events. These events drew as many as 4,000 (2004) homeless from central Arkansas and from around the state. The stand down events were community events that provided free medical care, mental health, health screenings and immunizations, legal assistance, and housing assistance, as well as food, clothing, haircuts, and showers to the homeless. These events not only drew attention to the plight of the local homeless population, but to homelessness in general. It also served to educate the community about homeless concerns (Arkansas Democrat Gazette: NLR Park to become brief oasis for needy. Sept 22, 2004).

The decrease seen in veteran homeless status could be attributed to the increase in funding for support and services for veterans. The literature for those veterans who return from military service after experiencing war and the violence of war reports that some struggle with the social challenges at home. Some veterans were successful with service-related problems, but there are also veterans who weren’t and
became homeless. The reasons for homelessness among veterans are numerous, such as isolation among friends and relatives, substance abuse, post-traumatic stress disorder, and a lack of post-service employment opportunities.

Recent and current politics on homelessness in Arkansas helps us understand the stigma and non-commitment to the homeless or homeless issues that continue to hinder efforts to alleviate and end homelessness.

In 2004, the National Coalition for the Homeless named the city of Little Rock the “meanest” place to be homeless out of 24 cities surveyed. During that time, the city of Little Rock was preparing for the opening of the Clinton Presidential Library by planning a police sweep of homeless persons living near the site (NBC News, 2004). In 2005, the Bush administration sent the Director of the US Interagency Council on Homelessness to Little Rock to endorse the “Ten Year Plan to End Homelessness.” Philip Mangano, Director, applauded the collaboration between community and local government to work together to end homelessness in Central Arkansas.

Efforts to establish homeless services and support continued to meet resistance from the local government. Although Little Rock and North Little Rock jointly awarded River City Ministries funding to increase its services while searching for a site for a day center (2007), little was accomplished in the “Ten Year Plan to End Chronic Homelessness in Central Arkansas.” The ten year plan was developed by a group made up of coalition members from Central Arkansas Team Care for the Homeless (CATCH), nonprofit, federal and local government representatives, as well as University of Arkansas at Little Rock and community advocates. These efforts continued to find a place to establish a day center in the area to serve the homeless of central Arkansas.
Many shelters and programs needed continuing funding in order to remain open to serve the homeless population.

The coalition team met resistance from cities of Little Rock and North Little Rock officials. Several sites were recommended for establishing a homeless day center, only to be dismissed due to pressure from city businesses and neighborhoods who would not support sites “not in our neighborhood” stigma. In the June 15th article by Kelly Connelly (KUAR news), Little Rock Mayor Mark Stodola reported three separate sites for consideration for a homeless day center. Ward directors for the sites were opposed to any plans for homeless programs or facilities citing an increased risk in crime and panhandling in their wards.

This pattern continued until the summer of 2011 (KATV, Breaking News, June 29, 2011) when the Little Rock City Board of Directors finally approved a possible site, not in downtown Little Rock, but in an industrial area outside the downtown business area. The new site, owned by Union Rescue Mission in Little Rock, was supposed to be renovated and opened by January 2012, according to the Mayor. The most recent news (Aug. 2012) from the *Arkansas Democrat Gazette* report that the day center site will open around Thanksgiving of this year, but the site is far from being ready.

To combat homelessness in the United States, The U.S. Interagency Council on Homelessness (USICH) published a report titled Opening Doors: Federal Strategic Plan to Prevent and End Homelessness (2010). This document states that one of the primary goals of this agency is to end homelessness by 2015 for veterans and chronic homeless persons, many of whom are older adults. The plan also calls for the end of
homelessness for families, children, and youth by 2015. The plan is aimed at providing programs and services to help address housing issues.

Some of the collaborative initiatives outlined in the USICH fact sheet indicate that our government has taken the task of ending homelessness to heart. One of the programs listed is the Veteran’s Affairs Supportive Housing Program (HUD-VASH). This program combines housing vouchers for rental assistance to qualifying veterans with case management and supportive services, such as clinical services offered by the VA. Housing and Services for Homeless Persons Demonstration (HUD-HHS Voucher Program) is a new program using HUD vouchers with supportive services from Human and Health Services designed to serve homeless families as well as chronic homeless persons.

This research also discussed some of the reasons for homelessness, especially chronic homelessness. Two of the most important predictive factors were housing availability and accessibility. Housing is assumed to be a basic right for Americans, yet many Americans go without housing, either through circumstances of physical or mental health, or the state of the economy. Implications of this and other factors need to be addressed if we are to end homelessness. On March 10, 2011, the National Law Center on Homelessness and Poverty reported that the US government filed an official response to end homelessness in America, including their recommendations from the United Nations Human Rights Council, acknowledging homelessness and its human rights obligations. Eric Tars (2010), Human Rights Program Director at the National Law Center, reported:

Three-quarters of Americans agree that housing is a basic “human right” and that the Obama Administration is supportive of reducing homelessness as a basic
human right obligation. Tars further requested that Americans urge the Administration to tell Congress to stop cutting billions of dollars of housing assistance from the budget. That would defeat the very purpose of the recommendations they say they support.

The United States Interagency Council on Homelessness recently released their Fiscal Year 2012 Federal Government Homelessness Budget Fact Sheet, which reported that Obama administration support for homeless programs and projects included a 23.4% increase in funding from Fiscal Year 2010, and a 13.3% increase over Obama’s Fiscal Year 2011 Budget Proposal. Obama is quoted as saying in 2011, “Now, more than ever, we have a responsibility to tackle national challenges like homelessness in the most cost-effective way possible, to end homelessness as we know it.”

Lastly, the Opening Doors Chronic Homeless Signature Initiative assists low-income, single adults who do not have children. These persons will meet eligibility criteria for Medicaid. This program will provide wrap-around services for these individuals, to include substance abuse and mental health services in order to give support that will promote independence and stability. Program funding will also be available for emergency food and shelter, runaway youth and homeless youth, homeless veterans, homeless providers, per diem grants, and HUD Emergency and Rapid Transition to Housing (HEARTH Act, 2009).

Recommendations

Recommendations for the improvement of this study are to focus on the older population and to include questions about doubling up with friends or relatives. Questions about the ability of those 50 and older to sustain themselves in the
community with support, and the way this ability is correlated to their homelessness, would be useful. The Point in Time survey used for homeless counts should include more questions that reflect older adults, their needs, and any additional services they may request for assistance.

Another recommendation has to do with methods and ways to survey those homeless persons who live in rural areas. These problems are the same as suburban and city homeless persons in that they are already an underserved, marginalized group, both young and older groups, but unlike city and suburban homeless, they have less access to services and support. Those who are homeless in rural areas are at an increased risk for both mental and physical problems, substance abuse, HIV/AIDS, and other concerns similar to that of suburban and city homeless, but with less access to support and services to help meet their needs. The McKinney-Vento Homeless Assistance Act (HEARTH Act.2009) made some amendment changes including the creation of a Rural Housing Stability Program to help meet the need for rural homeless persons, including the older homeless adult.

Education on homeless issues, community awareness, and support through community programs such as indigent health care services, as well as housing opportunities, will help improve the plight of the homeless American. As homeless programs are funded or re-funded, training and education on services and support will provide the best outcomes for homeless persons receiving assistance with the goal of sustainability and decreasing the numbers of chronic homeless persons. Programs for homelessness need further education on assessment and resources specifically for the older adult.
Current efforts to end homelessness are seen in the Veteran’s Administration programs to end homelessness among veterans by 2015. These programs and support will greatly benefit those older veterans who are 50 and older but do not address those homeless older adults who are not veterans. Recommendations for similar programs and support need to be available to non-veteran persons, including those 50 and older.

The US Department of Health and Human Services (2003-03) Program Assistance Letter cites recommendations from providers who serve elderly homeless persons include: comprehensive centers where older homeless adults can have access to all services in one location; the use of multidisciplinary teams in addressing older homeless persons’ concerns and needs; provisional housing which may help older homeless adults to reconnect with social support from family, friends and cohorts. Further recommendations should include alternate insurance for those older adults who are not yet eligible for Medicare nor have access to affordable health care, as well as outreach programs in shelters and programs that have services and support for older adults. Providing alternate health insurance will not put older homeless persons at risk for victimization from younger homeless individuals who are in shelters and programs.

Recommendations for immediate or current support in assessing at-risk elderly who live in the community. The need for programs and services to help older adults, who are frail and chronically homeless, with immediate housing will be vital in serving this special population, providing sustainable support and services whether in their own home or transitional housing is key reducing the risk of homelessness. Organizations such as the Committee to End Elder Homelessness (CEEH, 1991) collaborates with community-based organizations, services, and support for the elderly in their own
homes and in transitional housing, providing health care and other assistance until more stable or permanent housing can be found.

In the near and far future, community outreach, and advocacy will be vital in increasing awareness and knowledge about the homeless older adult. With knowledge from community outreach and support, older adults will have better understanding of the programs and services available to them. Advocates, geriatric case management for the older homeless, can navigate social services systems to ensure access and support as the maze of program eligibility requirements or location of services can be overwhelming to the older adult, especially those older adults who are experiencing homelessness for the first time.

Future recommendations of outreach education for communities and social service support systems will need to be available. Recommendations for interdisciplinary team approach in assessing and supporting the older adult will be needed in order to address the specific needs and concerns of the older adult population, as many older homeless adults require special attention in housing and programs.

Limitations of Study

In regards to researching homelessness in Arkansas, as well as the US, research is hampered by lack of funding and imprecise methods of data collection. The homeless in each district or state are consistently underreported. Since the distribution of federal and state funding is directly affected by the census data, underreporting homeless hurts the state’s ability to combat homelessness in their communities,
counties, and districts. The numbers form the 2010 census data will also affect congressional districts, resulting in a loss or gain of representatives in Congress who will vote on homeless programs.

Also, with the current economic woes in America, policies and funding are more likely to be directed at programs such as job training and mortgage rates, while spending cuts will affect programs such as Medicare, Medicaid, and Social Security, all of which are the lifeblood of older adults.

The limitations of these services (grant funding for homeless programs), are identified in the new guidelines for application in 2012 HUD grants. These limitations will be seen in the re-competition for grants; not grants that have, in the past, been renewed with little or no competition. In previous years, many grant awards were simply re-awarded to existing grantees.

Grants awarded in targeted areas including education for homeless children and youth, health care, benefit grants, supportive housing grants, and assistance in transition grants for the homeless.

For the qualitative findings, a survey was conducted on the Internet, via Survey Monkey, to local homeless providers in order to better understand providers of services for older homeless adults. While this data will help providers and volunteers who assist older homeless adults to better understand our aging homeless population and types of services available to assist them, the limitation is that many providers, although with internet access, either declined to participate or did not have time or interest in the survey. From the personal interviews, in general, information was subjective to how each provider views homelessness, as well as the agency in which they work.
Additionally, the researcher felt there was a need to collect additional information on each program’s mission about how, and how much, to help the homeless individual.

In addition to the quantitative data, this study was limited by the number of providers who participated and the mechanism of using an Internet survey site to collect data. While no significant changes were observed or reported, a few of the survey participants made comments about the need for specialized services for those homeless who are aging out as chronic homeless, or they predict the need for future older adults who may become homeless. The reasons given in the qualitative responses were population growth and poor economic outcomes, especially among older women.

Additional data is needed, including better qualitative data, to understand the homeless older adult in comparison to the younger homeless person. In particular, better data is needed regarding the length of time homeless and the factors associated with special considerations when providing supportive services for the older homeless population.

Another limitation again that collected data may not be an accurate count of the older homeless adult, since many older homeless adults “double up” with family and friends, avoiding shelters, streets, and supportive services. Significance of predictors was difficult to analyze in actual numbers as surveys were taken at two points in time, with no way to verify if those participants were the same cohort group from 2004 to 2011. Also, the number of shelters, as well as providers, changed during the time between 2004 and 2011, with the 2004 count including more shelters and additional homeless camps.
Between 2004 and 2011 there was an observed change in type and number of homeless programs and facilities in which to complete homeless surveys, which could also be seen as a contributing factor for decreased numbers in participating homeless persons in Central Arkansas.
APPENDIX A

PARTICIPANT INFORMED CONSENT FORM FOR POINT IN TIME HOMELESS SURVEY HOMELESS SURVEY CONSENT
For Interviewer:

Hi, my name is [your first name]. Thank you for taking part in this survey. You should have already been given a copy of the consent form. This form tells you that the survey is being conducted by UALR Social Work in conjunction with programs serving the homeless. The purpose is to collect information about homelessness and how best to serve individuals and families. Do you have any questions about it?

The survey should take about 10-15 minutes. It is completely confidential. The way you respond will in no way affect any of the services you currently receive.

We ask that you answer the questions as honestly as possible, however, if you are uncomfortable with any question, just say, “Skip it,” and we’ll move on. If this is agreeable to you, please be sure you’ve signed, initialed, or made a mark on the line indicating that you agree to be interviewed and we will begin the interview.
Point-In-Time Homeless Count

(*This Survey was used in 2004 data collection as well as 2011)

Client Survey

Please complete this form during the period of January 25-26, 2011. Refer any questions pertaining to this form to Carolyn Turturro, (501) 569-8472.

Facility (Program) Name: ________________________________

Phone: ________________________________

Person Completing Survey: ______________________________

Class: _________________________________

First letter of first name: _____    First letter of middle name: _____

First three letters of your last name: ______ ______ ______

Last four digits of Social Security Number: _____ _____ _____ _____

Your date of birth: _________/_________/_________ (month / day / year)

Do you consider yourself…

☐ Female
☐ Male
☐ Transgender

What is your racial background?

☐ American Indian
☐ Alaskan Native
☐ Asian
☐ Black/African American
☐ Native Hawaiian
☐ Pacific Islander
☐ White/Caucasian
☐ Other: _____________________________________________

Do you consider yourself to be Hispanic (Mexican, Mexican-American, Chicano)?

☐ Yes, Hispanic
☐ No, Non-Hispanic

Do you consider yourself to be a minority?
□ Yes
□ No

What is your living situation on the night of 1/25/2004 or 2011
(Where did you sleep last night?)
□ Sleeping in places not meant for human habitation (Unsheltered)
□ Sleeping in an emergency shelter for the homeless/domestic violence
□ Sleeping in a transitional shelter for the homeless
□ Stayed at place not my own (friend or family’s home or hotel)
□ None of the above, do not answer any more questions

Describe your family/household:
□ Head of a family with children
□ Member of a family with children
□ Head of a household without children

Member of a household without children ________________

Single individual ________________

A. For how many months have you been continuously without your own home (on the streets or in an emergency shelter)? ________ Months

Continuously for a year or more

B. How many times have you been without your own home in the last 3 years?
   □ 1st time in the past 3 years
   □ 2-3 times in the past 3 years
   □ At least 4 times in the past 3 years

Have you dealt with any of the following issues, now or in the past? (Please check all that apply.)
□ Mental illness
□ Alcohol abuse
□ Drug abuse
□ HIV/AIDS related illnesses
□ Serious health problems

Did you need special assistance in school? (Developmental disability)

No, none of these
Are you a: (Please check all that apply.)

- ☐ Victim of domestic violence
- ☐ Unaccompanied youth (under 18)
- ☐ Veteran of the U.S. Military

What is the zip code of the last place that you lived in before you became homeless?

_____ _____ _____ _____ _____

What is your total monthly household income? $_______________

A. Are you currently working?
   Yes
   No

B. How many hours per week?
   1-9
   10-19
   20-29
   30-39
   40 or more

At this point-in-time, which type of housing program would be most beneficial to you in finding a more permanent home?

- Emergency housing
- Transitional housing
- Permanent supportive housing
- Place of my own
For each family member (NOT including yourself).

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(check all that apply)  
- Severe mental illness  
- Chronic alcohol abuse  
- Chronic drug abuse  
- HIV/AIDS related illnesses  
- Victim of domestic violence  
- Veteran of the U.S. Military  

(check all that apply)  
- Severe mental illness  
- Chronic alcohol abuse  
- Chronic drug abuse  
- HIV/AIDS related illnesses  
- Victim of domestic violence  
- Veteran of the U.S. Military  

(check all that apply)  
- Severe mental illness  
- Chronic alcohol abuse  
- Chronic drug abuse  
- HIV/AIDS related illnesses  
- Victim of domestic violence  
- Veteran of the U.S. Military
What is the highest grade of school you have completed? ____________________
If you are currently working, what type of work do you do?
______________________________________________________________________
If you are not currently working, have you worked in the past? ________
Has the recent economic down-turn caused you to lose your job?
_____yes  _____no
Or to lose your housing?
_____yes  _____no
Have you ever been turned away from shelter in Central Arkansas when you wanted it?
_____yes  _____no
If you have been turned away, why was that?
_____ Shelter was full
_____ I was using alcohol or other drugs
_____ I had used up my allotted days for the month
_____ I had been banned from the shelter
(list reason: __________________________________________________________)
_____ I couldn’t pay the fee
_____ Other (list)
______________________________________________________________________
How often has that occurred?
_______ times per month
_______ times per year
_______ never
Thinking back to the first time you lost your housing, what led to your losing your home?
_____ domestic violence
_____ building demolished
_____ lack of affordable housing
_____ eviction
_____ loss of utilities
_____ loss of housing subsidy or benefits
_____ loss of TEA/welfare/other benefits
____ too old for foster care
____ recently released from jail or prison
____ released from residential treatment facility
____ spouse/parent/relative told you to leave
____ overcrowded housing
____ loss of employment
____ physical illness
____ physical disability
____ mental health problems
____ substance abuse problems
____ HIV/AIDS
Other
______________________________________________________________________

What was your housing situation like immediately before you lost your home?
____ a) living in own home or apartment
____ b) sharing a home or apartment (sharing expenses)
____ c) living with friends or family (they pay expenses)
____ d) Other (describe)
______________________________________________________________________

If (b), (c) or (d), how long did you live in that intermediate situation?
________________

Now, in thinking about your physical health, for HOW MANY DAYS during the past 30 days was your physical health good?     ________days

Now, thinking about your mental health (which includes, stress, depression and problems with emotions), for HOW MANY DAYS during the past 30 days was your mental health good?
_________ Days

Now, thinking about your safety, during the past 30 days have you experienced physical or sexual violence?
_____yes  _____no

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During the past thirty days, have you been robbed—that is, have you had money, checks or possessions stolen from you?
_____yes  _____no

In terms of your physical health, have you ever been told you have:
_____ Diabetes  
_____ high blood pressure  
_____ heart disease  
_____ cancer  
_____ other health problems
________________________________________________________________

30 a. Have you been prescribed medication that you should be taking regularly?
_____yes  _____no
b. If yes, for what type of problem?
______________________________________________________________________
c. Are you currently taking your medication?  _____yes  _____no
If no, why not________________________________________________________

Do you have any problems with:
    Hearing?  _____yes  _____no
    Vision (do you need glasses)?  _____yes  _____no
    If yes, Do you have them?  _____yes  _____no
If no, why not?
______________________________________________________________________
    Walking?  _____yes  _____no
    Have you fallen in the past 6 months?  _____yes  _____no
Is there anyone you could call on or go to for help if you got sick or needed help?
Number of family members  _______
Number of friends  _______
Number of service professionals  _______
What can the community do that would be most helpful for you at this time?
In closing, on a scale from 0-10, with zero being not effective and 10 very effective, how effective do you feel you are to obtain your own housing?
Not effective       Effective       Very Effective
On a scale from 0-10, with zero having no confidence and 10 having all the confidence in the world, how confident are you that you will be in that place of your own in the next six months?
0  1  2  3  4  5  6  7  8  9  10
Not confident       Confident       Very Confident
This concludes our interview. Thank you very much for your participation.
APPENDIX C

PARTICIPANT INFORMED CONSENT FOR HOMELESS PROVIDERS
Dear Participant:

This survey is being conducted by Jina P. Lewallen, Doctoral student at the University of North Texas Applied Gerontology Program, in order to better understand providers of services for older homeless adults. This research will help providers and volunteers who assist older homeless adults to better understand our aging homeless population and types of services available to assist them. I plan to publish/distribute results of this study that focus on the older homeless adult, based on the data provided by survey respondents, as part of my dissertation for PhD topic.

I would greatly appreciate you completing the survey on Survey Monkey. This survey can be accessed at:

http://www.surveymonkey.com/MySurvey_Responses.aspx?sm=85O%2bh%2bnQ4JicpyyiqArwvb18rW1HotELMTCBh7IG0GNaEnRIRZxb0FsucdJNBs0zNjNnpZ05UK3tl5CXOTDw%3d%3dand

Please answer all questions. If you do not have access, please email me at the address provided below and a survey will be mailed to you. Since the validity of the results depend on obtaining a high response rate, your participation is crucial to the success of this study. This provider survey will take approximately 20-30 minutes to complete. Your return of this survey indicates your consent to participate in this study. Please be assured that your responses will be held in the strictest confidence, unless you indicate otherwise.

The data in your completed survey will be aggregated and entered on a secure computer and paper surveys will be destroyed using shredding. All survey data on the
computer will be stored for the year after the data are recorded. If the results of this study were to be written for publication, no identifying information will be used.

Although this study may not be of direct benefit to you personally, it may be helpful to increase your understanding of the special challenges faced by older adults that are homeless. A possible benefit that may result from this study is to better understand trends in homelessness that may affect the older adult. Intended outcomes of the research results are to understand reasons for homelessness in the older adult through chronic homelessness and aging or other variables for the homeless older adult who may become homeless for the first time.

Contact information:

If you have any questions about this study, you can contact:

Jina P. Lewallen, LCSW, MA,
Doctoral Student, University of North Texas
Applied Gerontology Program

This study has been reviewed and approved by The University of Arkansas-Little Rock's Institutional Review Board (IRB). The IRB has determined that this study meets the ethical obligations required by federal law and University policies. If you have questions or concerns regarding this study, please contact the Investigator or Advisor.
APPENDIX D

HOMELESS PROVIDER SURVEY
Homeless Provider Survey

Provider information can enhance services for the homeless population. The purpose of this survey is to investigate resources that are available in Central Arkansas for our homeless population. The data from this survey will be added to dissertation research as part of data analysis on the homeless older adult.

By filling out this survey, you are consenting to participate in this study. All data will be aggregated unless you indicate otherwise. If you do not have access to Survey Monkey online, a copy can be mailed to you for completion.

The results of this survey will be available to all participating providers. A stamped, self-addressed envelope (SASE) will be provided for you to return your survey if you cannot access the survey. All identifying information will be omitted unless you, the provider, indicate otherwise.

Thank you for your participation.

Jina P. Lewallen, LCSW, MA
Doctoral Student-Applied Gerontology
University of North Texas
Homeless Provider Survey (on Survey Monkey. www.surveymonkey.com)

1. Type of Provider: Check all that apply
   ______ Emergency shelter program
   ______ Transitional housing
   ______ Permanent housing program
   ______ Programs that accept vouchers for temporary accommodation or other for profit
   ______ Food pantry
   ______ Soup kitchen
   ______ Physical health care program
   ______ Mental health care program
   ______ Alcohol/drug program
   ______ HIV/AIDS program
   ______ Drop-in center program
   ______ Outreach programs contact homeless program
   ______ Veterans program

2. What is your position/role in the agency?
   ______ professional / licensed
   ______ professional / unlicensed
   ______ para-professional
   ______ volunteer
   ______ Board member
   ______ supporter (financial)
________director
________clerical
________support staff (janitor, grounds, security)

3. How long have you been working with the homeless? ________

4. What types of changes have your observed in the homeless population in regards to age or any other characteristics? Please comment on your observations.
______________________________________________________________________

5. What do you think are most important factors that contribute to homelessness today?
______________________________________________________________________

6. Do you think there is a need for specialized funding for the older homeless adult?
_____Yes _____No _____Don't know

7. Considering that our world is aging, how should providers prepare for the older homeless adult?
______________________________________________________________________

8. Do you think special support and services are/will be needed to assist the aging homeless person? If so, what kind?
______________________________________________________________________

9. If you have any other comments or thoughts about older adults and homelessness, please add your comments below.
______________________________________________________________________

Thank you for your time.
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