

Occupational Therapy Needs Assessment of Male United States Veterans

Who Are Homeless

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This research, submitted by Karyn L. Best, has been approved and accepted in partial fulfillment of the requirements for the degree of Master of Science in Occupational Therapy from the University of Puget Sound.

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Abstract

The current occupational therapy research base related to individuals who are homeless is sparse, and few studies have identified the various needs of subgroups within the population. To provide appropriate interventions, treatment, and program development for homeless veterans, an understanding of their occupational performance, including impact of prior experiences, roles, and meaningful and valued activities is necessary. This study used qualitative methodology to explore the needs of a small number of male United States veterans in urban Western Washington who are currently or were previously homeless, in order to determine in what way the occupational therapy profession can best meet the needs of this client population. Two previously homeless veterans, an occupational therapist, and a social worker were interviewed. Themes derived from the responses of participants included the impact of decreased self-efficacy, the use of roles, and environmental supports and barriers. An increased understanding of the challenges, barriers, and supports that impact the lives of homeless veterans may provide occupational therapists with the knowledge to create appropriate and valid interventions to increase occupational performance.

The current knowledge base of research related to the occupational therapy intervention and treatment of individuals experiencing homelessness is limited and results are inconsistent (Herzberg, Ray, & Miller, 2006). The homeless population exhibits more health concerns and a higher mortality rate than other populations, with homeless veterans experiencing an increased and more severe outlook (Goldstein, Luther, Haas, Gordon, & Appelt, 2009; McGuire, Gelberg, Blue-Howells, & Rosenheck, 2009; Nyamathi et al., 2003; O'Toole, Conde-Martel, Gibbon, Hanusa, & Fine, 2003). Increased concern about the needs of populations experiencing disparities based on race, ethnicity, socioeconomics and geographic location, and the services provided to them has resulted in further studies. (Herzberg & Finlayson, 2001; Munoz, Dix, & Reichenbach, 2006). In 2003, the National Healthcare Disparities Report failed to address unique solutions for individuals experiencing homelessness, as cited in McGuire et al. (2009). Veterans who are homeless use relatively few medical services compared to their needs, and the quality of care is at times subpar in comparison to the rest of the population (Hwang et al., 2001). Professions, such as physicians, psychologists, social workers and therapists, that work closest with this population would benefit from additional continuing education and resources in order to become stronger advocates for the challenges faced by veterans who are homeless.

Although a vast amount of research from various disciplines exists on homeless populations and the outreach services provided them (Conrad et al., 1998; Nakashima, McGuire, Berman, & Daniels, 2005; Rosenheck & Mares, 2007), different subgroups may benefit from the adaptation of programs to suit their specific needs. Based on a 1996 survey, veterans composed 33% of the adult male homeless population (Burt et al.,

1999). Both the U.S. Department of Veterans Affairs (VA) and a broad variety of additional agencies have developed shelters and programs to accommodate the needs of veterans who are homeless. This significant portion of the population is an indication that additional services may be necessary to increase stability and independence in activities of daily living.

Occupational therapy has provided an important component in the health and rehabilitation of soldiers beginning in World War I, providing meaningful activities to improve function in clients with amputations, paralysis, mental illness and other medical concerns (Gutman, 1995). As a newly developing profession, occupational therapy obtained a great deal of professional development initially from collaboration with the United States military. As occupational therapy continues to evolve, understanding the needs of clients is imperative when providing appropriate care. In her 2009 address Dr. Kathleen Schwartz (2009) issued a “call to action,” stating that “like the founders, we are confronted with inequities and disparities in society that affect people’s health, quality of life, and participation.” To provide adequate services to the population of homeless veterans, it is necessary to determine what aspects of life are most important to them and select treatment methods that meet these needs.

Background and Significance

Studies on homelessness during the 1980’s concluded that factors such as a lack of affordable housing, income decline, loss of industrial jobs, and a fall in the economy resulted in increased numbers of people being left without a place to live (Rosenheck & Fontana, 1994). Although some problems are seen throughout the homeless population, others are more specific to distinct subpopulations.

Homeless Veterans. Previous data on the total number of veterans who are homeless and their needs was inconsistent, and additional research is necessary in order to determine how to create approaches that consider the needs of the population (Applewhite, 1997). Veterans with the greatest vulnerability for becoming homeless display a unique combination of mental health and non-psychiatric concerns that tend to increase over time. Factors that may indicate a risk of becoming homeless include social isolation, being unmarried and having limited support in the first year following discharge (Rosenheck & Fontana, 1994). Rosenheck, Frisman, and Chung (1994) found that the proportion of veterans in the homeless population was greater than that found in the general population (41.2% vs. 33.6%). The authors speculated that “slightly lower socioeconomic status...as well as poorer intellectual test results and greater problems with substance abuse” (p. 468), as well as more limited veteran’s benefits than those who served during war times could be the cause. The data used in this study were from 1985 to 1987, and may not accurately represent the current status of veterans.

A qualitative study by Applewhite (1997) using focus group interviews, reiterated the knowledge gap that exists related to the needs, lives, problems, and obstacles in obtaining services faced by homeless veterans. “The problems affecting homeless veterans include physical, addictive and post-military psychiatric disorders; social isolation, social and vocational dysfunction; mental health and community adjustment problems; war and non-war-related traumatic experience; and low self-esteem” (p. 20). This veteran population has unique concerns, such as PTSD, readjustment problems, feelings of victimization related to unmet expectations about war service recognition, resulting in the need for specialized programs and services.

The Department of Veterans Affairs currently provides the largest integrated network in the country for treatment and assistance services for veterans who are homeless, which includes dependents as well. Since being authorized in 1987, available programs have continued to grow and develop to include aggressive outreach to veterans living on the street and in shelters who may not seek help, clinical assessment and referral for medical treatment, long-term transitional assistance and case management, employment assistance, and supported permanent housing (United States Department of Veterans Affairs, 2009). Additional services such as temporary housing, warm meals, job assistance and assistance for obtaining veteran's benefits are also provided through churches, and community agencies and facilities. Local veterans obtain services from the American Lake VA Hospital, and facilities such as the Tacoma Rescue Mission, New Start, Hospitality Kitchen, and Comprehensive Mental Health that work directly with the population.

“Veterans often perceive health and social services systems such as the VA as bureaucracies that deliver the same treatment or service to all veterans who enter the agency without regard for their individual needs and preferences” (Applewhite, 1997, p. 28). As a result, many become disillusioned and turn away from the services because they do not feel their quality of life is improving. As a result further advocacy is necessary in order to obtain health care services and life care skills, such as coping mechanisms for mental health concerns and strategies to work through difficult situations that arise or are encountered in their environment.

OT Domain. Adolf Meyer (1921) described the role of occupational therapy as “giving opportunities rather than prescriptions” (p. 7) and defined the negative

implications of being unable to produce or see the worth of the activities done in a person's life, which can result in a decreased sense of self worth. Clients should be provided the opportunity to work, play, create, and learn, rather than just be given prescriptions. When given a chance to use personal strengths to create, a person is able to find appreciation for their time and abilities, allowing for improved success in life's challenges (Meyer, 1921). Activities viewed as important occur as the individual "learns to organize time and he does it in terms of doing things, and one of the many good things he does between eating, drinking and wholesome nutrition generally and the flights of fancy and aspiration, we call work and occupation" (Meyer, 1921, p. 9).

Occupational therapy began establishing concrete roots during World War I, in order to provide active, skilled rehabilitation for wounded soldiers. The use of reconstruction aides, primarily women wanting to serve their country, was the beginning of occupational therapy. Rehabilitative therapy involved primarily crafts in order to increase movement of extremities and increase motivation and mental processing (Woodside, 1971). Due to the emphasis of medicine during WWI, occupational therapy curriculums incorporated knowledge regarding disabilities and the empowerment gained through purposeful activities (Gutman, 1995). The profession continued to evolve over time based on societal needs, which also molded the OT program curriculum, creating a niche within health care. Reilly (1971) believed that by incorporating the latest technology, such as social psychology, into the profession, occupational therapy could expand from hospitals into community-based practice. Clients would represent the portion of the population living in "marginal physical and economic stations" but not requiring acute hospital care. These would be the populations that could benefit from

adaptation of their environment in order to improve their quality of life. The Occupational Therapy Practice Framework – 2nd Ed. (AOTA, 2009) includes an outcome, occupational justice, which emphasizes the importance of providing “opportunities for social inclusion and the resources to participate in occupations to satisfy personal, health, and societal needs” (p 663), which includes the homeless population.

The Model of Human Occupation developed by Kielhofner and associates, modernized and expanded upon the concepts of Adolf Meyer and Mary Reilly. In the Model of Human Occupation, Kielhofner (1995) defines human occupation as “the doing of work, play or activities of daily living within a temporal, physical, and sociocultural context that characterizes much of human life” (p. 1). The ability to participate and succeed in these human occupations is influenced by volition, habituation, performance capacity, and the environment in which they occur. A person’s prior experiences strongly impact current feeling and thoughts regarding competence and effectiveness, as well as defining meaningful activities and interests. All humans tend to use multiple roles, made up of consistent habits and routines, throughout the day to maintain structures. These patterns, along with the establishment of defined behavior viewed as appropriate by society, such as a parent, worker, or friend, provide familiarity and require little effort. However, maladaptive or unproductive behavior patterns can occur as a result of past experiences or environmental constraints, which strongly impair an individual’s occupational performance, creating decreased self-efficacy and competency. Performance capacity, which is based on each person’s unique physical and mental components, along with subjective experience, can also either positively or negatively affect occupational performance.

OT & Homelessness. Occupational therapists provide services to the homeless population primarily through shelters or similar housing programs. Because of an emphasis in more holistic and person-environment practice, occupational therapists address the needs of this population in a client-centered approach. Petrenchick (2006) stated that the goal of therapy in these settings is to provide clients with the daily living skills including prevocational skills, stress management, self-care, social and interpersonal skills, and community living skills. These skills are gained through practice and instruction, which can be generalized into a stable housing scenario (Herzberg & Finlayson, 2001).

A second approach involves focusing on participation within the environment by identifying and reducing occupational performance barriers and environmental constraints (Petrenchik, 2006). By identifying these obstacles, the client will be able to master experiences in the future, especially if provided the necessary strategies. By incorporating the model of person and environment, and minimizing obstacles preventing community participation, reintegration, if valued and meaningful to the veteran, may be possible (Petrenchik, 2006). Ongoing assessments and case management are also necessary to detect barriers that are not always evident until the client is engaged in activities (Herzberg & Finayson, 2001). Different considerations may be necessary in developing treatment for veterans of all ages who are homeless.

Current research indicates that homeless individuals with social supports are more likely to maintain stable housing for longer lengths of time (Conrad et al., 1998).

Occupational therapists are concerned about the issues related to limited basic living skills, lack of transportation, mental illness and addiction (Munoz et al., 2006). The goals

for the homeless population include strategies to enhance self-esteem, self worth and self-efficacy in order to improve personal attributes and for remaining housed if desired through job seeking skills and budgeting of funds by establishing new habits and routines (Livingston & Miller, 2006; Helfrich & Fogg, 2007). Intervention strategies should include “promoting engagement, providing structured activities, facilitating trusting relationships, limit setting for destructive behaviors, and positive reinforcement” (Munoz et al., 2006). Helfrich and Fogg (2007) determined that teaching life skills, especially to those individuals also experiencing psychosocial dysfunction can promote housing stability and increase independence in the community. No other discipline understands the importance of occupational participation and its impact on disability prevention (Livingston & Miller, 2006). Although needs assessments have been performed for entire populations, no research exists related to appropriate occupational therapy treatment methods for the needs of homeless veterans.

Herzberg et al. (2006) reported that although research related to the occupational therapy treatment of the homeless population exists, development of a strong body of evidence is still in the beginning stages. A lack of consistency persists in assessment approaches, intervention, and in the choice of theory to guide treatment. The diversity of age and gender in the demographics of the homeless population has not been thoroughly explored. The vast majority relate to women and children who are homeless, rather than males, who compose a greater percentage.

Client needs and preferences do not always correspond with the services provided (Rosenheck & Lam, 1997). Because occupational therapy uses a holistic, client-centered approach, we are able to promote meaningful activity for different individuals, and work

towards increasing the quality of life. The purpose of the current study is to explore the needs of a small number of male United States veterans in the Tacoma area who are currently or were previously homeless, in order to determine in what way the occupational therapy profession can best meet the needs of this client population.

Method

Research Design

Recommendations by the National Institute of Mental Health and U.S. Department of Health, Education, and Welfare (USDHEW) for executing a needs assessment of groups or institutions, and a master's thesis (Wyler, 1998) were used in the overall design of this study. The use of a needs assessment as a research tool assists in 1) evaluating existing programs, 2) responding to the actual needs of a population in addition to those considered necessary by clinical authorities, and 3) planning new programs to encompass the identified needs of the existing population (Warheit, Bell, & Schwab, 1977). By determining the needs of homeless veterans, occupational therapists and other medical professions will be capable of prioritizing intervention goals and implementing more effective programs that meet current unmet health care needs. The USDHEW recommends structured instruments, such as face-to-face interviews, as an appropriate method to gain valuable information from participants. Interviews allow greater detail and depth to be gained (Warheit, et al., 1977).

Thus, in this study a qualitative approach was implemented using a case study framework for interview questions adapted from checklists that focus on the interests and values of participants and services used. Interviews were semi-structured, allowing the ease and flow to be more conversation-like. By including a case study approach to the

gathering of data, the researcher was able to more thoroughly explore the experiences of the participant related to the focus of the study (Portney & Watkins, 1993). The participant described in his own words and explained to the researcher the values, feelings and behaviors embedded in personal experiences. The interviewer not only listened to what the participant verbally said, but also observed concurrent behaviors.

Participants

The populations of interest for this study were veterans who were currently or previously homeless and individuals providing services to these veterans. Participants were recruited by nomination. Five area shelters and soup kitchens, two local occupational therapists, and two community health organizations were contacted by telephone. No responses were received from either the soup kitchens or shelters. The VA Hospital required additional approval by the VA's Institutional Review Board for the Protection of Human Subjects (IRB) committee, which exceeded the time permitted for completing this study. The resulting four participants included two previously homeless veterans who are currently housed, a case manager from Greater Lakes Mental Health, and an occupational therapist from Comprehensive Mental Health, all in the Puget Sound area. Veteran participants were obtained by nomination through a staff member at Greater Lakes Mental Health, based on the provided inclusion criteria for potential subjects. Inclusion criteria required the individual to be male, English speaking, have served in the United States military, have been homeless for a minimum of six months, and have received services from either the Department of Veterans Affairs or community-based agencies. The age of the participant was not used to determine inclusion or exclusion, as a broader range of ages provided greater understanding of the

diversity of needs that exist within the population. The occupational therapist, having a minimum 3 years of experience working with veterans who are homeless, was obtained by nomination through peers. The staff member was also obtained through nomination by an occupational therapist, based on the criteria of having at least six months of experience working with the population. Pseudonyms were created to maintain the confidentiality of each participant.

Roseanne, an occupational therapist, has worked for the citywide encampment program for 21 years, in addition to 12 years with individuals who are veterans and have chronic mental illness, and 10 years in the military. She currently works for a community based mental health facility that provides services to individuals who are homeless.

Melanie has been a case manager for Greater Lakes Mental Health for 9 months, and provides weekly treatment sessions and assistance obtaining services to individuals currently housed at a Housing First program. This model provides housing to individuals who are homeless, often with a dual diagnosis and fewer restrictions than the continuum of care model.

George, age 50, served in the United States Army from 1976 to 1979, and has been chronically homeless for over 30 years. He moved to the Puget Sound area to be closer to family, has held a multitude of labor type jobs, and opted to seek housing in order to provide a place to spend time with his family. He is currently in the process of acquiring Supplemental Security Income (SSI) due to health concerns impacting his ability to maintain employment.

Joseph, age 55, served in the United States Army from 1972 to 1975, and has also been chronically homeless for over 30 years prior to deciding to obtain housing. He

joined the service in order to leave his childhood home in Texas where he did not feel he fit in. He has resided in Oregon, Alaska, and Washington during his time of homelessness. He is currently receiving Supplemental Security Income (SSI) due to health concerns impacting his ability to maintain employment.

Instrumentation

The Kohlman Evaluation of Living Skills (KELS), Canadian Occupational Performance Measure (COPM) and an Activities Wheel (Rosenfeld, 1993) were used in the development of interview questions. The activity wheel assisted in determining the daily routine of the veteran population that is homeless.

The KELS (Kohlman-Thomson, 1992) was originally developed for use in a short-term inpatient psychiatric unit. The goal of the assessment is to determine an individual's independence in performing basic daily activities through the use of tasks and interview questions. Areas of strong performance, as well as challenging activities are identified. The inter-rater reliability was found to be significant ($p < .001$) with a variance from 74% to 94% agreement. Concurrent validity was also established.

The COPM, developed by Law, et al (1994), attempts to determine changes in the participant's perceived self-perception of occupational performance over time. Occupational performance is defined as the relationship between the person, the environment, and occupation. The purpose of the assessment is to determine areas of concern, as well as evaluate performance and satisfaction related to three performance areas (self-care, productivity, and leisure). Self-evaluation is used to obtain information about the participant's opinion related to how well an activity is completed, their satisfaction with the activity, and the importance of the activity (Law, et al, 1994).

Participants will be asked questions about activities they want to do, need to do or expect to do through the day, as well as which are the most challenging and provide the greatest satisfaction.

Procedures

In the fall semester of 2008, the researcher completed a socio-cultural awareness (SAW) project for OT 606 Health Care Systems, which provided a strong foundation for experiences and concerns related to populations of homeless persons, which included 40 volunteer hours at Hospitality Kitchen, a soup kitchen, in downtown Tacoma; reading of biographies, and watching 4 hours of documentaries.

Prior to beginning interviews with participants, approval was gained from the University of Puget Sound Institutional Review Board for the Protection of Human Subjects (IRB). A mock interview was conducted on campus in order to practice voice tone, question clarity, appropriate responses, and formulating follow-up questions. Additional time was spent with an experienced qualitative researcher refining the interview question guide and strategy.

Participants were allowed to choose the location of the interview, with interviews ranging from 1 to 2 hours. Before starting the tape-recorded interview, participants signed consent forms documenting their willingness to participate in the study and to be audio taped. Questions were asked in the same sequence to each participant, allowing an organized comparison of the results to occur (Warheit et al., 1977). After obtaining demographic information, the initial question asked of occupational therapists and staff member participants was “tell me about this facility and your work with homeless veterans.” The veteran population was asked to “tell me about your experiences with

homelessness.” The use of a broad question may have encouraged the participant to provide a detailed verbal description, which may include those events and issues of greatest value (Agar, 1980). Additional questions were open-ended regarding activities performed throughout the day, knowledge of available programs, programs tried, those programs found to be effective, and additional programs that could be created to address unmet needs. Field notes were also maintained regarding the cultural portrayals and population stereotypes, and the researcher’s thoughts, actions, and behaviors following each interview.

Peer examination by an experienced qualitative researcher was performed, including checking research plans, implementation of methods, and results to validate the researcher’s findings and interpretations. Krefting’s (1991) account of Guba’s model of rigor in qualitative research was applied throughout the research design to enhance dependability, credibility, transferability, and confirmability. Strategies included a nominated sample procedure, interview technique, field journal, triangulation, and code-recode.

Data Analysis

Data reduction, display, conclusion drawing, and verification are required for reliable qualitative data analysis (Miles & Huberman, 1994). Credibility was established by use of triangulation through three data collection methods; interviews, observations, and a field journal. Prior to beginning the interview process, the researcher was emerged into the population through exposure to documentaries films and volunteer experiences at a local soup kitchen. A field journal was maintained, which reflected the resulting feelings and thoughts of the experience. Journaling also occurred following each

interview to retain the essence of each participant's actions, behaviors, and appearance. Contents of the three methods were analyzed for themes through coding by hand and theme mapping using the software program Inspiration. The code-recode procedure was conducted on all data, with recoding at least one week later, in order to compare the results for dependability. The Model of Human Occupation (Kielhofner, 1995) was used as a framework in the determination of themes and in the organization of the key concepts provided by each participant.

Results

An analysis of the data obtained from interviews, field notes, and observations revealed several common themes related to the needs of veterans who are homeless. Using Kielhofner's Model of Human Occupation as a framework, the theme titled "Helpless, Lost, and Forgotten" reflects volition, "Old Habits Die Hard" relates to habituation, and "It's Almost Like Camping Out" defines the environment.

Helpless, Lost, and Forgotten

As a result of prior traumatic events during childhood or as adults, many individuals who are homeless have difficulties believing in the presence of safe environments or interactions with other people. Both veterans reflected on the desire to escape from their childhood homes, in addition to having a challenging time creating connections with other people from an early age. Joseph, a previously homeless veteran reflected "I just didn't really fit in at home...I didn't want to be there and it was like, I am going to be stuck here unless I find some kind of way out."

Participants discussed the impact of losing everything as a catalyst for chronic homelessness. Joseph described the scenario of finding himself in downtown Portland

after learning everything he owned had been stolen. Similarly, George, a previously homeless veteran, stated, “I just didn’t want to settle down because I just lost everything I had.” He also noted that he was unable to maintain employment due to a health concern, and as a result lost his apartment. Both veterans reported situations of being taken advantage of on at least one occasion, resulting in increased inhibition. Roseanne, an occupational therapist, supported the veterans’ experiences by noting:

I believe that people ultimately...have a sense of some kind of home. I believe that ultimately they all want to live a decent life, but when you have been kicked around in the streets for years and years and years...why would you trust anybody?

Melanie, a social worker, commented that “there is always that fear that you are going to have the rug pulled out from underneath you...and they felt for some reason like they failed themselves or the system failed them.” She later stated:

The promise that if we go into the Army we are going to have all these benefits and be taken care of for life and we become dependent on those and when they are not there, there is sort of a learned helplessness that comes into play and a feeling that society really still owes them – and that kind of bitterness and disappointment can really contribute to becoming homeless and staying homeless.

All participants, both veterans and those providing services, described the impact of stereotypes and the loss of human dignity on the self-efficacy of veterans who are homeless. Joseph reflected on days when “nobody wants to have anything nice to say and everybody is rude to you...some days it feels like the whole world is against you...” He also describes the frustration “where no one will let you in their store. You can’t go in

any place...Nobody will talk to you...What do you do? Where do you go? How do you deal with that?" He discussed the unease that exists with the arrival of police officers, as a result of previous arrests or removals from "camping" sites. George stated multiple times that he just "got tired of being around people." Melanie supported the views of the veterans by reflecting, "...Being homeless is a way to say f-you to the system. I am off the grid, you know? You can't track me down. You don't know where I live ...". She also believes that it provides "the ability to call your own shots and autonomy – dignity."

However, veterans also encounter individuals who provide positive encouragement and improve their self-efficacy, such as Melanie and Roseanne, professionals providing services to the population. Joseph made friends with baristas and shop owners at locations he frequented. "Many find value in regaining their dignity, and the opportunity to encounter people who are genuine in nature. The importance of being seen," stated Melanie. Roseanne further describes the appreciation and thanks she receives from her clients when she gives "a piece of time."

Old Habits Die Hard

When asked to describe a typical day, both veterans reflected there is no typical day. They described the impacts of weather, time of year, intrusion by police or other people, and obtaining access to daily needs determined the course of the day. Simple tasks, such as moving possessions to a new location, finding a meal, showering, or getting a change of clothing required great amounts of time and could absorb the majority of an entire day. The use of public transportation entails the budgeting of time, with Joseph explaining that a two-hour block was needed for a one-way trip from his camping site to Greater Lakes Mental Health. George also described planning ahead and arrived

early to the drop-in medical clinic in order to be one of the first people in line when seeking services. From Roseanne's experience, the population spends the majority of the day attempting to gain "access to food and access to alcohol and access to money."

Accomplishing daily needs is also hindered by the need to obtain safe camping sites. Locations for camping were described as fluid and constantly changing. George and Joseph both reported that one month was the longest they stayed in any one location, with the shortest being less than one day. However, Joseph stated, "You try to go back to places that you already know because you know that this place works to stay there." The process of finding or relocating to a new site requires a great deal of time. Joseph discussed the challenges required to "pack up everything everyday or find some place to stay and leave your stuff so that people when they walk by don't notice it or nobody is going to bother it." George stated "my campsite nobody would find it. It was deep in stuff – people wouldn't want to go find me through the vines...there are certain areas you can get into where nobody can find you unless you want them to and you stay there." Both veterans reported to keeping their site clean and tidy and maintained organization and structure. The choice of campsite also considers the location of basic necessities, such as public restrooms or port-a-potties, access to food, and distance from people. George reflected on the enjoyment he felt waking up to the sound of birds and the running water of a stream, which is an aspect of living outdoors that he misses. "It was very quiet there."

The majority of veterans who are homeless opt to avoid the use of shelters, and use the service only in the result of inclement weather. Joseph described the overcrowding of shelters that exists during the winter months, with as many as 150 beds

tightly packed into a small room, and a convergence of individuals with varying degrees of cognition and substance abuse. He concluded, “I felt safer sleeping under a tarp beside the freeway than I did in the shelter.” Roseanne noted:

People hate the shelter. Drugs, alcohol, being treated really badly... They hate to have to take a shower with everyone else. They hate to live inside – most of the homeless do not like to be with people, so they do not want to be in a dorm kind of thing. Even in winter when it is freezing, people will tell me they do not want to go to a shelter.

Regularly both veterans suffered from insomnia, sleeping for only two to three hours of broken sleep on many nights. George reflected that he would “just sit and listen to nature. There was nothing else to do. You just sit there and relax and try to force yourself to sleep, but you know you can’t.”

A variety of organizations in the downtown Tacoma area provide meals to individuals who are homeless or with limited finances through soup kitchens and food banks. Showers, laundry facilities, and clothing can be obtained from area churches, such as the Crossing, which operates on an appointment schedule. Joseph reflected, “when these clothes need to be washed, I go to the clothing bank, I get new clothes – give them these.” Because of local family support, George was able to use the accessibility of family in order to obtain food, to take a shower, and to wash clothes. Based on Roseanne’s experience with veterans who are homeless, in contrast to the activities completed by the two veteran participants, the majority of a day is occupied obtaining food, alcohol, and money. She further described that in the evening individuals return to

their camp, where they consume drugs and alcohol. Roseanne concluded that, “It is like survival.”

Leisure Activities. Melanie reflected that the veterans she works with “are in the process of finding things that are going to guide them in day-to-day life and provide meaning for them.” She also noted that “old habits kind of die hard” and even after finding housing, they find the same activities meaningful and valuable. Walking was described as more than just a means of moving from one location to another. Both veterans described it as a form of enjoyment and method of relaxation. Melanie also stated that even once stably housed, many veterans still choose to engage in this activity.

All participants reported the importance of “hanging out” and spending time with friends at local soup kitchens and shelters, such as Hospitality Kitchen or Nativity House. Joseph reflected that it was “nice to have some place you can go have a cup of coffee. And in a lot of places there was stuff to read,” such as Starbucks and Freighthouse Square, which also provided access to a restroom, and people to communicate with. In comparison, George opted to spend a larger portion of time with his two children, especially on the weekends.

George admitted to “little spurts of having fun” using primarily marijuana, but also “wouldn’t do it for long, cause that way I wouldn’t get hooked on it.” Melanie stated that drugs are “something to do to pass the time and escape a little from the dreariness of what it is like to live on the streets.” Neither veteran admitted to heavily using drugs, with the risk of dependence acting as a deterrent.

Roles. Both veteran participants were married and divorced at least once. Rosanne noted, “Half are alienated from their families.” George still maintains close

contact with two of his children and his older sister, but admitted, “they care about me, but I can’t live with them.” His four other children have alienated him. Joseph is no longer in contact with his family, having “lost touch and lost their addresses.” He also reflected, “Truly there are some people that have no business being a parent. Sadly, I found out the hard way, I am one of them.” Through her experience, Melanie noted that family provides a “huge source of support” and “provides a reason to stay stable...” She also believes that “the people that don’t have family...they have less going for them and they have less to lose and less to gain.” George discussed his decision to obtain stable housing. The year before he had also been offered an apartment, but had refused, but this time “I thought about my children and decided that I wanted housing so that they could come visit me...without my own place you can’t have children and I wanted my kids to come visit because I had already lost enough.”

George determined he has “three friends that I could trust with my life,” all of which he has known for over 13 years, but stated that “as long as there is no emergencies they leave me alone...” Joseph noted that he maintains acquaintances, is a solitary person, and has difficulty allowing himself to develop the trust necessary to establish greater friendships. Similarly, Rosanne has observed that friendships are “superficial relationships to get their needs met.”

George and Joseph provided information about previous work experience, but also discussed how chronic health concerns are now preventing them from maintaining steady employment. They are both seeking Supplemental Security Income (SSI). The jobs of greatest enjoyment were those that involved limited contact and association with people, such as driving a truck or taxicab, or remodeling stores.

It's Almost Like Camping Out

Veterans and professionals discussed the importance and difficulties related to learning about and finding resources. Roseanne has noticed that veterans who are more capable are able to articulate their needs and obtain services, while veterans with more severe mental health concerns are unable to voice their needs, and thus have greater difficulty obtaining services.

All participants discussed the importance of networking and communication amongst the homeless population to gain information. Rosanne described the population as close, creating strong bonds between each other. She continued by stating it is “the kind of old days depression kind of thing where word of mouth” spreads valuable information. Joseph noted the assistance he obtained when he initially found himself homeless:

“And the junkies I ran into were like, okay, we will let you stay with us one night...here is where you go for help. Go here and tell them you want this program. Social services wouldn't help me. Churches wouldn't help me. The junkies told me here is where you find food. Here is where you find help. They have this program for veterans over here.”

He also described carrying around lists of resources, which he provided to individuals he believed had recently become homeless and needed direction.

Both veteran participants reported outreach workers as a valuable source of assistance. Melanie reported that outreach workers for Greater Lakes Mental Health visit areas commonly used by individuals who are homeless, such as major intersections or commonly used camps, in order to make contact and provide incentives to increase the

likelihood of seeking services, and to inform them about available housing options.

Outreach workers also distribute brochures encompassing all available services and resources. Joseph reported that outreach workers acted as a liaison between his doctor's office and a state government agency in order to obtain benefits.

The majority of services and agencies, such as the Department of Social Health and Services (DSHS), Comprehensive Mental Health, Greater Lakes Mental Health, and outreach services are located in "the downtown core," with some additional agencies in neighboring cities. Veteran participants, as well as the two participants working with the population, discussed the importance of caseworkers in gaining services. Melanie noted that one of the first services provided to most veterans involves obtaining SSI, veterans' benefits, and other options that they may qualify for. These organizations also provide support and resources to answer any questions that may arise regarding services for the homeless population, such as the appeals process which occurs when apply for SSI "because most people are generally rejected or denied the first time no matter what." These professionals, including occupational therapists, social workers and case managers, provide valuable insight and support, and are familiar with the procedures and paperwork required for initially obtaining benefits or adjusting to changes in benefits due to increased income. Melanie stated that most veterans "have some sort of disability – helping them learn how to navigate the system with the steps, and also be as independent as possible" will allow for greater confidence within their lives. The veteran participants also discussed the importance of being provided roundtrip bus passes by organizations to allow accessibility to services.

Roseanne described how her organization is contacted when individuals who are homeless seek the medical services at hospitals, “and then we get called because the ER doesn’t want to deal with them.” Unfortunately most of these individuals “are on drugs and alcohol, who go so they can get a fix,” not individuals requiring legitimate medical care, who often fail to seek treatment. When one of these individuals is a veteran, she attempts to obtain services through the VA. “We try to get them advocacy with the VA, and that is just damn near impossible.” Rosanne works with 50 to 60 additional agencies, such as Greater Lakes Mental Health, to provide housing options to veterans who are homeless when unable to gain the assistance of the VA. “So we have lots of success stories. It is just that they are few and far between.”

Both veterans reported the use of pre-paid cell phones, which provide increased safety, an additional method of networking, a connection to family in George’s situation, as well as a convenient and accessible method of maintaining contact with doctors, DSHS, case managers, and other agencies. Joseph reflected that owning a cell phone “really uncomplicated my life.”

Initial attainment of benefits tends to be a time consuming process and requires the assistance of professionals. George reported that he waited three years in order to receive medical insurance for chronic pain that began 15 years ago in the joints of his lower extremity. He believes this is because “men have a lot more trouble getting DSHS...I was in pain and needed to see a doctor, but I had to prove to them I was in enough pain to qualify.” Both veterans also discussed the negative implications related to some individuals who are “fakes”, and who take advantage of the system.

All participants described the challenges related to obtaining services through the Department of Veterans Affairs (VA), which Roseanne believes is impacted by accessibility and the treatment of individuals. Melanie noted, “primarily you see a lot of disillusionment with the VA system and how it is set up to support them...but they are dragging their feet – the VA – or they are overloaded or it is just a bureaucratic nightmare.” When encouraging veterans to seek services, Rosanne responded, “They won’t go apply for social security. They won’t go for an interview for GAU – they won’t go and apply to the VA because they are so frustrated with the system.” As a veteran herself, she has experienced similar challenges related to obtaining the promised benefits. She believes that a more visible VA representative in areas frequented by the veteran population that is homeless would provide increased motivation and renew trust in the system.

George qualifies for some VA benefits and occasionally used the medical services, but encountered wait times of eight to nine hours. In addition to the extensive time waiting to be seen, he also stated, “all the guys coming back from Iraq and those other places need to be seen first. The hospital is packed – so let them get taken care of. I don’t want to take up space that they need right now.” Melanie reflected:

It is upsetting to see people who served and sacrificed, and their lives and minds were changed forever – and to see them have to struggle to get services they were told are available and are told daily are available to them, yet they are faced with this reality that the services are not very useful.

As an OT, Roseanne has talked “to them about dreams and recovery and all that kind of stuff and...many of them would like a better life.” She also has faith that the system can change, but is impaired by “bureaucracy”. She concluded that:

It really is about you or me or anybody saying this can happen and this can happen. I can do my part, but I am not willing to take on the toxicity of the system...I hate the VA but I am not going to let their problems that are bigger than me sour the way I interact with the clients.

Discussion

Helpless, Lost and Forgotten

Veteran participants discussed feelings of social isolation, of being unmarried, and having limited support in the first year following discharge, which are increased risk factors for becoming homeless as described by Rosenheck and Fontana (1994). These client factors, the veterans “specific abilities, characteristics, or beliefs” (AOTA, 2008), greatly impact their occupational performance in all areas. George and Joseph both reported feelings of isolation from society as early as childhood, both were divorced, and their first episode of homelessness was within one year of discharge from the service. In addition, both veterans received fewer benefits than individuals who served during wartime, consistent with Rosenheck, Frisman, and Cheng (1994). However, neither participant reported a history of substance abuse, which the previous authors considered an additional implication of risk. An awareness of the negative impacts of substance abuse acted as a deterrent for the veteran participants, and may be one important factor that allowed them to remain engaged in meaningful activities and to pursue stable housing. The promise of benefits and services following discharge from the military was

not followed through with and may have contributed to decreased trust, but this factor does not appear to be a primary cause of either veteran participants becoming homeless.

Although both veteran participants reflected on the desire to return to society, they also described feeling safe and enjoyed the independence and anonymity provided by homelessness. The inability to feel safe in shelters and other aspects of the community impacted not only their interaction with society, but also their ability to seek assistance and services. All the participants provided examples of prior experiences of being taken advantage of or denied assistance, possibly decreasing feelings of safety in their environment and with people, supporting the research of Applewhite (1997) who defined similar concerns that create barriers. As a result of decades of being treated with limited human dignity, many demonstrated decreased self worth, such as George's feelings that younger veterans were more deserving of immediate care. These encounters and the resulting lack of trust may have prevented veterans from obtaining the services available to them, as reported by Roseanne and Melanie, along with impacting their occupational performance in additional necessary tasks throughout the day.

Old Habits Die Hard

The impact of role strain, occurring when an individual is unable to meet all the "obligations and aspirations" required when attempting to maintain multiple roles, interferes with successful engagement in meaningful occupations. The responsibilities and requirements that exist for the role of homelessness cause the individual to exert all available time and energy to successfully completing necessary ADL and IADL (Kielhofner, 2005), resulting in the need to eliminate other roles. Both veteran participants described the role of homelessness in relation to regular relocations to new

camps, as well as the completion of basic needs through structured daily routines and habits. However, after the performance and completion of each task, limited time remained to engage in additional roles. The role of husband ended in divorce for both veterans. Both veterans had estranged children. Health concerns resulted in both veterans becoming unemployable, even though they reported past employment satisfaction. Melanie and Roseanne, also discussed the impact related to the ill treatment of soldiers returning from the Vietnam War, which may have resulted in role confusion. Kielhofner (2005) believed that engagement in few roles, which appears to exist in the lives of the veteran population, negatively impacts psychosocial wellbeing and results in the loss of identity, purpose and structure in life.

All the participants reflected upon the diversity and unpredictability encountered each day by veterans who are homeless. Because a large portion of the day was spent obtaining daily needs, such as food and shelter, they had difficulty maintaining, establishing and engaging in a diversity of leisure activities. Results of a study by Munoz, Garcia Lisak and Reichenbach (2006) found that female participants residing in a homeless shelter also identified problems in the area of leisure activities. The activities identified as meaningful by veteran participants included walking, spending time with friends at soup kitchens and shelters, or relaxing in a favorite location, which may provide a healthy source of relaxation and stress management. Relatively little research exists regarding the priority, value, and meaning of leisure activities for the homeless population.

Family support, as described by Conrad et al. (1998), appears to increase the likelihood of seeking and maintaining stable housing. The expectations of family provide

value and purpose to a veteran's life, and instill a basic need for stability. Involvement with family also provides the establishment of important occupational roles, such as father, brother, or grandfather. Those individuals with family ties may have a stronger vision of their future, as well as a stronger support system, which is necessary when transitioning from chronic homelessness to stable housing within a community setting. In addition, the presence of family in the area improves the motivation to gain stable housing provides a place to visit and spend time together. Supporting these conclusions, George related his desire to have a safe location to socialize with his children as his reason for seeking stable housing.

As reflected in the Occupational Therapy Practice Framework, because of the complexity and multidimensionality of individuals, differences exist in the meaning and purpose of occupations (AOTA, 2008). In the process of losing so much in life, the establishment of habits, routines and roles is of great importance. Participants discussed the difficulty of changing the habits and routines established while chronically homeless, such as maintaining addresses through soup kitchens. Although not found in prior research, veterans who are homeless appear to rely on established routines and habits in order to maintain structure within their lives, such as the value of keeping the area where they reside tidy and organized. The transitional period of obtaining stable housing may provide the opportunity to explore new roles, engage in new meaningful activities, or return to previous hobbies and activities.

It's Almost Like Camping Out

The subculture that has developed within the homeless population, described by all participants, allows for a highly effective means of communication. Informal

networking, such as by word of mouth, can provide information and knowledge that is just as, if not more valuable than official resources through the VA. By providing their valuable knowledge and experience to individuals who have recently become homeless, such as where and when to find the best food, the safest locations to sleep, and what agencies will provide the necessary care, long-term chronically homeless individuals appear to gain increased meaning as well as expand upon or create new roles for themselves. In addition, the commonality of military service may result in initial trust. Both veterans also discussed the importance of cell phones in maintaining communication and allowing networking with doctors' offices, family, and other community organizations or individuals.

However, the importance of outreach workers, case managers, and other professionals is also a key component. By exhibiting empathy and demonstrating dignity while working to establish services, they encourage the development of trust and confidence in veterans. The occupational therapist and social worker had a very thorough understanding of the barriers and supports that are frequently encountered by veterans attempting to obtain services. They considered the advocacy of the population's needs one of the highest priorities, in addition to fulfilling the basic needs of acquiring food, shelter, and financial support.

The degree of financial assistance available varies greatly within the veteran population that is homeless. High functioning individuals may have worked with social workers or other professionals to established VA benefits and SSI, or may currently have employment. Others, as a result of severe mental illness related to schizophrenia or PTSD, may lack the skills required to set up and maintain these provisions. For some

individuals, obtaining improved funding sources may provide a starting point for finding stable housing, while others may continue to use the newly obtained funds for purchases that inhibit their ability to maintain housing, such as drugs and alcohol.

Professionals and veterans clearly defined the concerns and barriers created by the VA, also defined by Applewhite (1997). Although the program attempts to provide adequate services for veterans, many do not receive the promised level of treatment, and as a result of prior experiences become disillusioned with the system. Roseanne and Melanie both reported the need for change within the VA system in order to provide well-deserved and higher quality care for the population of veterans who are homeless.

In addition, the time required to file the necessary paperwork, and the length of time individuals wait to receive medical care can be extensive, resulting in some individuals using other available resources, such as hospital emergency rooms, homeless clinics or outreach facilities, while others opt to take no action. The process was described by participants as frustrating not only to the population of veterans who are homeless, but also for professionals attempting to assist these individuals in obtaining the services, which supports the research of Applewhite (1997).

By describing her own challenges in obtaining benefits through the VA for her time in the military, Roseanne is able to substantiate the difficulties that homeless veterans must encounter when attempting to gain access to the same benefits. In order to provide more useful benefits and assistance to veterans who are homeless, changes must be made to the current VA system. Veterans and those who provide services to veterans who are homeless have found repeated issues in obtaining and receiving the benefits that were promised.

Implications for Occupational Therapy

Occupational therapy provides clients opportunities to practice roles, habits and skills in a safe environment in order to improve their occupational performance during meaningful activity. When working with this population OTs can engage clients in activities that promote reconstructing habits and roles in order to increase participation in additional activities, which may not have been considered while engaging in the maladaptive role of homelessness. It is also necessary to take the time to learn about other valuable components in their lives, such as leisure activities, roles, and sources of support, in addition to providing resources to obtain basic life necessities. Role competence, “the ability to effectively meet the demands of roles in which the client engages” (AOTA, 2008) should be considered the outcome measure.

Additional consideration should pertain to an awareness of the services and benefits that are most beneficial and accessible, such as drop-in health centers, soup kitchens, and churches providing clothing and showers. Providing support and advice throughout this process may provide opportunities to enhance a client’s sense of achievement, competency, and self-efficacy. Occupational justice, which “ensures that clients are afforded opportunity for full participation in those occupations in which they choose to engage,” (AOTA, 2008) encourages occupational therapists to increase their knowledge of the services and benefits that are available to clients who may be homeless.

As evidenced by results of this study, difficulties exist in obtaining VA services and benefits for veterans who are homeless. To improve veterans’ accessibility, occupational therapist could work towards providing opportunities and skills to veteran

clients to explore the required procedure to obtain services in a safe and supported environment. Skills obtained throughout the process can then be generalized into other applicable areas of their lives. Although advocating for the needs of veterans who are homeless is a very valid and important component for occupational therapists working with this population, encouraging self-advocacy can result in increasing independence and self-efficacy.

To meet the needs of the homeless population, the use of several consultative sessions could be devoted to the implementation of assistive technology to improve occupational performance. As demonstrated by veteran participants, the use of pre-paid cell phones provides an important means of networking, social inclusion, and safety measure. In addition, some cell phones also have the capabilities to act as alarms and calendars, which can allow for increased independence and structure by modifying the environment. By promoting communication and fully listening to the needs of each client, the appropriate intervention approach and outcome measure can be determined.

Limitations

The sample of size of two veterans limits the transferability regarding all the possible needs and services available and used by the homeless population of veterans. Both gentleman were high functioning, reported no issues with chemical dependency, and George maintained contact and obtained support from his family. In addition, both veterans were in stable housing and living in the same facility, operated by Greater Lakes Mental Health, which could also impact generalizability, as the participants may have characteristics not present in the majority of currently homeless population of veterans, as some may never reach desire stable housing.

Time limitations prevented the ability to obtain two additional participants, an occupational therapist and staff member employed at American Lake Veterans Hospital. Additional time with participants may also have increased their perception of safety and allowed for increased comfort throughout interviews, providing greater depth in the information provided by the veteran participants. Also, no follow-up interviews were completed in order to verify the emergent themes to increase confirmability. Finally, Roseanne provided only 40 minutes to be interviewed, which may have impacted the depth and amount of information gained about the veteran population she provides with services.

Future Research

A significant area for future research would compare veterans who are in stable housing to those currently homeless to determine if certain characteristics result in housing being sought. Replicating the current study with a larger sample of veterans reflecting the statistical demographics of the population would also provide a more complete understanding of the needs of veterans who are homeless and who might benefit from occupational therapy. Additional research should also strive to gain a greater understanding regarding meaningful daily activities, value of leisure and relaxation, and the impact of maladaptive roles on occupational performance.

Development and administration of a survey to occupational therapists throughout the country that provide treatment and services to veterans who are homeless may also define additional areas within the occupational therapy scope of practice which are not currently being met. The resulting information could be used in the development of programs to provide safe opportunities for veterans who are homeless to explore new

roles or reconstruct old ones, in addition to improving personal causation and occupational performance.

Summary

Although the needs of veterans who are homeless do not appear to vary greatly from those of the population as a whole, a greater understanding of the barriers and supports that impact occupational performance will allow occupational therapists to provide improved client-centered care. Providing opportunities to develop new roles or reconstruct prior roles in safe environments will allow clients to increase competence and self-efficacy, thus increasing personal capacity and stability within their lives. In addition, occupational therapists could provide valuable insight into the restructuring of programs designed to assist in providing services to veterans who are homeless, including simplification and accessibility.

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Appendix: Interview Guide

Veterans

- 1) I'd like to hear about your experiences with homelessness.
- 2) Describe a typical day for you?
 - a. Is there a difference between weekdays and weekends?
 - b. What is a good day like?
 - c. What is a bad day like?
 - d. Where do you spend the most time during the day?
 - i. Do you enjoy spending time there?
 - ii. Are there other activities that you would rather do during the day?
- 3) What do you like to do during the day?
 - a. What about leisure, ways you relaxed?
 - b. Are any of the activities or tasks difficult for you?
 - c. Are they important to you?
- 4) What are some tasks, chores, activities that you feel like you have to do each day?
 - a. Are any of them difficult for you?
 - b. Are they important to you?
 - c. Is there something else that you would rather be doing?
- 5) I'm interested in what types of services and resources you use?
 - a. How do you get financial support?
 - b. How do you receive and cash your benefit checks (if applies)?
 - i. What if you don't get it one month?
 - ii. How do you keep your money safe?

- iii. How do you spend it?
 - c. Which resources or services are the most helpful to you?
 - d. How did you find out about these services?
 - e. Which services or programs don't help you?
 - f. Is there a routine or process you have to go through to receive the services?
 - g. Are there any other services or resources that you think would help you more?
 - h. What gets in your way of receiving services?
- 6) Are there certain people in your life who support you most?
- a. Are you in touch with your family?
 - b. How often do you see them?
 - c. Who do you spend the most time with during the day?
 - d. Do you have friends that are supportive?
- 7) I was wondering what you do if you get sick or get injured?
- a. What types of illnesses or injuries would you get help for?
 - b. How do you get health care services?
 - c. How do you feel about the treatment you get?
 - d. Are you able to follow treatment recommendations? Are the treatment recommendations helpful? Are they difficult sometimes?
- 8) I was curious about how you get around the city?
- a. Is there some type of transportation that you use?
- 9) Where do you go to wash your clothes or shower?

- a. How easy is it for you (ie to get there, wait times, etc)
- 10) I'm interested to know where you spend most nights?
- a. How did you end up finding this facility?
 - b. What did you have to do to be able to sleep here?
 - c. Where are some other places you have slept?
 - d. What are some other locations and how easy were they to access for you?
- 11) I am curious if there are certain values and beliefs that are important to you?
- Meaningful aspects of life?

Occupational Therapists

- 1) Tell me about your experiences working with the veterans who are homeless?
- 2) I'd like to hear more about this facility, and the services and resources you provide?
- 3) What are some challenges you have encountered while working here?
- 4) Describe a typical day for a veteran who is homeless?
 - a. Is there a difference between weekdays and weekends?
 - b. What is a good day like?
 - c. What is a bad day like?
 - d. Where does this population spend most of day?
 - i. Do you think there are other activities they would rather be doing?
What are they?
 - ii. What do they do to relax, leisure activities?
- 5) What types of services and resources do veterans use?

- a. How do they get financial support?
 - b. How do they receive and cash benefits checks (if applies)?
 - i. What if they don't get it one month?
 - ii. Do you know how they keep their money safe?
 - iii. What do they spend it on?
 - c. Which services and resources do you think are the most helpful?
 - d. Which services and resources aren't as helpful to?
 - e. What gets in the way of their receiving services?
 - f. Are there any other services or resources that you think would help more?
 - g. Where do they go if they want to take a shower or wash your clothes?
 - h. Where do they sleep, if not using shelters, etc?
- 6) Do you know who in their lives are supportive?
- a. Do you know whether your clients stay in contact with their family? How often do they see them?
 - b. Do you know who they spend the most time with?
 - c. Who are their friends?
- 7) I was wondering what they do if they get sick or get injured?
- a. What types of illnesses or injuries would they get help for?
 - b. How do they get health care services?
 - c. How do you feel about the treatment they receive?
 - d. Are the treatment recommendations helpful? Are they difficult sometimes to follow through on?
- 8) Do you know how they get around the city?

- a. Is there some type of transportation available?
- 9) I was curious if you know what kinds of things the population likes to do during the day?
- a. Are any of them difficult for them?
 - b. Do you think these activities have importance to them?
- 10) What are some things that you feel like the population has to do, such as chores or routines?
- a. Are any of these activities difficult for them?
- 11) I was wondering if while you have worked with this population you have noticed distinct values and beliefs. Meaningful aspects of life?

Staff Members

- 1) Tell me about your experiences working with the veterans who are homeless?
- 2) I'd like to hear more about this facility, and the services and resources you provide?
- 3) What are some challenges that you have encountered while working here?
- 4) Describe a typical day for a veteran who is homeless?
 - e. Is there a difference between weekdays and weekends?
 - f. What is a good day like?
 - g. What is a bad day like?
 - h. Where does this population spend most of day?
 - i. Do you think there are other activities they would rather be doing during the day?

- ii. What about leisure activities and methods of relaxation?
- 5) What types of services and resources do veterans use?
- a. How do they receive financial support?
 - b. How do they receive and cash benefits check (if applies)?
 - i. What if they don't get it one month?
 - ii. Do you know how they keep their money safe?
 - iii. What do they spend it on?
 - c. Which services and resources do you think are the most beneficial?
 - d. Which services and programs aren't as helpful to veterans?
 - e. What gets in the way of receiving services?
 - f. Are there any other services or resources that you think would help more?
 - g. Where do they go if they want to take a shower or wash your clothes?
 - h. Where do they sleep, if not using shelters, etc?
- 6) Do you know who in their lives are supportive?
- a. Do you know whether your clients stay in contact with their family? How often
 - b. Do you know who they spend the most time with?
 - c. Do they have friends that are supportive? The dynamics of the Commons?
- 7) I was wondering what they do if they get sick or get injured?
- a. What types of illnesses or injuries would cause them to help?
 - b. How do they get health care services?
 - c. How do you feel about the treatment they receive?

- d. Are they given treatment recommendations that are helpful and can be followed through with?
- 8) Do you know how they get around the city?
- a. Is there some type of transportation available?
- 9) I was curious if you know what kinds of things the population likes to do during the day?
- a. Are any of them difficult for them?
 - b. Do you think these activities have importance to them?
- 10) What are some things that you feel like the population has to do?
- a. Are any of these activities difficult for them?
- 11) I was wondering if while you have worked with this population you have noticed distinct values and beliefs. Meaningful aspects of life?