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EXPLORING HELP-SEEKING INTENTIONS OF HOMELESS VETERANS ATTENDING A STAND DOWN EVENT

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EXPLORING HELP-SEEKING INTENTIONS OF HOMELESS VETERANS ATTENDING A STAND DOWN EVENT

by

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Dedication

This is dedicated to the veterans, volunteers, and executive board of members of East Bay Stand Down. You serve those who have served and have remained true to the ethos of never leaving our wounded behind.

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Abstract

EXPLORING HELP-SEEKING INTENTIONS OF HOMELESS VETERANS ATTENDING A STAND DOWN EVENT

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Lack of help-seeking behavior among homeless veterans results in higher burden of disease and lower quality of life. No studies have been conducted involving help-seeking intentions of homeless veterans within the veteran stand down population. Pender's Revised Health Promotion Model was used to guide this descriptive correlational study with the aim of exploring the extent selected personal characteristics and experiences and behavior-specific factors affect help-seeking intentions among homeless veterans attending a stand down event.

A convenience sample of 86 homeless veterans (mean age 56) was recruited from a 3-day veteran stand down event in Northern California. Each participant was screened for head injury utilizing the Ohio State University Traumatic Brain Injury Identification Method (OSU TBI-ID). Participants also completed a battery of questionnaires, including a socio-demographic information sheet, Medical Outcomes Study: Social Support Survey (MOS-SSS), General Self-efficacy Scale (GSE), and Generalized Help Seeking Questionnaire (GHSQ).

The majority of the study participants were African American. The majority of participants also had a history of involvement with the justice system and a prior head injury. The findings showed that perceived social support and perceived self-efficacy were significant predictors for intention to seek help. The variables of race/ethnicity, history of involvement with the justice system, history of head injury, perceived self-efficacy and perceived social support accounted for 31% of the variance.

Based on the findings, expansion of peer mentor support, individualized case management, and expansion of homeless patient aligned care teams is recommended, as well as increased support for community outreach events such veteran stand downs. Future research should focus on expanding the present study to other homeless veteran settings and also include a study to evaluate actual long-term outcomes following homeless veteran participation in community outreach events.

Chapter 1

Introduction

Ending veteran homelessness is the VA's priority initiative, funding is available, and homeless services are prevalent. However, the missing piece is identifying the characteristics that predict a higher level of help-seeking intention among homeless veterans within communities. Determining the predictors of help-seeking intentions among homeless veterans attending a stand down event could drive the development of successful, community-based strategies by both nurses and policy makers to promote help-seeking behavior among homeless veterans, thereby improving veteran health and well-being.

Background and Significance

Over 40,000 veterans experience homelessness in the United States. On a single night in 2017, the majority of homeless veterans sought protection in emergency shelters, transitional housing programs, or safe havens. Over 38% of homeless veterans were found to reside in locations not suitable for human inhabitation (HUD: U.S. Department of Housing and Urban Development, 2017).

The U.S. Department of Veterans Affairs (VA) and community grassroots organizations offer resources for housing solutions, community-based health care, and local employment services in order to reduce homelessness among U.S. veterans and improve their quality of life. Despite the existence of these services, 65% of homeless veterans end up utilizing emergency departments and urgent care settings for healthcare (O'Toole, Johnson, Redihan, Borgia, & Rose, 2015). In addition, only 17.2 % homeless veterans reported actually utilizing VA homeless services (HUD, 2017), even though this

resource at the VA connects veterans with housing solutions, rehabilitation, mental health services, and community employment services. The reliance on urgent and emergency health care settings results in much higher costs and diminished continuity and coordination of care as compared to services provided by the Department of VA health care or if care is received within a familiar primary care setting (O'Toole et al., 2015). It is important to promote the utilization of primary care and case management by homeless veterans to facilitate coordinated care with sustained support. But in order to accomplish this, veterans must first seek help from a source they trust outside of emergency health care.

Lack of help-seeking behavior among homeless veterans can result in earlier death from often preventable and treatable causes (Hudson, Flemming, Shulman, & Candy, 2016). The majority of homeless persons do not seek help for chronic illnesses and mental health disorders (Petrovich, Pollio, & North, 2014), even though individuals who are homeless have higher rates of chronic illness, mental health disorders, substance abuse, history of head injury, and history of incarceration (Glynn et al., 2016; Topolovec-Vranic et al., 2017; United States Department of Veterans Affairs, 2017). Studies found that despite the availability of care, veterans experience several barriers to seeking help in order to receive on-going support.

Among homeless veterans, the specific reasons for delay in seeking care include lack of trust in the VA or doctors, being assigned to student doctors, not being able to smoke, not having identification, being treated poorly, being afraid of what the healthcare provider might find, being asked too many questions, not being sober, being embarrassed about their appearance, and lack of knowledge in navigating primary care (O'Toole et al.,

2015). In addition, both primary care and acute care settings may not address the social determinants affecting predisposing, reinforcing, and enabling factors that affect help seeking. Addressing predictive factors of help-seeking behavior can help homeless veterans to maintain permanent housing and obtain basic needs (O'Toole et al., 2015; Szymkowiak, Montgomery, Johnson, Manning, & Thomas, 2017).

Factors that have a strong, positive influence on intention to engage in help seeking are social connections in the community such as intimate partners, friends, parents, religious leaders, mental health professionals, and helplines (Erickson, Yorgason, & Vaughn, 2008). These connections often precede a person's decision to seek health care and utilize other available resources. Current literature does not describe the social networks homeless veterans turn to in times of need. In addition, the characteristics of homeless veterans that predict help-seeking intentions are unknown. Understanding help-seeking intentions and the characteristics associated with those intentions are key to the development of tailor-made interventions, which might increase homeless veteran engagement in existing housing, healthcare, and employment services (Wilson, Deane, & Ciarrochi, & Rickwood, 2005).

In a grass-roots effort to promote community connections of homeless veterans with available organizations that provide housing, employment, and healthcare resources, various community nonprofit organizations across the United States conduct Veteran Stand Down events. These events deliver onsite medical assistance, housing resources, and social support to facilitate the care of homeless veterans within communities. Stand-downs often involve the collaboration of veteran organizations, non-profit groups, the VA, and the U.S. military. Since its inception in 1988, over 52,000 veterans and family

members have received care at more than 190 independent stand-down events (National Coalition for Homeless Veterans, 2015).

Research describing the characteristics of veterans attending stand down events or the predictors of health seeking intentions among veterans within this setting is not available. Due to the large number of homeless veterans attending stand down events and the commitment of resources to stand downs by multiple organizations, it is important to study this population in order to develop more effective strategies that promote receipt of sustained care long-term housing, and employment.

Theoretical Framework

Pender's Revised Health Promotion Model (RHPM) (Pender, 1996) was used as a guide for this study (see Figure 1). The Health Promotion Model (HPM) was developed by Nola Pender in 1982 and was revised in 1996 based on changing theoretical perspectives. The RHPM acknowledges the modern definition of health as not being simply disease-free. The basis of Pender's model is that a person's quality of life can be improved and health care dollars saved through the promotion of healthy lifestyles. Two theories underlie the RHPM to include the Expectancy-Value Theory and the Social Cognitive Theory (Bandura, 1997; Feather, 1982). The Expectancy-Value Theory states a certain course of action will lead to a positive, desired outcome. The Social Cognitive Theory is focused on self-efficacy, predicting that the higher the level of confidence in one's ability to perform will lead to the likelihood of achieving the behavioral outcome. The principles of the RHPM have been applied to a series of studies explaining and predicting health promoting behaviors such as increasing exercise behaviors and activity, improving nutrition, increasing the use of hearing protection, health promoting behaviors

of homeless women in shelters, and women with female-specific cancers using complementary and alternative modalities (Eschiti, 2008; Kerr, Lusk, & Ronis, 2002; McCullagh, Lusk, & Ronis, 2002; Wilson, 2005; Wu & Pender, 2005). Because it is not limited to a certain health outcome, the RHPM can be applied to many different subject areas.

The three major concepts from the RHPM used in this study are: a) individual characteristics and experiences, b) behavior-specific factors, and c) behavioral outcome (Pender, 1996). By applying these three concepts in this study of homeless veterans, certain veteran characteristics were identified as predictors of health-promoting (help-seeking intention) behavior. The two areas of the RHPM not addressed in this study are Prior Related Behaviors and Activity-Related Affect and are displayed in gray in the Figure 1.

Conceptual Definitions of Terms

Individual characteristics and experiences include the personal factors of veterans' age, race/ethnicity, gender, history of involvement with the justice system, and history of head injury (Pender, 1996).

Behavior-specific factors include the interpersonal influence of perceived social support, perceived self-efficacy, perceived barriers to seeking help, and perceived benefits of seeking help. Situational influences include receipt of benefits to include receipt of service-connected VA disability payment, receipt of Medicaid, Medicare (Medi-Cal), Tricare, and/or Veterans health care benefits (Pender, 1996).

Perceived social support includes perceived interpersonal influences from family, peers, providers, and situations. It is the encouragement or direct assistance provided by others (Wu & Pender, 2005).

Perceived self-efficacy is the perception of self-confidence to achieve a desired outcome with one's available resources (Bandura, 1997).

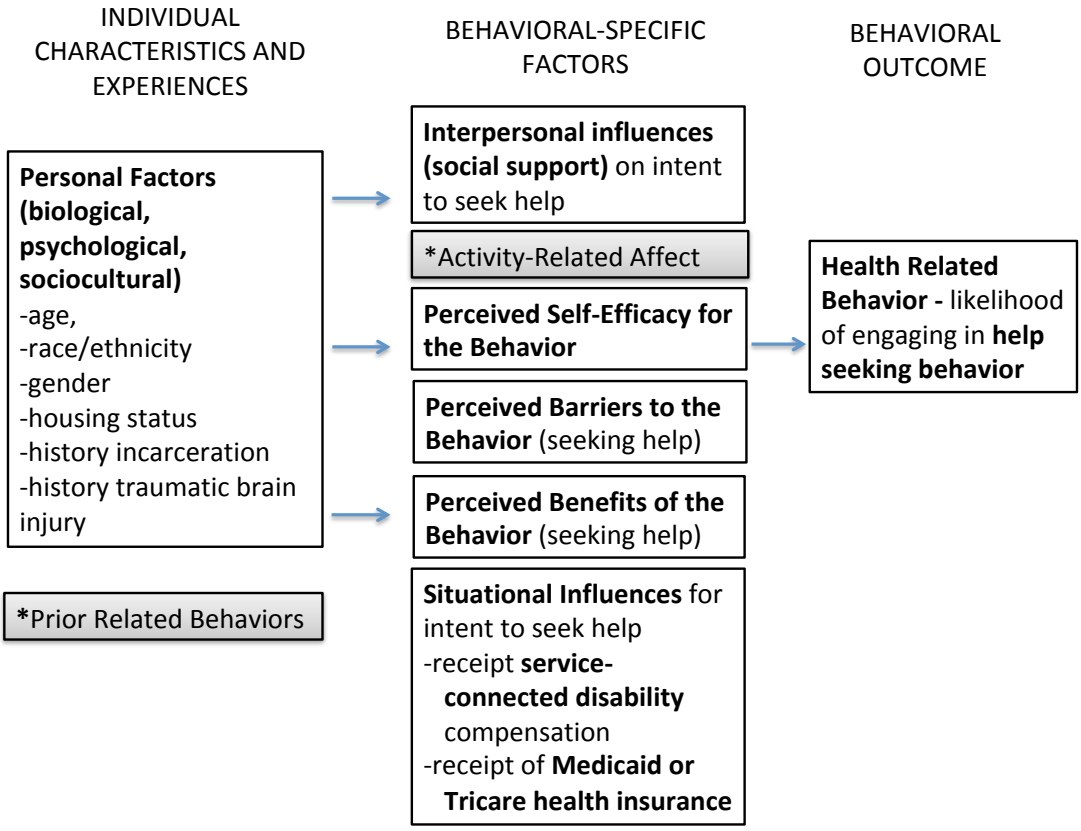
Perceived barriers are the barriers to help seeking to include anything that an individual perceives limits or prevents him/her from receiving help to include health care or support in general.

Perceived benefits include anything that an individual perceives would benefit him/her as a result of help-seeking behavior.

Situational influences include whether or not the participant currently receives any disability benefits through the VA and/or receives Medicaid (Medi-Cal), Medicare, Tricare, and/or Veterans' health care benefits.

Behavioral outcome is the health promoting behavior (help-seeking intention).

The RHPM was the best choice for this study because it is used as a guideline to identify positive factors that influence participation in health promoting behaviors (help-seeking intention). Due to the nature of the cross-sectional descriptive correlational study, the prior related behaviors and activity-related affect are not explored in the current study. This provides nurses with direction for developing effective interventions that promote healthy lifestyles and the attainment of personal goals, thereby improving veterans' quality of life.



Note. *Denotes variable not included.

Figure 1. Theoretical framework schematic based on Pender's Revised Health Promotion Model (Pender, 1996)

Statement of Purpose

The primary aim of this descriptive correlational study was to examine the impact of selected individual characteristics and experiences and behavior-specific factors on the behavioral outcome of help-seeking intention among homeless veterans attending a stand down event. The secondary aim of this study was to explore perceived benefits and barriers of seeking help among the veterans attending a stand down event.

Research Questions

Based on the purpose of this study, literature support, and the theoretical framework of Pender's Revised Health Promotion Model (Pender, 1996), the following research questions were used. In a sample of homeless veterans from the stand down event conducted in northern California:

1. What are the characteristics of perceived social support, perceived self-efficacy and intention to seek help among homeless veterans?
2. What are the selected personal characteristics (age, race/ethnicity, gender, history of involvement with the justice system, history of traumatic brain injury), and behavioral specific factors (perceived social support, perceived self-efficacy, receipt of disability compensation and/or health benefits) that significantly contribute to the variance of the intention to seek help among homeless veterans?
3. Among homeless veterans, what are the most common perceived barriers to seeking help and the most common perceived benefits of seeking help?

Chapter 2

Review of the Literature

The most common definition used to identify a homeless veteran is someone who has a veteran status and lacks a fixed, regular, and adequate nighttime residence (Martins, 2008; O'Toole et al., 2015; U.S. Department of Veterans Affairs, 2011). This definition also includes those housed in shelters, temporary housing or those at imminent risk of losing shelter, such as through a court-ordered eviction. Over 15,000 veterans are found in places not suitable for human habitation (U.S. Department of Urban Development, 2017). Using Pender's Revised Health Promotion Model (see Figure 1) as a guide, the following is a selective review of literature pertinent to the study. This review covers the behavioral outcome of homeless veterans' intention to seek help. It will also include an examination of individual characteristics and experiences of homeless veterans in regards to age, race/ethnicity, gender, history of involvement with the justice system, and history of head injury. Existing literature regarding homeless veteran behavior-specific factors will also be reviewed to include the areas of perceived social support, perceived self-efficacy, perceived barriers to seeking help, and perceived benefits of seeking help as well as whether homeless veterans receive benefits such as a service-connected disability (monetary benefit paid to veterans who are determined by VA to be disabled by an illness or injury that was incurred or aggravated during active military service) and/or a form of government funded health coverage to include Medicaid, Medicare, Tricare, and/or Veterans health care.

Individual Characteristics and Experiences

According to the RHPM, individual characteristics and experiences can directly influence the behavioral outcome (Pender, 1996). As discussed later, seeking help is largely influenced by demographic characteristics and sociocultural factors (Cornally & McCarthy, 2011). However, the link between individual characteristics and experiences of homeless veterans and the behavioral outcome of help-seeking intentions is understudied.

Age and race/ethnicity. Approximately 48% of the U.S. veteran population is aged 51 and older. In a study of elderly homeless veterans in Los Angeles (N=59), aged 65 and older, researchers found that veterans reported less education and small social networks. The veterans expressed how health and substance use issues led to loss of social support, eviction, and then homelessness (Berk-Clark & McGuire, 2014). Older homeless veterans have more medical problems and are especially vulnerable to negative outcomes related to homelessness. Overall, homeless veterans are older, more likely to be disabled, a member of an ethnic minority, have a history of incarceration, and to have experienced at least one traumatic brain injury (O'Toole et al., 2015; Szymkowiak et al., 2017; U.S. Department of Veterans Affairs, 2011). In a study of incarcerated veterans (N=30,834), African Americans veterans were over 5 times more likely and Hispanic veterans over 4 times more likely to be incarcerated than White veterans across age groups (Tsai, Rosenheck, Kasprow, & McGuire, 2013). It has also been demonstrated that veterans who are African American are less likely to have access to healthcare benefits (Tsai, Link, Rosenheck, & Pietrzak, 2016).

Gender. Prior research has demonstrated gender differences among veterans seeking care. In a recent survey comparing male and female veterans' utilization of VA health and behavioral health services following an episode of homelessness, researchers found male homeless veterans are three times more likely to utilize substance abuse services than female homeless veterans, even though women are more likely to receive compensation for disabilities connected to military service (Montgomery & Byrne, 2014). However, females more frequently use outpatient medical treatment and seek social support, while males are more apt to utilize emergency departments.

These gender differences in accessing care emphasize the need to further explore how gender correlates with the type of help-seeking intentions among homeless veterans. In the existing literature, research is absent on homeless veterans who identify as transgender. For reasons that are unclear, transgender individuals have been found to have a higher prevalence of gender dysphoria than the general population. Transgender individuals also experience societal stigmatization, resulting in lack of confidence and difficulties in forming close relationships (Lutwak et al., 2014). Therefore, it is also important to understand the characteristics of help-seeking intentions among the homeless veteran transgender population.

In addition to help-seeking differences among gender, the rate of homelessness is also different in genders. The majority of homeless veterans are male, but the number of female homeless veterans is increasing. A 2011 report by the U.S. Government Accountability Office (GAO) found that the number of homeless female veterans increased 140% between 2006 and 2010. A study comparing homeless female veterans with homeless male veterans in a national housing program found that over 26%

homeless female veterans (*n*=4,686) had children living with them, whereas less than 8% of homeless male veterans had their children living with them (Tsai, Rosenheck, & Kane, 2014). In this same study, males had higher rates of incarceration, over 68% compared with less than 42% of homeless female veterans. In addition, male homeless veterans had much higher rates of drug abuse (44.84% vs. 28.50%), whereas female homeless veterans had higher rates of post-traumatic stress disorder (36.60% vs. 27.11%).

History of involvement with the justice system. A history of involvement with the justice system is connected with veteran homelessness and reduced help seeking. A large-scale study (N= 30,348) found that 30% of incarcerated veterans had a history of homelessness. This is five times that of the general population. Also, the chronically homeless incarcerated veterans were more likely to report they had a serious medical and mental health problem at the time of their offense than all other incarcerated groups (Tsai, Rosenheck, Kasprow, & McGuire, 2014). Over half of the U.S. veterans with a history of criminal justice involvement reported a problem with substance abuse, but less than one-third engage in treatment program. This places these vulnerable veterans at increased risk of homelessness and recidivism (Glynn et al., 2016). In order to increase homeless veterans' utilization of resources and health care services, it is important to explore how a history of involvement with the justice system affects help-seeking intention and the type of sources homeless veterans are more likely to access for help.

In addition to the history of incarceration, disability could also have an impact to veterans help-seeking behaviors. A study of female veterans found that over 39% had a service-connected disability (Washington et al., 2010). The VA Office of the Inspector General (2012) reported that female homeless veterans experienced three times the rate of

traumatic brain injury (TBI) before separation from the military than their housed female veteran counterparts.

History of head injury. Lack of self-initiated action involving one's own health or functional status and goal-directed behavior is common following TBI. TBI is associated with lack of participation in rehabilitation, family life and social reintegration (Arnould, Rochat, Azouvia, & Van der Linden, 2013). Apathy, a general reduction in motivation, negatively impacts treatment and recovery efforts following a head injury and affects at least half of patients at some stage of the post-TBI period (Starkstein & Pahissa, 2014). In addition, people who have experienced a head injury have higher rates of depression, anxiety, post-traumatic stress disorder, suicidal tendencies, lack of inhibition, and substance abuse (Belanger et al., 2011). A secondary data analysis (Corrigan et al., 2013), which contained the results of the Ohio State University Traumatic Brain Injury Identification (OSU TBI-ID) screening found significant associations between prior TBI and anxiety, depression, and substance abuse (N=4,464). Further exploration of a lifetime history of TBI and its relationship with help-seeking behavior is necessary because co-occurring conditions present challenges in community reintegration and involvement in treatment, negatively affecting help-seeking intentions.

A history of TBI is also strongly associated with homelessness. In a Canadian study of homeless veterans (N=2088) with mental illness, the authors found that 53% of participants reported a history of a TBI with loss of consciousness. In addition, 40% of those reporting TBI had contact with the criminal justice system in the past 6 months (Topolovec-Vranic et al., 2017). In a study of 229 homeless veterans seeking VA homeless services, over 90% reported a history of TBI with an average of three TBI

episodes, and with most head injuries occurring prior to becoming homeless (Barnes et al., 2015). History of TBI may affect an individual's ability to engage in treatment for physical and psychological conditions. These factors place veterans at increased risk for homelessness. It is likely that homelessness and TBI share a bi-directional relationship in which factors such as risk for assault and substance abuse increase the risk of sustaining a TBI, and factors associated with a TBI such as reduced social support and income increase the risk of homelessness (Barnes et al., 2015).

Behavior Specific Factors

Behavior specific variables within the health promotion model have major motivational significance. These variables can be modified through interventions in order to adopt and sustain a healthful behavior (Pender, Murdaugh, & Parsons, 2011). This study explores the behavior specific variables to include perceived social support, perceived self-efficacy, perceived benefits, and perceived barriers. These variables are essential to examine in determining the factors attributing to the intention to seek help.

Social support. Social support falls under interpersonal influences on the Health Promotion Model. Interpersonal influences make up three areas to include expectations and norms of significant others, social support, and learning through observing others. All three determine a person's predisposition to engage in a health-promoting behavior, but social support is the avenue to the sustaining resources offered by others. Social support is an individual property and includes the instrumental and emotional encouragement for a person to both initially access and maintain resources (Pender et al., 2011). Adequate social support has been associated with positive health outcomes. Lack of social support is associated with homelessness. When people need help, they usually

turn to someone within their social network (Nagai, 2015). People who are homeless may lack a positive social network, thereby reducing the likelihood of seeking help.

A study of 1,438 veterans enrolled in Housing and Urban Development-Veterans Affairs Supported Housing (HUD-VASH) sites nationwide evaluated the availability of family and/or peers as sources of support (O'Connell & Rosenheck, 2016). The study found that the majority of homeless veterans identified at least one close person in their lives. In fact, the rates of the availability of any source of social support were estimated to be 30 to 50% higher among homeless veterans than rates of support among samples of homeless non-veterans. The study did not address how the availability of social support actually influenced help-seeking intentions. However, results suggested that the availability of support from family members is associated with more positive outcomes for homeless veterans, such as reducing the length of time homeless (O'Connell & Rosenheck, 2016).

An additional study indicated that social support, along with service-connected disability status, and satisfaction and continuity with providers, predicted homeless veterans' trust in providers over time (van den Berk-Clark & McGuire, 2014). In a study of veterans in Utah, the most consistent and important predictor of help seeking was community attachment (how well they felt they fit into the community) (Erickson et al., 2008). Also, community attachment doubled the odds of having a friend or relative to provide transportation and tripled the odds of having a friend or relative provide emotional support (Erickson et al., 2008). This makes exploring the relationship between level of social support and type of help-seeking intention important. Avenues for social support can help veterans who are currently homeless gain housing or encourage them to access other available resources that could improve quality of life (O'Connell &

Rosenheck, 2016). Future interventions may need to involve a focus on both veterans and their most common source of social support that they turn to for help, which might be associated with self-efficacy.

Perceived self-efficacy. Self-efficacy is the self-confidence to achieve a desired outcome with one's available resources (Bandura, 1997), affects healthcare use, and helps to overcome stressful situations (Benight & Bandura, 2004). Prior research involving self-efficacy of veterans has focused on veterans returning from wars (Blackburn & Owens, 2015; Porcari et al., 2017). A study by Porcari et al. (2017) utilized the General Self-Efficacy Scale that measured general trait-like self-efficacy in a wide variety of situations among 325 Afghanistan and Iraqi veterans and service members who had registered for physical or mental health services at a VA between 2001 and 2007. The results indicated that intention to seek help for a psychological problem was negatively correlated with self-efficacy ($r = -.12$; $p < 0.05$). However, no published research can be found that specifically examines relationships between self-efficacy and help-seeking intentions among the homeless veteran population. To better understand this, it is also important to explore what the homeless veterans perceive to be the barriers to and benefits of seeking help.

Perceived barriers and perceived benefits. Homeless veterans can face multiple barriers when seeking help such as lack of transportation, fragmented health care services, difficulty scheduling and keeping appointments, perceived or actual stigma of homelessness, lack of trust, social isolation, and competing basic needs (O'Toole, Johnson, Aiello, Kane, & Pape, 2016). Factors preventing veterans from seeking help at the VA Health Care System specifically include difficulty navigating the system, being unfamiliar with available resources, and difficulty in accessing medical providers via

phone (Zucchero, McDannold, & Mcinnes, 2016). An additional barrier is worry about arrest or stigma due to criminal history or outstanding warrants (Tsai, Rosenheck, Kasprow, & McGuire, 2013). According to Tsai et al. (2013), a large percentage of homeless veterans have criminal histories that may impede access to resources due to other than honorable discharge or for fear of incarceration. A study involving a focus group of combat veterans on post deployment difficulties and help-seeking barriers found that the major barriers to seeking mental health care were concern of others' negative reactions (public stigma), internalization of negative messages (self-stigma), and concerns about the help-seeking process itself such as talking to a stranger and trusting the therapy process (Cornish, Thys, Vogel, & Wade, 2014).

Concerning perceived benefits, past literature involves treatment preferences in veterans with combat experience. A recent study of returning U.S. veterans reported perceived benefits of seeking care was to receive help with various veteran benefits, post-traumatic stress disorder, dental, vision, hearing, and pain management issues (Crawford et al., 2015). In addition to perceived benefits and barriers, the situational factors also could impact individual's help seeking behaviors.

Situational influences. Personal perceptions of a situation can either facilitate or hinder a behavior. Situational influences can affect a person's insight and awareness, changing personal perceptions thereby enforcing commitment to health action. These influences can be considered determinants of health and facilitate the maintenance of health-promoting behaviors (Pender et al., 2011).

The situational influences related to receipt of VA service-connected disability benefits and being eligible for Medicaid (Medi-Cal), Medicare, Tricare and/or VA health

care benefits may affect help-seeking behavior and the type of care homeless veterans receive. Among veterans aged 18 to 64 years, approximately 13.8% had TRICARE, 6.4% had Medicaid coverage, 10.1% had VA health care only, 7.2% were uninsured, 58.7% had private insurance, and 3.9% had some other insurance. Among veterans aged 65 and older, 38% were covered by Medicare. Younger veterans were more likely to be covered by VA health care only or to be uninsured (Zelaya & Nugent, 2018). These available benefits may cause veterans to utilize various sources for health seeking, increasing fragmented health care. On the other hand, many health care providers within communities may not accept Medicaid or TRICARE coverage, leading veterans to instead utilize the emergency room for health care needs, especially if they are not registered for VA health care benefits.

Certain veterans may receive disability compensation for an injury or illness incurred or aggravated during active military service. A study comparing veterans with post-traumatic stress disorder (PTSD) (N=3,337) who received VA disability benefits to those not receiving benefits found that receiving PTSD service-connected disability benefits was associated with less homelessness (12.0% vs. 20.0%, p=.02) (Murdock et al., 2011). According to the U.S. Department of Housing and Urban Development (2015), of veterans experiencing homelessness, 53% are disabled. A secondary data analysis study in homeless veterans (N= 16,912) found that over 50% of the frequent utilizers of emergency department and mental health inpatient services had a service-connected disability (Szymkowiak et al., 2017). This may demonstrate that having service-connected disability benefits actually encourages use of emergency services

through the VA instead of participation in preventive health care such as routine primary care services due to easier access.

In another study, homeless veterans utilizing VA services under the age of 65 were two times more likely to be eligible for Medicaid than non-homeless veterans utilizing VA services (64% vs. 30%). This is important to identify because it is possible, despite access to many services, these homeless veterans receiving disability compensation and health benefits may have different methods of help seeking. This also raises concerns regarding fragmented care as homeless veterans may seek help from different sources across systems outside the VA (Tsai & Rosenheck, 2014).

Behavioral Outcome

Understanding help-seeking intentions and behavior is necessary in order to identify factors that can be improved in order to facilitate engagement in care (Wilson et al., 2005). Measuring current help-seeking intentions significantly predicts actual help-seeking behavior in the future. Intentions are developed by a person's attitudes toward the behavior, social norms, and perceived control over the help seeking (Azjen, 1991). Therefore, the intention to seek help from different sources can lead homeless veteran to actual help-seeking behavior, increasing the chances of veterans seeking primary care, housing, and/or employment services.

Help-seeking intentions. Homelessness exacerbates health problems and complicates engagement in help-seeking behavior (Glynn et al., 2016). Care is often centered on treating complications of homelessness due to a harsh environment, untreated mental health problems and substance abuse, and untreated chronic health conditions. Homeless veterans have high rates of emergency department use and hospitalizations

with an underutilization of primary care and preventive health services. One survey of homeless adults found that more than 40% used an emergency department (ED) at least once in the previous year (Hastings et al., 2011). A study of veterans (N=1533) found that only one of every six veterans reported using VA homeless or social services while they were homeless and 56% of mentally ill homeless veterans had used VA services at some time in their lives (Tsai, Link, Rosenheck, & Pietrzak, 2016).

A recent study utilized the General Help Seeking Questionnaire (GHSQ) to predict veteran (N= 325) intention to seek help from a variety of sources for a psychological problem (Porcari et al., 2017). The authors found that veterans were more likely to indicate they would seek help if they had a mental health service-connected disability through the VA. However, lower level of help seeking reduced the likelihood that veterans would apply for a service-connected disability. In this same study, participants were most likely to indicate they would seek help for a psychological problem from their partner/spouse, family, or friends over clergy or the Internet. The majority of veterans were extremely unlikely to indicate intent to seek help from any formal source, such as a medical professional. Also, lower self-efficacy correlated with veterans' intention to seek help ($r=-12$; $p<.05$) (Porcari et al., 2017).

The negative effects of delayed help seeking are evident and include delayed diagnosis and treatment and poor outcomes (Cornally & McCarthy, 2011). Efforts to improve help seeking among homeless veterans must start with examining their intentions to seek help from both formal and informal sources. Prior research has not determined what variables are significant in predicting intention to seek help among veterans who are homeless. The majority of research on help seeking of veterans focuses on seeking help for psychological problems and has only made connections between help

seeking and veterans who have experienced war, incarceration, traumatic brain injury, disability, and/or minority status.

Summary of the Relevant Literature

In summary, the existing literature establishes that compared to the general population, veterans experiencing homelessness tend to be older, and a member of an ethnic minority. Homeless veterans have a higher rate of chronic medical conditions, mental health problems, and substance abuse, disability, history of involvement with the justice system, and history of head injury. Research has found that all of these factors affect social networks and housing status and that even though homeless veterans have a rate of health insurance that is comparable to the general population, they more likely to utilize emergency departments and have low utilization rates of VA homeless services. Finally, veterans, in general, tend to seek help from a friend, partner, or spouse.

Existing literature is limited in understanding the factors that predict help-seeking intention or actual help seeking. It is also limited in examining self-efficacy in relation to help-seeking behavior among homeless veterans. The current research on help-seeking intention revolves around veterans experiencing incarceration, combat, traumatic brain injury, and disability, but is limited related to help seeking as it relates to veterans experiencing homelessness.

Through this scholarly literature review, important variables have been identified that require further exploration in regard to their contribution to help-seeking intentions among homeless veterans. Factors for a quantitative analysis are based on concepts contained in the RHPM and include the individual characteristics of age, race/ethnicity, gender, history of involvement with the justice system, and history of TBI. Also, the

behavior-specific factors identified for further study include social support, perceived self-efficacy, perceived barriers to help seeking, and perceived benefits of help seeking.

To contribute to nursing's body of knowledge, it is important for future research to comprehend the factors that either increase or reduce homeless veterans' intentions to seek help from different sources. By accomplishing this, interventions can be developed with a focus on the factors that promote the positive influences on help seeking. Since help seeking tends to precede actual health seeking, properly developed interventions can help homeless veterans establish sustained social support, preventive care, housing, and employment.

Chapter 3

Methods

The primary aim of this descriptive correlational study was to examine the impact of selected individual characteristics and experiences and behavior-specific factors on the behavioral outcome of help-seeking intention among homeless veterans attending a Stand Down event. The secondary aim of this study was to explore perceived benefits and barriers of seeking help among the veterans attending a stand down event.

Research Design

A descriptive correlation research design was used to describe the characteristics of social support, self-efficacy, and help-seeking intention among the homeless veterans. In addition, to identify the associations among the above variables and the significant predictors for help-seeking intention. This design was developed to answer the following research questions for this study:

1. What are the characteristics of social support, self-efficacy and intention to seek help among homeless veterans?
2. What are the selected personal characteristics (age, race/ethnicity, gender, history of involvement with the justice system, history of traumatic brain injury), and behavioral specific factors (social support, self-efficacy, receipt of disability compensation and/or health benefits) that significantly contribute to the variance of the intention to seek help among homeless veterans?
3. Among homeless veterans, what are the most common perceived barriers to seeking help and the most common perceived benefits of seeking help?

Setting

Over 100 veteran Stand Down events are held across the country throughout the year. The Veteran Stand Down in Pleasanton, California was utilized as the setting for this study. This event is known as *East Bay Stand Down*. This particular stand down event was used for this study because of the potential access to a larger number of veterans as compared to other stand down events in smaller cities. In addition, the researcher assisted with the planning and organization of this event in the past and is familiar with the personnel, volunteers, and location, making it accessible and more convenient to facilitate collaboration with organizers in establishing the research site and procedures.

Sample

Study participants were all veterans experiencing homelessness. Homelessness, for purposes of this study, was defined as in Section 330(h)(5)(A) of the Public Health Service Act, which is "an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations, and an individual who is a resident in transitional housing. A homeless person is an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or in any other unstable or non-permanent situation" (National Health Care for the Homeless Council, 2015). Participants were excluded if they did not meet this definition of homelessness.

Sample size. Because there is no prior study of this population from which to estimate sample size, the G* Power computer program was utilized to perform calculations (Faul, Erdfelder, Lang, & Buchner, 2007). Using regression analysis with medium effect size of .15, significance level of $p<0.05$, and 9 predictors, the resulting required sample size was 109 to have an 80% of power to prevent type II error.

Protection of Human Subjects

The proposal for this study was submitted to the University of Texas at Tyler (UT Tyler) Institutional Review Board (IRB) for approval (See Appendix A). The East Bay Stand Down organization did not require IRB approval. The Executive Board Chairman of East Bay Stand Down authorized the researcher to conduct the study during the event. Either the researcher or research assistant discussed informed consent with potential participant and provided a copy of the informed consent form to participants. Either the researcher or RA also obtained verbal consent from each participant prior to completion of the surveys. Veterans' privacy was protected through the use of partitions, providing veterans a private area to complete the surveys and to ask the researcher any necessary questions.

The importance of confidentiality and non-judgment was stressed during the consent and research process. No veterans became distressed when completing surveys, but counseling services (chaplains and psychologists) were on site if the need arose. At any time, the participants could refuse or withdraw from the study. The researcher emphasized that participation in the study would not affect their right to receive resources and care at the stand down event.

The researcher and RA completed the Course in the Protection of Human Subjects (CITI). The researcher and RA also completed the online training module for the OSU TBI-ID method on the Ohio State University, Ohio Valley Center for Brain Injury Prevention and Rehabilitation site prior to administering this questionnaire to veterans.

Instruments

Questionnaires that were used to collect the data included a) socio-demographic, situational factors, perceived benefits, and perceived barriers questionnaire (Appendix B), b) Ohio State University Traumatic Brain Injury Identification (OSU TBI-ID) questionnaire (Appendix C), c) Medical Outcomes Study Social Support Survey (MOS-SSS) questionnaire (Appendix D), c) General Self Efficacy (GSE) Scale (Appendix E), and d) General Health Seeking Questionnaire (GHSQ) (Appendix F). All questionnaires were self-reported and completed onsite prior to the closing of the stand down event.

Socio-demographic questionnaire. Participants were asked to complete a researcher-designed questionnaire. This survey included questions about age, race/ethnicity, gender, and whether or not veterans have a history of involvement with the justice system.

Ohio State University Traumatic Brain Injury Identification (OSU TBI-ID). The OSU TBI-ID questionnaire (Corrigan & Bogner, 2007) was used to screen for traumatic brain injury (TBI). The OSU-TBI is a standardized method for obtaining a person's lifetime history of TBI through a 5-minute structured interview consisting of 5 questions. The answers are then rated using a scale with 1 being *no history of TBI* (all answers are no) to 5 being *severe TBI* (the most severe injury reported involved loss of

consciousness exceeding 24 hours. The OSU-TBI includes criteria is consistent with the Centers for Disease Control for surveillance of TBI (CDC, 2010).

In convenience samples recruited from two treatment programs for persons with substance abuse disorders (*n*=119) interrater reliability for the OSU-TBI was found to be high (0.84-0.95) with six of the seven dimensions exceeding 0.90 using Interclass correlation coefficients. The study also supported predictive validity (*n*=103) (Corrigan & Bogner, 2007). Predictive validity has been demonstrated in studies of TBI in prisoners, psychiatric diagnosis in veterans seeking outpatient substance abuse, and veterans with spinal cord injury (Bogner & Corrigan, 2009; Budd et al., 2017; Corrigan, Bogner, & Holloman, 2012; Olson-Madden et al., 2010). No studies could be found that utilize the OSU TBI-ID within the homeless veteran population.

Medical Outcomes Study Social Support Survey (MOS-SSS). The MOS-SSS (Sherbourne & Stewart, 1991) was used in this study to measure interpersonal influence of social support, is a 19-item, self-administered questionnaire developed to assess four components of perceived availability of social support including (1) Emotional support/Informational support, (2) Tangible support (including material support), (3) Positive social interaction (does person have friends that are available) and (4) Affectionate support (including loving and nurturing relationships). The MOS-SSS was developed for use in the Medical Outcomes Study (MOS), a two-year study of patients with chronic health conditions. The MOS-SSS is scored by obtaining a score for each subscale, then calculating the average for each item in the subscale. To calculate the overall support index, the average of the scores for all 18 items and the score for the one additional item were calculated. Using a formula, scales can be transformed to a 0-100

scale. A higher score indicates more support (Sherbourne & Stewart, 1991).

For the MOS-SSS, internal consistency for overall support was .97. Internal consistencies for subscales were emotional/informational support (.96), tangible support (.92), affectionate support (.91) and positive interaction (.94) (Sherbourne & Stewart, 1991). Results from the Gjesfjeld, Greeno, Kim, and Anderson (2010) study of mothers with a child in mental health treatment (N=330) indicated a reliability coefficient for the total score of .96 and reliability of .94 and .83 for the 12-item scale and 4-item scale respectively. The MOS-SSS has been used with low-income populations, mothers in the U.S., and African American women (Gjesfjeld et al., 2010). In addition, the MOS-SSS has examined social support and identified demographic and health correlates among American Indians aged 55 years and older with an overall Cronbach's alpha score of .95 (Contea, Schureb, & Goins, 2015).

Generalized Self-Efficacy (GSE) scale. Perceived self-efficacy was the second behavior specific factor examined. The instrument used to measure perceived self-efficacy was the GSE (Schwarzer & Jerusalem, 1995). The scale was developed to assess a general sense of perceived self-efficacy to predict coping with daily hassles as well as adapting after various stressful life events. This scale relies on the belief that one's own actions are responsible for successful outcomes. It is self-administered with 10 items, requiring an average of 4 minutes to complete. Responses are on a 4-point Likert Scale labeled "not at all true" (1 point), "hardly true" (2 points), "moderately true" (3 points), and "exactly true" (4 points). The total score is calculated by finding the sum of the all items. For the GSE, the total score ranges between 10 and 40, with a higher score indicating more self-efficacy (Schwarzer & Jerusalem, 1995).

The General Self-Efficacy Scale is correlated to emotion, optimism, and work satisfaction. In samples from 23 nations, Cronbach's alphas ranged from .76 to .90. Criterion-related validity is reflected in many correlation studies where positive coefficients were found with favorable emotions, dispositional optimism, and work satisfaction. Negative coefficients were found for depression, stress, health complaints, burnout, and anxiety (General Self Efficacy Scale, n.d.). This instrument has been found to be a reliable and valid measure of the perception of self-efficacy in studies of patients in psychiatric outpatient care and combat veterans, with a Cronbach's alpha ranging between .79. and .93 (Cuevas & Penate, 2015; MacEachron & Gustavsson, 2012; Porcari et al., 2017).

Situational influences. Participants were asked whether or not they currently receive compensation for a service-connected disability through the VA, and whether or not they currently receive Medicaid, Medicare, Tricare, and/or Veterans health care benefits. Participants answered "yes" or "no" to each answer choice. These questions were included on the questionnaire following the socio-demographic questions (see Appendix B).

Perceived barriers and perceived benefits of seeking help. As a secondary aim to the study, the perceived barriers to and benefits of seeking help were examined. Participants were asked to list three barriers to seeking help. They were also asked list three benefits to seeking help. The questionnaire was open-ended, asking participants to list the top three from most important to least important. These questions were administered after the questions about receipt of benefits (see Appendix B).

General Help Seeking Questionnaire (GHSQ). The GHSQ subscale on personal-emotional problems was used to measure participants' help-seeking intentions from different sources. The GHSQ is known to be a flexible measure of help-seeking intentions that can be used in a variety of study populations. The GHSQ includes two subscales, one to measure the personal-emotional problems and the other one for suicidal problems and all with acceptable reliability. In this study to avoid stigmatization, only the personal-emotional problems subscale was used (Wilson et al., 2005). Items were scored on a scale of 1 (extremely unlikely) to 7 (extremely likely). A higher total score means higher level of help-seeking intention. Cronbach's alpha for the personal-emotional problems subscale is .70 with a test-retest reliability of .86.

The GHSQ has been utilized to explore help-seeking intentions in veterans and service members with a history of combat deployments, focusing on psychological needs (Blais & Renshaw, 2013; Porcari et al., 2017). These two studies did not indicate instrument reliability.

Participants were also asked a single question about their willingness to seek health care services on a regular basis, such as from a primary care provider. Participants rated their likelihood of seeking health care on a regular basis (at least once every 6 months), such as from a primary care. Participants rated the likelihood using a 7-point Likert scale, 1 (extremely unlikely) to 7 (extremely likely).

Study Procedure

After obtaining IRB approval from UT Tyler and the approval from the East Bay Stand Down Executive Chair, the researcher began the study procedure. Data was collected at the stand down event held in Pleasanton, California September 20-22, 2018

over a period of 3 days. Over 300 veterans participated in this stand down event. The veterans reside onsite, sleeping in tents at the encampment over the 3-day duration of the stand down event. Three long tables were set up with partitions where veterans reviewed and provided informed consent and completed the surveys. Convenience sampling using the consecutive sampling approach was utilized. Veteran status was verified by stand down personnel prior to veterans registering and entering the event. Status was confirmed by proof of Certificate of Release or Discharge from Active Duty (DD Form 214). Most veterans pre-registered for the stand down through volunteers located at different shelters, churches, and organizations servicing the homeless population in the East Bay area. If a participant did not have a copy of the DD Form 214, Veteran's Administration personnel screened for veteran status and were able to verify participants' veteran status. To meet inclusion criteria, veterans had to meet the above definition of homelessness and must be able to read and must speak English. The researcher or research assistant verbally asked potential participants to determine if they met inclusion criteria.

One research assistant (RA) was placed at the table in the designated research area in order to explain the research study to veterans. Prior to the start of the study, the researcher trained the RA by reviewing the informed consent information provided to participants, providing study purpose and procedures, and doing a mock practice/walk through of study procedures at event site.

If a veteran was interested in participating in the study, the potential participant was allowed time to consider and could return to the table at a later time, if necessary. Once participants decided they were interested in participating, either the researcher or

RA screened for eligibility. If qualified for the study, the researcher or RA provided the written information on the study (see Appendix F) and verbally reviewed the consent with the potential participant, answering any questions. The veteran was then verbally asked if they consented to participate in the study. The veteran was also provided with the option return to complete the surveys later in the day, if necessary. Once the participant verbally consented, the researcher or RA ensured they received a copy of the consent form. Then, the researcher directed the veteran to a separate private area behind the screening/consent table in order to complete the surveys. During the event, chaplains and a psychologist were onsite to assist should a veteran become distressed when completing surveys.

One of the surveys, the OSU-TBI ID, required the researcher or RA to personally interview the veteran. The researcher and RA completed the online training module for the OSU-TBI ID method on the Ohio State University, Ohio Valley Center for Brain Injury Prevention and Rehabilitation site prior to administering this questionnaire to veterans. The researcher and one RA also completed the Course in the Protection of Human Subjects (CITI). This was to ensure that research activities are conducted ethically and in a manner that protects the rights of participants. As noted previously, the interrater reliabilities for the OSU TBI-ID were high, indicating instrument consistency between raters (Corrigan & Bogner, 2007).

Upon completion, the participants turned in completed surveys to the researcher or RA. The researcher or RA reviewed it for completion. A reflective bag with a small flashlight and pair of socks was provided to each participant after completion. On average, the entire process (screening and survey completion) took approximately 20

minutes. The data was de-identified to ensure confidentiality and saved to a confidential research computer that was password protected. Surveys are maintained in locked cabinet in researcher's office. Records will be kept for a minimum of 3 years.

Methods of Data Analysis

All data were analyzed using the Statistical Package for the Social Science (SPSS, version 20). Responses were coded and entered twice to ensure accuracy of the data. Prior to substantive analyses, the data were subjected to cleaning to check for impossible or improbable values. Frequency distributions were examined for reasonable approximations to normality for all continuous variables. Non-normal data were handled by the process of transformation of data or the use of non-parametric statistics. Internal consistency reliability measures for all instruments were calculated using Cronbach's alpha coefficients. The linkage between construct, conceptual variables, and operational variables are detailed in the Table 1.

Table 1

Conceptual and Operational Definitions

Construct	Variable	Conceptual definition	Operational definition
Individual Characteristics and Experiences	Personal demographic factors	Age in years, race/ethnicity, and gender	Responses on personal characteristics questionnaire indicating age in years, race/ethnicity (White, Hispanic, Latino, or Spanish origin, Black or African American, and other), and gender (male, female, transgender, or does not identify as female, male, or transgender).
Individual Characteristics and Experiences	History of Involvement with the justice system	Individual having been in jail or prison for any period of time and/or being on probation for any period of time	Responses on personal characteristics questionnaire indicating yes or no to whether participant has ever been in jail for any period of time (incarcerated).
Individual Characteristics and Experiences	History of head injury	Individual having a history of having an injury to the head, which resulted in loss of consciousness, or at least leaving the person feeling dazed, confused or disoriented	Ohio State University TBI Identification Method (OSU TBI-ID) screening questionnaire self-report of TBI over a lifetime. Participant responses to 5 questions rated on a scale with 1 being *no history of TBI* (all answers are no) to 5 being *severe TBI* (the most severe injury reported involved loss of consciousness exceeding 24 hours).
Behavioral-specific factors	Social Support	An individual's interpersonal influences from family, peers, providers, and situations; the encouragement or direct assistance provided by others	The MOS-SSS (Sherbourne & Stewart, 1991) was used in this study to measure interpersonal influence of social support. A 19 Likert-type 5-point items, self-administered questionnaire assessed four components of perceived availability of social support including (1) Emotional support/Informational support, (2) Tangible support (including material support), (3) Positive social interaction (does person have friends that are available) and (4) Affectionate support (including loving and nurturing relationships). For overall support, The total score is calculated by finding the sum of the all items and calculated the average of the scores for all 18 items and the score for the one additional item. A higher score indicated a higher level of

			social support.
Behavioral-specific factors	Perceived Self-efficacy	An individual's self-confidence to achieve a desired outcome with one's available resources	Measured by the general self-efficacy scale (GSE). Self-administered with 10 4-point Likert type items labeled "not at all true" (1 point), "hardly true" (2 points), "moderately true" (3 points), and "exactly true" (4 points). The total score is calculated by finding the sum of the all items. For the GSE, the total score ranges between 10 and 40, with a higher score indicating more self-efficacy.
Behavior-specific factors	Perceived barriers	Anything that an individual perceives limits or prevents him/her from receiving help to include health care or support in general.	Participants asked to list the top three barriers to seeking help from most important to least important.
Behavior-specific factors	Perceived benefits	Anything that an individual perceives as a benefit of seeking help to include health care or support in general.	Participants asked to list the top three benefits to seeking help from most important to least important.
Situational Influences	Receipt of service-connected disability	An individual's receipt of disability payments for an injury or illness caused by or connected with prior military service.	Whether or not the participant currently receives any disability payment from the VA for a service-connected disability.
Situational Influences	Receipt of health insurance	Current health insurance coverage through the VA, Medicaid, Medicare, and/or Tricare	As reported on personal characteristics questionnaire where participants check which health insurance coverage they have, if any.
Behavioral outcome	Intention to seek help	The intention to seek help from informal and formal sources for different issues decision-making process that is problem focused, has intentional action, and has interpersonal interaction	The GHSQ subscale on personal-emotional problems was used to measure participants' help-seeking intentions from different sources. Ten 7-point Likert-type items are scored on a scale of 1 (extremely unlikely) to 7 (extremely likely). The higher total scores means higher level of help-seeking intention.

Analysis Plans for the Research Questions

To answer the first research question about the characteristics of social support, self-efficacy and intention to seek help among homeless veterans, descriptive statistics were used to calculate the mean and standard deviation scores of social support, self-efficacy and intention to seek help. The level of statistical significance for all of the research questions was set at $p < .05$

To answer the second research question, hierarchical linear regression analysis was used to evaluate help-seeking intentions from the various sources to determine the selected personal characteristics (age, race/ethnicity, gender, history of involvement with the justice system, history of traumatic brain injury), and behavioral specific factors (social support, self-efficacy, and receipt of benefits) that significantly contribute to the variance of the intention to seek help among homeless veterans. Pearson correlations were used as initial tests of associations among the independent variables (age, race/ethnicity, gender, history of incarceration, history of head injury, perceived social support, perceived self-efficacy, and receipt of benefits) with the dependent variable (help-seeking intentions).

To answer the third research question, descriptive statistics were used. Results were ranked and compared based on the top barriers to seeking help and the benefits of seeking help identified by participants. Categories were developed using content data analysis. Pender's RHPM was utilized as a guide in the development of categories.

Chapter Four

Results

The findings of this cross-sectional descriptive correlational study of help-seeking intention of homeless veterans are presented in this chapter. All data was analyzed using the Statistical Package for the Social Science (SPSS, version 20). Responses were coded and entered twice to ensure accuracy of the data. Prior to substantive analyses, the data was cleaned to check for impossible or improbable values. Frequency distributions were examined for reasonable approximations to normality for all continuous variables. Normal distribution for all instrument scores was tested. Based on inspection of histogram and boxplot, three outliers with a z-score above 3 existed for the self-efficacy variable and were not included in the final data analysis. The level of statistical significance for all of the research questions was set at $p < .05$. Description of sample characteristics, reliability of each instrument, and data regarding each of the three research questions are reported.

Description of the Sample

A total of 89 participants took part in the study. However, three were excluded due to the following: one participant left prior to completion of first questionnaire, one participant completed the study twice, and it was determined that one participant actually had stable permanent housing. This left a total sample size of 86.

In this theory-based study, the individual characteristics and experiences were described through examining age, race/ethnicity, gender, history of involvement with the justice system, and history of TBI. Participants ranged in age from 23 to 79 years with a mean age of 55.93 (SD= 11.74). The majority of the participants were male (n = 74,

86%) and African American (*n* = 38, 44.2%), had a history of involvement with the justice system (*n* = 67, 77.9%), and had a history of a head injury (*n* = 79, 91.9%). For those with a history of a head injury, almost one third of them experienced a TBI in the moderate or severe category (*n* = 25, 29.1%). Mean age of first head injury was 16.58 (*n* = 79, SD = 9.921) ranging from ages 3 to 52. The most common cause of head injury among males was a motor vehicle accident. The most common cause of head injury among females was domestic abuse (*n*=7, 64%).

Under behavioral specific factors, situational influences explored included receipt of service-connected disability and health insurance. The majority of participants were receiving VA service-connected disability compensation (*n* = 45, 52.3%). In addition, the majority of participants had health insurance coverage through either the Veterans Health Administration, Medicaid (also known as Medi-Cal), Medicare, and/or Tricare (n = 77, 89.5%) with VHA being the most common type of coverage (*n* = 41, 47.7%). Of the 86 participants, 72 (83.7%) had received some type healthcare from the VHA prior to attending the stand down event. Characteristics of the participants are detailed in the Table 2.

Table 2

Sample Demographic Information

Variable (N = 86)	*n*	%
Age (2 missing))		
23 to 40	11	12.79
41-49	9	10.47
50 and over	64	74.42
Race/Ethnicity (*1 missing)*)		
White	18	20.93
Hispanic, Latino, or Spanish	7	8.14
Black or African American	38	44.19
More than one race/ethnicity	16	18.60
Other	6	6.98
Gender (*0 missing*)		
Male	74	86.05
Female	11	12.79
Do not identify as female, male or transgender	1	1.16
History of Incarceration (*1 missing*)		
No	18	20.93
Yes	67	77.91
History of Head Injury (0 missing)		
None	7	8.14
Mild without LOC (dazed/Memory lapse)	29	33.72
Mild (LOC < 30 min)	25	29.07
Moderate (LOC between 30 min and 24 hours)	14	16.28
Severe (LOC > 24 hours)	11	12.79
VA Service-Connected Disability (*1 missing*)		
No	40	46.51
Yes	45	52.33
Health Insurance (*1 missing*)	8	9.30
No	77	89.53

Yes		
Health Insurance Type (*13 missing*)		
Veterans Health Administration	41	47.67
Tricare	1	1.16
Medicare	10	11.63
Medicaid (Medi-Cal)	7	8.14
More than one of above	14	16.28
Received Healthcare from VHA prior to event (*0 missing*)		
No	14	16.28
Yes	72	83.72

Descriptive Analysis of Research Instruments

Instruments used for this study were based on Pender's Revised Promotion Model (Figure 1). Individual characteristics and experiences including age, race/ethnicity, gender, and history of involvement with the justice system were collected through the use of a personal characteristics/sociodemographic form. The additional individual characteristic and experiences variable of history of head injury was explored though the use of the Ohio State University Traumatic Brain Injury (OSU-TBI) Identification Form. Data on behavioral-specific factors was collected through use of the Medical Outcomes Study Social Support Survey (MOS-SSS) for perceived social support, General Self-Efficacy (GSE) Scale for perceived self-efficacy. Questions about the situational influences of receipt of service-connected disability and health insurance benefits were included on the personal characteristics form. Questions asking about benefits and barriers to help-seeking behavior were also included on the personal characteristics form. The behavioral outcome of help-seeking intention was examined through the use of the General Help Seeking Questionnaire (GHSQ). The internal consistency of the instruments used in this study, including subscales, were assessed and all had an acceptable Cronbach's alpha coefficients (> .70). Means and standard deviations for each instrument are reported in Table 3. In addition, the normal distribution for all instrument scores was described.

MOS-SSS. The MOS-SSS was used to describe the characteristics of social support that the veterans perceived. The possible range of scores is 19 to 95 for the 19-item MOS-SSS, with a higher score indicating a greater amount of perceived social support (Sherbourne & Stewart, 1991). The actual range of scores obtained from the veterans

was 20 to 95 (M= 54.69, SD= 17.19), which was normally distributed. The Cronbach's alpha for the MOS-SSS was .961 for this study.

GSE. To describe the characteristics of self-efficacy, participants completed the General Self Efficacy (GSE) questionnaire. The possible range of scores is 10 to 40 for the 10-items, with a higher score indicating a greater amount of self-efficacy (Schwarzer & Jerusalem, 1995). The actual range of scores obtained from the veterans was 14 to 40 (M=28.98, SD=4.86), which was normally distributed. Cronbach's alpha for the GSE was .905 for this study.

GHSQ. To describe the intention to seek help, participants completed the General Help Seeking Questionnaire. The possible range of scores is 10 to 70, with a higher score indicating a greater amount of intention to seek help (Wilson et al., 2005). The actual range of scores obtained from the veterans was 14 to 40 (M=32.56, SD=9.55), which was normally distributed. The Cronbach's alpha for the GHSQ was .709 for this study.

Table 3

Descriptive Statistics for Social Support (MOS-SSS), General Self-Efficacy (GSE), and General Help Seeking Questionnaire (GHSQ) Scales

Instrument	*N*	Number of Items	Mean	*SD*	Scale range	α
MOS-SSS	86	19	54.69	17.19	19-95	.961
MOS-SSS subscales:						
Emotional/informational	86	8	24.84	7.81	8-40	.939
Tangible	86	4	9.95	4.69	4-20	.898
Affectionate	86	3	8.64	4.01	3-15	.947
Positive social interaction	86	3	8.98	3.30	3-15	.941
Additional item (Someone to do things with)	86	1	3.05	1.20	1-5	.958
GSE	82	10	28.98	4.858	10-40	.905
GHSQ	86	10	38.50	10.74	10-70	.709
Intimate partner	86	1	3.64	1.97	1-7	--
Friend	86	1	3.91	1.62	1-7	--
Parent	86	1	3.14	2.14	1-7	--
Other relative/family member	86	1	3.39	1.86	1-7	--
Mental health professional	86	1	4.12	1.91	1-7	--
Phone helpline	86	1	2.92	1.94	1-7	--
Doctor/General practitioner	86	1	4.31	1.83	1-7	--
Minister or religious leader	86	1	3.40	1.97	1-7	--

Results for Research Question 1

Research question one: What are the characteristics of social support, self-efficacy, and intention to seek help among veterans experiencing homelessness? To answer this question, the mean scores of the sum for the MOS-SSS, GSE, and the GHSQ were calculated for each. In addition, the MOS-SSS was converted to an index score (0-100) to compare the level of social support among veterans in this study to the adults with chronic conditions who participated in the Medical Outcomes Study (Sherbourne & Stewart, 1991). The mean scores for questions on all three instruments was also examined.

Social support. Social support was measured by the MOS-SSS. The mean of the sum scores of MOS-SSS was 54.69, which indicated a low level of social support. For the subscales of the MOS-SSS, the mean of the sum scores for emotional was 24.84 (SD=7.81), tangible was 9.95 (SD=4.69), affectionate was 8.64 (SD= 4.01), and positive social interaction was 8.98 (SD=3.30).

Among the four social support subscales, participants scored highest in the area of emotional and informational support with a mean score of 3.13 (SD=.98), indicating *some of the time* to *most of the time* participants have someone to count on to listen, give information and good advice, share worries and fears, and someone to understand. Participants scored the lowest on the tangible support subscale with a mean score of 2.51 (SD=1.18), indicating *a little of the time* to *some of the time* participants had someone to help if confined to bed, someone to provide transportation to the doctor, someone to prepare meals if unable, and someone to help with daily chores if sick.

In order to compare the MOS-SSS results of the present study with that of the Medical Outcomes Study (Sherbourne & Stewart, 1991), a two-year study of 2,987 patients ages 18 and older (M=55) with chronic conditions, the total scores for overall social support and subscales were converted to an index score (0-100). Compared to the findings from Medical Outcome Study, the homeless veterans in the current study reported a statistically significantly lower overall functional support index score (47 vs 70.1; $t(85) = -9.482$, $p<.001$), and in the four specific types of social support, emotional, tangible, affection, and positive social interaction (all $p <.001$).

Self efficacy. Self-efficacy was measured by the General Self Efficacy (GSE) scale. The mean of the sum scores was 28.98 (SD=4.86). The participants' mean score for individual items on the survey was 2.84, indicating that participants felt that it was *hardly true* to *moderately true* that they had the self confidence to achieve a desired outcome with available resources.

For the GSE, there is no cut-off score designating a person as having high or low perceived self-efficacy (Schwarzer & Jerusalem, 1995). However, analyzing descriptive data from an international dataset (Schwarzer, 2006) including 18,000 respondents from 24 nations, the average sum score on the GSE was 29.46 (SD=5.33) and the mean score for individual items was 2.94. Based on this comparison, the present study's results indicate the average total score and individual item mean on the GSE is only slightly below the average for the general population, both nationally and internationally. Comparing to an additional study of combat veterans with a history of traumatic brain injury (n=64) (Lawrence, Matthieu, & Robertson-Blackmore, 2017), the mean sum score

of participants was actually higher (M=32.4, SD=5.6) than the present study of homeless veterans.

Help-seeking intentions. Help-seeking intention was measured by the General Help Seeking Questionnaire (GHSQ). The average participants' total score on the GHSQ was 32.56 (SD = 9.55). The mean score for individual items on the survey was 3.25, indicating that participants were between unlikely and slightly likely to have intent to seek help from a formal or informal source for a personal or emotional problem.

In the present study, the highest individual item mean score (M=4.31±1.81) in the GHSQ was intention to seek help from a doctor/general practitioner, followed by intention to seek help from a mental health professional (psychologist, social worker, or counselor; M=4.12±1.91). Participants' lowest intention to seek help was from a phone helpline. Among informal sources, participants had the highest intent to seek help from a friend (M=3.91, SD=1.62) followed by a partner (M=3.64, SD=1.97). In the current study, help-seeking intentions was higher in Black or African American participants (*n*=38, M= 39.47± 10.39) than White (*n*= 18, M= 33.61± 8.91). However, there was no statistically significant difference between two ethnic groups ($t(54) = -1.707$, $p = .093$).

When asked to list other types of help seeking, a total of ten participants responded. The participant responses included *a stranger*, *alcoholics anonymous*, *Buddhist leader*, *colleague*, *God*, *myself*, *someone I just met but learned that he/she is a vet*, and *someone I've seen who has shown compassion*. When answering the question, "I would not seek help from anyone," the mean score was 3.02 (SD=2.058), indicating that overall, participants were *unlikely* to not seek help from anyone.

As an additional question, participants were asked "*How likely are you to seek help for health care on a regular basis (not for emergencies) such as from a regular primary care provider?"* The mean score was 5.27 (SD=1.903), indicating that participants were *likely* to *very likely* to seek primary health care on a regular basis.

Results for Research Question 2

The second research question was: What are the selected personal characteristics (age, race/ethnicity, gender, history of incarceration, history of traumatic brain injury), and behavioral specific factors (social support, self-efficacy, receipt of disability compensation, receipt of health benefits) that significantly contribute to the variance of the intention to seek help among homeless veterans? This question was analyzed by multiple regression analysis to determine the extent to which variables with a significant correlation ($p < .05$) contributed to the intention to seek help. Two additional personal factors were included based on their significant correlation to overall social support.

Before the hierarchical regression analyses were performed, either Pearson's or Spearman's correlation was used to examine the associations between the nine independent variables and the dependent variable of help-seeking intention (see Table 4). Intention to seek help was significantly correlated with social support ($r = .513$, $p < .01$) and perceived self-efficacy ($r = .380$, $p < .01$), indicating that a higher level of social support and a higher level of self-efficacy are both associated with a higher level of intention to seek help. Among the social support subscales, Emotional had the highest correlation with intention to seek help ($r = .468$, $p < .01$) and Tangible had the lowest correlation with intention to seek help ($r = .396$, $p < .01$). Ethnicity was weakly correlated with intention to seek help ($r_s = .215$, $p = .048$), and history of head injury significantly correlated with social support ($r = -.297$, $p < .006$). The individual characteristics and experiences of age, gender, history of involvement with the justice system, and history of head injury were not significantly associated with the intention to seek help. Under behavioral-specific factors, the situational influences of receipt of service-connected

disability and receipt of health insurance were also not significantly associated with intention to seek help.

A hierarchical multiple linear regression analysis was conducted to identify the personal characteristics and behavioral specific factors that explain the variance of intention of homeless veterans' intention to seek help (see Table 5). The assumptions for regression analyses were evaluated for possible bias. The results did not violate any assumptions of the regression analysis. The Durbin-Watson statistic verified independent observation with a score of 1.729. Because of the correlation between history of head injury and social support, variance inflation factor result was verified to be 1.00, demonstrating that multicollinearity was not an issue between the two independent variables.

Guidelines to determine which variables should be added into the model were based on Pender's Revised Health Promotion Model. The first block of predictors included three of the individual characteristics and experiences comprising of participants' race/ethnicity, history of involvement with the justice system, and history of head injury. In the second block, behavior specific factors were added to include social support and self-efficacy. Race-ethnicity was chosen due to its significant correlation with intention to seek help. History of involvement with the justice system and history of head injury were chosen due to their significant correlation with social support. The two behavior specific factors of perceived social support and perceived self-efficacy were chosen due to their significant correlation with intention to seek help.

The first block of the model including individual characteristics and experiences was not significant ($R^2 = .011$, $R^2_{adj} = -.028$, $F[3,76] = .273$, $p = .844$). Perceived social

support and perceived self-efficacy were entered as the second step, which accounted for a total of 31.1% variance to intention to seek help ($R^2 = .355$, $R^2_{adj} = .311$, $F[5,74] = 8.137$, $p < .001$). However, perceived social support ($\beta = .45$, $p < .001$) and perceived self-efficacy ($\beta = .33$ $p = .001$) were the only significant predictors in the final model, indicating that an individual is more likely to seek help if they have a higher level of both perceived social support and perceived self efficacy.

Table 4

Correlations for Personal Characteristics and Experiences, Behavior Specific Factors

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Age	---													
2. Ethnicity[#]	-.043	---												
3. Gender	-.240*	-.008	---											
4. History involvement justice with system	-0.63	-.182	-.255*	---										
5. VA Disability	.038	.056	-.176	-.021	---									
6. Insurance	-.133	-.023	.028	-.071	.019	---								
7. History Head Injury	.011	-.162	-.019	.099	.106	.015	---							
8. Social Support Overall	-.019	.053	.067	-.126	-.073	-.116	-.297**	---						
9. Social Support Emotional	-.031	.056	.080	-.220*	-.100	-.153	-.187	.842**	---					
10. Social Support Tangible	-.063	.080	.037	.-.080.	-.034	-.099	-.094	.805**	.651**	---				
11. Social Support Affectionate	-.026	.052	.013	.-.030	-.118	-.012	-.269*	.794**	.644**	.628**	---			
12. Social Support Positive Interaction	.008	-.090	.057	.-.123	-.106	-.088	-.258*	.820**	.611**	.599**	.736**	---		
13. Perceived Self-Efficacy	-.105	.008	.057	.046	.010	.036	-.100	.162	.147	.117	.225*	.186	---	
14. Intention to Seek Help	-.104	.215*	.012	-.075	-.107	.090	-.084	.513**	.468**	.396**	.420**	.445**	.380**	---

*$p < .05$. **$p < .01$ [#] Ethnicity correlation determined by Spearman's Rho

Table 5

Summary of Hierarchical Regression Analysis for Variables Predicting Intention to Seek Help

(N = 79)	Model 1			Model 2		
Variable	*B*	*SE B*	*β*	*B*	*SE B*	*β*
Race/Ethnicity	0.38	0.50	.087	.49	.41	.11
History of Involvement with Justice System	-1.26	2.96	-.049	-.71	2.44	-.03
History Head Injury	.11	1.10	.01	1.36	.915	.14
Perceived Self-Efficacy				.71	.205	.33*
Perceived Social Support				.28	.06	.45**
R^2		.01			.36	
Adjusted R^2		-.03			.31	
F for change in R^2		.27			19.73**	

*$p < .05$. **$p < .01$.

Results for Research Question 3

Research question 3: Among homeless veterans, what are the most common perceived barriers to seeking help and the most common perceived benefits of seeking help? To examine this question, descriptive data was obtained using two open-ended questions to determine benefits of seeking help and barriers to seeking help. Responses were collapsed into categories, frequencies were then calculated within each category. Pender's Health Promotion Model was used as a guide in identifying the final, broader categories for responses. The categories aligned with factors listed in the model under individual characteristics and experiences and also behavior-specific factors (Pender et al., 2011). See Table 6 for the list of categories and frequency of responses regarding benefits of help seeking. See Table 7 for a list of categories and frequency of responses regarding the barriers to help seeking among veterans attending a stand down event.

The category identified as the most important benefit of seeking help among participants was *situational influences improved* (*n*=24, 24.4%). Regarding benefits of seeking help, situational influences involved receiving healthcare, improving physical or mental health, help with problems in general, and obtaining disability benefits and/or VA benefits. The category of *interpersonal influences* was the most important barrier to help seeking identified by participants (*n*=35, 40.7%). Regarding barriers to seeking help, interpersonal influences in this study involved lack of trust, negative past experiences, lack of others caring or listening, and stigmatization.

Table 6

Descriptive Statistics Benefits of Help Seeking Categories

Category	Most Important *n*=78 n (%)	2nd Most Important *n*=69 n (%)	3rd Most Important *n*=53 n (%)
Perceived self-efficacy increased (Gaining knowledge and skills to meet goals)	20 (23.3%)	11 (12.8%)	9 (10.5%)
Interpersonal influences increased (Social support/connectedness)	13 (15.1%)	18 (20.9%)	20 (23.3%)
Situational influences improved (Get healthcare, better physical or mental health, help with problems, get disability benefits, get VA benefits)	24 (27.9%)	22 (25.6%)	13 (15.1%)
Immediate needs get addressed (Housing, food, financial, employment, safety)	21 (24.4%)	18 (20.9%)	11 (12.8%)

Table 7

Descriptive Statistics - Barriers to Help Seeking Categories

Category	Most Important *n*=76 n (%)	2nd Most Important *n*=66 n (%)	3rd Most Important *n*=53 n (%)
Personal Factors			
(Substance abuse, physical or mental health issues, sense of pride, wanting isolation)	10 (11.6%)	4 (4.7%)	7 (8.1%)
Interpersonal Influences			
(Lack of Trust, negative past experiences, lack of others caring, lack of others listening, stigmatization)	35 (40.7%)	23 (26.7%)	19 (22.1%)
Situational Influences			
(Care processes such as problems navigating services, wait time, limited staffing, no privacy, no benefits, no ID, language barrier)	18 (20.9%)	26 (30.2%)	17 (19.8%)
Immediate competing demands			
(Basic needs not met, no housing, no money, hungry, too sick, too sad, legal problems)	13 (15.1%)	13 (15.1%)	10 (11.6%)

Summary of Results

This chapter presented the results of this cross-sectional, descriptive correlational study to explore the impact of selected individual characteristics and experiences and behavior-specific factors on the behavioral outcome of help-seeking intention among homeless veterans attending a stand down event. The secondary aim of this study was to explore perceived benefits and barriers of seeking help among the veterans attending a stand down event.

The results indicated that for individual characteristics and experiences, participants' mean age was over 55 and the majority of participants were African American and male. Over 77% of participants had a history of involvement with the justice system and over 90% had a history of head injury. Concerning behavioral-specific factors, the majority of veterans was receiving VA service-connected disability and/or had health insurance coverage through VHA, Medicare, Medi-Cal, and/or TRICARE, with VHA being the most common coverage.

Based on the overall functional index score on MOS-SSS, study participants experience a low level of perceived social support. Compared to the large-scale Medical Outcomes Study (Sherbourne & Stewart, 1991) of people with chronic illness, participants in the present study had a significantly lower overall functional support index score as well as lower index scores for all four social support subscales. Among the four subscales, based on individual mean scores, participants in this study scored highest in the area of emotional and informational support and lowest in tangible support.

For perceived self-efficacy, the mean scores for individual items demonstrated a low level of self-efficacy. However, a large study of international data indicated that the

participants in the present study were only slightly below the average for the general population, nationally and internationally.

Participants in the present study had a much lower level of help-seeking intention when comparing the sum scores on the GHSQ with a study of non-homeless men in (Cornish et al., 2014). In the present study, based on results of the mean score for individual items, participants indicated they were only unlikely to slightly likely to seek help from either informal or informal source for a personal or emotional problem. Participants reported they were most likely to seek help from a doctor/general practitioner followed by a mental health professional. They were least likely to seek help from a phone line. Among informal sources, participants most likely to seek help from a friend, followed by a partner. Participants were also likely to very likely to seek primary care on a regular basis.

Intention to seek help was significantly correlated with social support and perceived self-efficacy, with the strongest correlation being social support. Among the social support subscales, emotional social support had the highest correlation with help-seeking intention and tangible social support had the lowest. Ethnicity was slightly correlated with intent to seek help. History of head injury was significantly correlated with social support.

The individual characteristics and experiences of race/ethnicity, history of involvement with the justice system, and history of head injury, along with the behavioral specific factors of social support and self-efficacy accounted for 31% of the variance of intention to seek help. Perceived social support and perceived self-efficacy were the only significant predictors in the final model.

The most important benefit of seeking help identified by participants was that situational influences improved, which involved receiving healthcare, increased physical or mental health, help with problems in general, and obtaining disability or VA benefits. Participants identified the category of interpersonal influences as the most important barrier to seeking help, which involved lack of trust, negative past experiences, lack of others caring or listening, and feelings of stigmatization.

Chapter 5

Discussion and Conclusion

This study examined age, race/ethnicity, gender, history of involvement with the justice system, history of head injury, social support, perceived self efficacy, receipt of disability from VA, and receipt of health insurance as factors that predict homeless veterans' intention to seek help. Veterans in this study also identified the most important benefits and barriers to help seeking. This chapter focuses on study findings and subsequent conclusions. The discussion focuses on study findings with respect to principal findings of research questions and additional findings. Furthermore, this chapter addresses the strengths and limitations of this study, implications for clinical practices, and recommendations for further research.

Principle Findings

Characteristics of social support, self-efficacy, and intention to seek help among homeless veterans. People experiencing homelessness have complicated needs that require high levels of social support (Porcari et al., 2017). Despite homeless veterans requiring more social support, the perceived social support in the present study participants was significantly lower compared to the Medical Outcomes Study (Sherbourne & Stewart, 1991) of the general U.S. population. Social support has been identified as a significant buffer and an important resource to deal with stress. Lack of social support could further negatively impact future help seeking and subsequent achievement of personal goals.

It is also important to note that participants in this study scored highest in the area of emotional social support. This study did not ask the participants where their emotional

support came from; however, most likely their emotional support comes from other people experiencing homelessness since the homeless population is more likely to maintain social connections with other people experiencing homelessness (Walter et al., 2016). On the other hand, participants scored lowest in the area of tangible social support. This involves the provision of material support, which might be the most needed form of support for this population; however, it was the type they perceived to be least present.

Participants in the current study reported a compatible average self-efficacy with the results obtained from a large-scale study including the general population in 25 countries (Scholz et al., 2002). Another study of veterans returning from combat (MacEachron & Gustavsson, 2012) also had only a slightly higher mean individual item score on the GSE compared to the present study. An additional study of combat veterans who had experienced a TBI had a higher mean sum score on the GSE (Lawrence et al., 2017). An important question is why veterans in the present study had a level of self-efficacy comparable to the U.S. general population. One explanation could be that even though they are facing the challenges of homelessness, veterans may still maintain a level of self-efficacy compatible to the general population due to past military experiences. Most veterans have persisted in the face of adversity and have most likely experienced past success. According to Bandura (1997), success with past experiences can increase a person's perceived self-efficacy.

Participants in the current study were unlikely to have help-seeking intention from either informal or formal sources for their personal or emotional problems. A separate study (Porcari et al., 2017) of active duty service members returning from combat

utilizing the GHSQ found that help-seeking intention from a physician/nurse practitioner and a mental health professional were much lower than the present study of homeless veterans. However, similar to the present study, the active duty service members returning from combat were also more likely to seek help from friends.

Little is known about the help-seeking intention of veterans experiencing homelessness and no research has been conducted on help-seeking behavior of veterans attending a stand down event. Therefore, a comparison of help-seeking intentions with other study results of homeless veterans within stand down populations cannot be made. Also, comparing total scores on the GHSQ with other studies is not possible due to utilizing only the first part of the GHSQ scale. In addition, the questions included can vary between studies because researchers to select which help sources to include in the scale items (Wilson et al., 2005).

Predictors for intention to seek help. The regression analysis indicated selected personal factors (race, history of involvement with justice system and head injury) along with perceived self-efficacy and social support explained 31% of the variance of seek help-seeking intention; only perceived social support and perceived self-efficacy were significant predictors, with perceived social support being the most significant predictor for help-seeking intention. A separate study (Porcari et al., 2017) of active duty military returning from combat utilizing the GHSQ also found social support to be a significant predictor of help-seeking intention.

The findings for social support and perceived self-efficacy as significant predictors of intention to seek help demonstrate that before people seek help, they not only have to select a source of social support, but they must also make the decision to act, and that

decision to act is dependent on a person's level of self-efficacy (Cornally & McCarthy, 2011). This aligns with Pender's theory that commitment to a plan of action initiates a behavioral event, propelling a person into action, unless there is a competing demand that cannot be avoided or resisted (Pender et al., 2011).

Perceived benefits and barriers of seeking help. Last, this study identified the top three benefits of seeking help and the top three barriers to seeking help among homeless veterans. The category identified by participants as the most important benefit of seeking help was the improvement of situational influences. Situational influences included receiving healthcare, improving physical or mental health, help with problems in general, and obtaining disability benefits and/or VA benefits. Situational influences are considered to be determinants of health behavior. Interventions that facilitate acquisition of these benefits can help promote and sustain help seeking (Pender et al., 2011) within this vulnerable population of veterans.

Interpersonal influences was the most important barrier to help seeking identified by participants. Interpersonal influences involved lack of trust, negative past experiences, lack of others' caring or listening, and feelings of stigmatization. Similarly, in a separate study (O'Toole et al., 2015), homeless veterans reported lacking trust in the VA and doctors, being treated poorly, lacking involvement in their own care decisions, and not being sober as barriers. Clearly, trust, negative experiences, stigma, and difficulties navigating health care systems serve as barriers to help seeking.

Additional Findings

An additional finding from this study worthy of further examination is the high rate of history of head injury among both male and female participants. For females, the

predominant cause of head injury was domestic abuse, whereas for males, the most common cause was fighting, followed by motor vehicle accidents. Current findings support previous research (Metraux et al., 2013), which identified the high rate of TBI among homeless veterans.

In the present study, a more severe history of head injury was significantly correlated with a lower level of overall social support, as well as lower affectionate and positive social interaction. Impaired neurocognitive abilities such as memory, mood, and/or concentration problems experienced by this population interfere with maintaining social support, long-term housing, or independently navigating care systems, making it difficult for veterans to benefit from existing resources (Twamley et al., 2019).

Strengths and Limitations of the Study

Study strengths. No other studies have been conducted involving help seeking of homeless veterans within the veteran stand down setting. In addition, few studies have been conducted involving help seeking of homeless veterans in any setting. Another strength is the fact that this is a theory-based study that tests the overall effectiveness of using Pender's Revised Health Promotion Model as a guide in determining the factors that predict intention to seek help among homeless veterans.

The setting in which the study was conducted was a safe environment and allowed the researcher access to homeless veterans outside of the Veterans Administration. Because data collection occurred over short period of time, history, maturation, and regression were not issues.

Study limitations. This study is limited in that it surveyed a preexisting sample population not formed at random, but through self-selected convenience sample (selection bias). Also, the participants in this setting may all have certain characteristics predisposing them to certain outcomes. For example, based on the study setting, all of the veterans already have some degree of help-seeking behavior. Otherwise, they would not be attending a stand down event. This may also be a threat to external validity due to not being able to generalize the study sample to individuals in other homeless veteran settings. Diffusion of treatment may have also been a threat to internal validity, because the camaraderie available amongst participants at stand down events can lead them to answer more positively regarding social support and help-seeking behavior.

Mortality was a threat to internal validity due to participants reviewing and consenting to the study, but then not actually completing the surveys. This was due to the many distractions of other resources and the length of time taken to complete the five surveys. To reduce diffusion of treatment, the researcher attempted to recruit participants early on and encourage completion at the beginning of the stand down event to prevent the participation in stand down activities and communication with other participants from skewing the results, particularly to self-efficacy and social support scales.

Due the sample size being smaller than the priori one, a post-hoc power analysis was calculated to ensure no type II error in this study. The hierarchical regression analysis used a sample size of 86, with an alpha level of .05, and an overall $R^2_{adj} = .311$ for five predictors have a power more than 80.

Conclusion

Based on the review of findings, several implications for clinical practice exist involving the need to promote social support and self-efficacy in the clinical setting (both acute and primary care) as well as through community outreach settings. Recommendations for future studies are also made based on concerns veterans expressed regarding lack of trust and negative care experiences. In addition, research outside stand down events and a longitudinal study to determine the long-term outcomes of homeless veterans participating in outreach events such as stand downs are recommended.

Implications for Clinical Practice

Social support and self-efficacy were significant factors in this study affecting whether or not veterans experiencing homelessness intend to seek help. However, due to negative past experiences and feelings of fear, shame, or stigma, veterans may be unable to maintain the long-term relationships necessary to solve problems, even though they desire social connections and want to achieve personal goals. Homeless veterans feel compelled to seek help for treatment for a health issue, but may not have enough rapport and trust in the nurse or other health care provider to ask for help in gaining long-term housing and receiving assistance with tangible needs such as transportation and basic needs (Szymkowiak et al., 2017). Mistrust and lack of connections with others may lead veterans experiencing homelessness to feel disempowered and unwelcome in many formal settings designed to provide care to this population.

These results stress the importance of including peer support mentorship in the care of veterans. This is reflected in the quote by a veteran participant in the current study who wrote, “Seeing is believing. Being able to speak, listen, and be guided by

another veteran that has experienced what I have and knows what steps I need to do next." Prior studies have reflected the importance of informal sources such as peers to promote veteran engagement in treatment through support groups. The most recent success in the area of peer support has been seen in veteran treatment courts where shared veteran culture can motivate justice-involved veterans to participate in problem solving. A study employing content analysis determined that this method inspires a sense of obligation to do well not only for themselves, but for fellow veterans (Ahlin & Douds, 2015). This supports the behavior-specific factor of interpersonal influences in Pender's Health Promotion Model where social support encourages a behavior by tapping into the sustaining resources that can be offered by others and providing encouragement that leads a person to commit to a plan of action (Pender et al., 2011).

In order for help seeking to occur, a person must select a source of social support such as friends, family, or professionals who the person feels has the knowledge and skills to solve or lessen their problems (Cornally & McCarthy, 2011). Participants in this study had significantly lower overall social support. They also expressed many barriers to seeking help, similar to findings from prior literature that, compared to the general population, homeless veterans experience more barriers establishing and maintaining social networks that can connect them with the psychological and material resources needed to help them cope (Walter, Jetten, Dingle, Parsell, & Johnston, 2016). However, participants in the current study expressed that they were likely to seek help from a healthcare provider as measured by the General Help Seeking Questionnaire, indicating a health care provider could be one of the important social supports that homeless veterans can access.

Because this population of homeless veterans actually had a high rate of health insurance coverage and received primary care on a regular basis, integrating veteran mentors and peer support into clinical care as well as community outreach programs (for example, stand downs and veteran treatment courts) would be an effective way to promote help-seeking behaviors. This would utilize a veteran's emotional support network to access and maintain the use of tangible social support sources. A study of 3,543 homeless veterans among 33 different VHA facilities with homeless medical homes and patient-aligned care teams found that that the features significantly related to high rates of outpatient care and overall reduction in both emergency department use and hospital admissions were integration of social supports and social services into clinical care. Additional features significantly related to reduction in ED use and hospital admissions were outreach to and integration with community agencies (O'Toole et al., 2016).

Mentor peer support can also increase help seeking in that peers can assist veterans in improving their situational influences by helping them navigate material needs such as transportation, guidance with completing paperwork, and receiving needed resources such as accessibility equipment. This is especially important due to the high rate of head injury, aging population, and history of incarceration among the homeless veteran population in this study. The use of peer mentors in the delivery of health care services is an existing program within the VHA and veterans have reported both emotional and instrumental benefits of peer services through having someone both listen and help with concrete tasks (Resnik, Ekerholm, Johnson, Ellison, & O'Toole, 2016).

Next, self-efficacy should be promoted by increasing veteran's personal empowerment. Nurses and other health care providers can support personal empowerment by not only reducing stigma and mistrust through nonjudgmental and respectful attitudes, but also by involving the veteran in care decisions, offering knowledge and clear guidance regarding available resources and options. This population of veterans not only requires more complex health care, but in this same clinical setting, they have a need to be heard. This is demonstrated by comments written by participants about barriers to help seeking identified to include:

"They won't listen to me. One-sided – don't see things from my perspective."

"Made to feel *less than*."

"Stereotyping of veterans who are homeless and suffer from moral injury."

By addressing these barriers related to interpersonal influences, homeless veterans will be more likely to seek help in order to achieve identified long-term goals. This reflects the importance of training health care providers on veteran culture, care, and motivational interviewing, and unconscious bias.

Individualized case management for sustained care coordination within the health care setting and at outreach events such as stand-downs would benefit this population of veterans. As an example, homeless patient aligned care teams (H-PACT) at the VA collaborate with HUD-VASH offering permanent housing and case managers. This housing-first strategy has been successful in integrating social, physical, and mental health care needs to provide homeless veterans with long-term support (O'Toole et al., 2015). To promote both social support and self-efficacy, individualized case managers services should include ensuring care continuity, providing housing first, ensuring

veterans receive extra support during housing transitions, staff flexibility when providing support, encouragement, and belief in the veteran's potential for change and growth (Gruenewald, Doan, Poppe, Jones, & Hutt, 2018). The government must continue to support and expand high quality homeless patient aligned care teams H-PACT at the VHA that address not only health care needs, but also social disparities that are common among veterans experiencing homelessness.

Addressing disparities at treatment sites and/or outreach events can reduce future emergency department use and hospitalizations by improving living conditions and healthy behavior. Access to medical care by itself does not improve environmental conditions and self-management of habits (Bandura, 1997). Veterans experiencing homelessness within this stand down population are likely to seek health care, but may be less likely to ask for help related to social determinants affecting housing status. Therefore, during clinical care appointments, it is imperative for nurses and other health care providers to also address the short-term and long-term social disparities homeless veterans are experiencing, along with their immediate health care needs. Housing status should be addressed and case management services offered any time veterans present for treatment at a health care setting (both hospital and primary care setting) or outreach event.

It is also important that homeless veteran outreach events across the country be funded and supported legislatively in order to provide a standardized, holistic framework similar to that found at East Bay Stand Events in that they are multi-day events offering onsite medical care, chaplains, veterans' treatment court, hygiene care, laundry services, clothes, food, and care for companion animals. At these events, veterans should also

have onsite access to VA resources as well as multiple community-based not for profit 501(c)(3) organizations that provide needs assessment, case management, employment and training, housing, and legal assistance. Multi-day events provide veterans with more time to access needed resources and to make social connections in an environment that supports military culture.

And last, it is also necessary to ensure incarcerated veterans are connected with social support services immediately after release (Rosenheck et al., 2010). Community outreach programs such as stand down events can be effective in connecting justice-involved veterans with housing options and social support to reduce recidivism and homelessness. This could be accomplished by ensuring peer mentors and case managers work with incarcerated veterans prior to release and also by ensuring a smooth transition to a VHA patient aligned care team designed solely for veterans newly released from prison to ensure receipt of intensive care management services.

Recommendations for Future Studies

The present study should be expanded to community settings outside of stand down events in order to determine external reliability. Future studies should also include a longitudinal study to evaluate the actual long-term quality of life outcomes of veterans following their involvement in community outreach events such as stand-downs.

In the current study, among the various types of social support, emotional support has the highest correlation with intention to seek help and followed by positive interaction; therefore, a future study should identify the actual sources of their emotional support, as well as the effectiveness of adopting the use of peer mentors in clinical care to provide social support and further improve and sustain help-seeking behavior.

Conclusion

Despite high levels of health insurance coverage, disability compensation, and receipt of primary care services, veterans still face barriers to permanent housing. Prior research supports the notion that health insurance is often used as a measure for having access and receiving care. However, in reality, people experiencing homelessness have often had negative care experiences, lack of social support, and limited self-efficacy influencing their intention to seek help (O'Toole et al., 2015) and preventing them from accessing, navigating, and maintaining resources needed to exit homelessness.

The results of this study support the use of Pender's RHPM is an effective guide to determining the factors that predict intention to seek help among homeless veterans. The findings reflect the importance of addressing homeless veterans' interpersonal influences through promoting understanding of veteran culture among healthcare providers and nurses. Also the use of peer mentors and individualized case managers can address situational influences by assisting veterans to gain the benefits needed to reach goals. And last, funding and support of community outreach events such as stand downs and the expansion of homeless patient aligned care teams can help promote social support and self-efficacy among veterans experiencing homelessness within this population, thereby increasing homeless veterans' intention to seek help.

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Appendix A: Personal Characteristics Survey

Personal Characteristics Questions

Participant ID# _____

Questionnaire: *Demographics, history of incarceration, health insurance, VA healthcare services in the past, perceived benefits of seeking help, and perceived barriers to seeking help*

Please answer the following questions. **ALL** answers are **confidential (will be kept private).**

1. **What is your age?** _____

2. **What is your race/ethnic group? Please mark all that apply with an X.**

   ☐ White

   ☐ Hispanic, Latino, or Spanish origin

   ☐ Black or African American

   ☐ Asian

   ☐ American Indian or Alaska Native

   ☐ Middle Eastern

   ☐ Native Hawaiian or Other Pacific Islander

   ☐ Some other race, ethnicity or origin. Please list: _____

3. **What is your gender?**
   ☐ Male ☐ Female
   ☐ Transgender
   ☐ Do not identify as female, male, or transgender

4. **Have you ever been in jail** for any period of time (incarcerated)? ***Reminder: This information is protected and confidential (it will be kept private).***
   ☐ Yes ☐ No

5. **Do you receive compensation (payments) from the VA for a service connected medical condition (disability)?**

   ☐ Yes ☐ No

6. **Do you have Tricare, Medicare, Medicaid, and/or currently registered to receive VA healthcare?** ☐ Yes ☐ No

   If yes, which one(s)? (check all that apply):
   ☐ Tricare ☐Medicaid ☐Medicare ☐VA healthcare

7. **Did you receive any healthcare from the VA prior to attending East Bay Stand Down 2018?** ☐ Yes ☐ No

8. **What do you feel are the benefits of seeking help from others?** Please list your **top three** in the order they are important to you, with 1. being the most important to you:

   1.

   2.

   3.

9. **What do you feel are the barriers or problems when trying to get help from others?** Please list your **top three** in order they are important to you, with 1. being the most important to you:

   1.

   2.

   3.

Appendix B: Ohio State University TBI Identification Method Questionnaire

Name: ID#: Current Age: Interviewer Initials: Date:

Ohio State University TBI Identification Method — Interview Form

Step 1

Ask questions 1-5 below. Record the cause of each reported injury and any details provided spontaneously in the chart at the bottom of this page. You do not need to ask further about loss of consciousness or other injury details during this step.

I am going to ask you about injuries to your head or neck that you may have had anytime in your life.

1. In your lifetime, have you ever been hospitalized or treated in an emergency room following an injury to your head or neck? Think about any childhood injuries you remember or were told about.
   ☐ No ☐ Yes—Record cause in chart
2. In your lifetime, have you ever injured your head or neck in a car accident or from crashing some other moving vehicle like a bicycle, motorcycle or ATV?
   ☐ No ☐ Yes—Record cause in chart
3. In your lifetime, have you ever injured your head or neck in a fall or from being hit by something (for example, falling from a bike or horse, rollerblading, falling on ice, being hit by a rock)? Have you ever injured your head or neck playing sports or on the playground?
   ☐ No ☐ Yes—Record cause in chart
4. In your lifetime, have you ever injured your head or neck in a fight, from being hit by someone, or from being shaken violently? Have you ever been shot in the head?
   ☐ No ☐ Yes—Record cause in chart
5. In your lifetime, have you ever been nearby when an explosion or a blast occurred? If you served in the military, think about any combat- or training-related incidents.
   ☐ No ☐ Yes—Record cause in chart

Interviewer instruction:
If the answers to any of the above questions are "yes," go to Step 2. If the answers to all of the above questions are "no," then proceed to Step 3.

Step 2

Interviewer instruction: If the answer is "yes" to any of the questions in Step 1 ask the following additional questions about each reported injury and add details to the chart below.

Were you knocked out or did you lose consciousness (LOC)?

If yes, how long?

If no, were you dazed or did you have a gap in your memory from the injury?

How old were you?

Step 3

Interviewer instruction: Ask the following questions to help identify a history that may include multiple mild TBIs and complete the chart below.

Have you ever had a period of time in which you experienced multiple, repeated impacts to your head (e.g. history of abuse, contact sports, military duty)?

If yes, what was the typical or usual effect—were you knocked out (Loss of Consciousness - LOC)?

If no, were you dazed or did you have a gap in your memory from the injury?

What was the most severe effect from one of the times you had an impact to the head?

How old were you when these repeated injuries began? Ended?

Step 1	Step 2						
	Loss of consciousness (LOC)/knocked out				Dazed/Mem Gap		Age
Cause	No LOC	< 30 min	30 min-24 hrs	> 24 hrs	Yes	No	

If more injuries with LOC: How many?_____ Longest knocked out?_____ How many ≥ 30 mins.?_____ Youngest age? _____

Step 3	Typical Effect		Most Severe Effect				Age	
Cause of repeated injury	Dazed/ memory gap, no LOC	LOC	Dazed/ memory gap, no LOC	LOC < 30 min	LOC 30 min - 24 hrs.	LOC > 24 hrs.	Began	Ended

Adapted with permission from the Ohio State University TBI Identification Method (Corrigan, J.D., Bogner, J.A. (2007). Initial reliability and validity of the OSU TBI Identification Method. J Head Trauma Rehabil, 22(6):318-329.

(Continuation from reverse side, if needed)

Name: ID #: **Current Age:** _____ **Interviewer Initials:** _____ **Date:** _____

Step 1	Step 2						
	Loss of consciousness (LOC)/knocked out				Dazed/Mem Gap		Age
Cause	No LOC	< 30 min	30 min-24 hrs	> 24 hrs	Yes	No	

If more injuries with LOC: How many?_____ Longest knocked out?_____ How many ≥ 30 mins.?_____ Youngest age? _____

Step 3	Typical Effect		Most Severe Effect				Age	
Cause of repeated injury	Dazed/ memory gap, no LOC	LOC	Dazed/ memory gap, no LOC	LOC < 30 min	LOC 30 min - 24 hrs.	LOC > 24 hrs.	Began	Ended

Interpreting Findings

A person may be more likely to have ongoing problems if they have any of the following:

- **WORST**
  One moderate or severe TBI
- **FIRST**
  TBI with loss of consciousness before age 15
- **MULTIPLE**
  2 or more TBIs close together, including a period of time when they experienced multiple blows to the head
- **RECENT**
  A mild TBI in the last weeks or a more severe TBI in the last months
- **OTHER SOURCES**
  Any TBI combined with another way that their brain function has been impaired

For more information about TBI or the OSU TBI Identification Method visit:

- Ohio Valley Center at OSU
  www.ohiovalley.org/informationeducation
- BrainLine.org
  www.brainline.org

(Updated July 2013)

Appendix C: Medical Outcomes Study: Social Support Survey

Page 3
ID # _____

Social Support Survey

People sometimes look to others for companionship, assistance, or other types of support. How often is each of the following kinds of support available to you if you need it? **Choose one number from each line by circling it.**

Emotional/informational support	**None of the time**	**A little of the time**	**Some of the time**	**Most of the time**	**All of the time**
Someone you can count on to listen to you when you need to talk	1	2	3	4	5
Someone to give you information to help you understand a situation	1	2	3	4	5
Someone to give you good advice about a crisis	1	2	3	4	5
Someone to confide in or talk to about yourself or your problems	1	2	3	4	5
Someone whose advice you really want	1	2	3	4	5
Someone to share your most private worries and fears with	1	2	3	4	5
Someone to turn to for suggestions about how to deal with a personal problem	1	2	3	4	5
Someone who understands your problems	1	2	3	4	5

Tangible support	**None of the time**	**A little of the time**	**Some of the time**	**Most of the time**	**All of the time**
Someone to help you if you were confined to bed	1	2	3	4	5
Someone to take you to the doctor if you needed it	1	2	3	4	5
Someone to prepare your meals if you were unable to do it yourself	1	2	3	4	5
Someone to help with daily chores if you were sick	1	2	3	4	5

Affectionate support	**None of the time**	**A little of the time**	**Some of the time**	**Most of the time**	**All of the time**
Someone who shows you love and affection	1	2	3	4	5
Someone to love and make you feel wanted	1	2	3	4	5
Someone who hugs you	1	2	3	4	5

Positive social interaction	**None of the time**	**A little of the time**	**Some of the time**	**Most of the time**	**All of the time**
Someone to have a good time with	1	2	3	4	5
Someone to get together with for relaxation	1	2	3	4	5
Someone to do something enjoyable with	1	2	3	4	5

Additional item	**None of the time**	**A little of the time**	**Some of the time**	**Most of the time**	**All of the time**
Someone to do things with to help you get your mind off things	1	2	3	4	5

Appendix D: Self-Efficacy Questionnaire

Page 4
ID # _____

General Self-Efficacy Questions

	Not at all true	Hardly true	Moderately true	Exactly true
1. I can always manage to solve difficult problems if I try hard enough	☐	☐	☐	☐
2. If someone opposes me, I can find the means and ways to get what I want.	☐	☐	☐	☐
3. It is easy for me to stick to my aims and accomplish my goals.	☐	☐	☐	☐
4. I am confident that I could deal efficiently with unexpected events.	☐	☐	☐	☐
5. Thanks to my resourcefulness, I know how to handle unforeseen situations.	☐	☐	☐	☐
6. I can solve most problems if I invest the necessary effort.	☐	☐	☐	☐
7. I can remain calm when facing difficulties because I can rely on my coping abilities.	☐	☐	☐	☐
8. When I am confronted with a problem, I can usually find several solutions.	☐	☐	☐	☐
9. If I am in trouble, I can usually think of a solution	☐	☐	☐	☐
10. I can usually handle whatever comes my way.	☐	☐	☐	☐

Appendix E: General Help Seeking Questionnaire

Page 5
ID # _____

General Help Seeking Questionnaire

If you were having a personal or emotional problem, how likely is it that you would seek help from the following people?							
Please indicate your response **by putting a line through the number that best describes** your intention to seek help from each help source that is listed.							
1 = Extremely Unlikely 3 = Unlikely 5 = Likely 7 = Extremely Likely							
Intimate partner (e.g., girlfriend, boyfriend, husband, wife, de' facto)	1	2	3	4	5	6	7
Friend (not related to you)	1	2	3	4	5	6	7
Parent	1	2	3	4	5	6	7
Other relative/family member	1	2	3	4	5	6	7
Mental health professional (e.g. psychologist, social worker, counselor)	1	2	3	4	5	6	7
Phone helpline (e.g. Lifeline)	1	2	3	4	5	6	7
Doctor/General Practitioner	1	2	3	4	5	6	7
Minister or religious leader (e.g. Priest, Rabbi, Chaplain)	1	2	3	4	5	6	7
I would not seek help from anyone	1	2	3	4	5	6	7
I would seek help from another not listed above (please list in the space provided, (e.g., work colleague. If no, leave blank) _____	1	2	3	4	5	6	7

Additional question:

How likely are you to seek help for health care on a regular basis (not for emergencies) such as from a regular primary care provider? Please answer by putting line through the number that best describes your intention to seek health care on a regular basis. **1 = Extremely Unlikely 3 = Unlikely 5 = Likely 7 = Extremely Likely**	**1**	**2**	**3**	**4**	**5**	**6**	**7**

Appendix F: Participant Informed Consent

THE UNIVERSITY OF TEXAS AT TYLER

Informed Consent to Participate in Research

Institutional Review Board # Sum2018-159
Approval Date: July 11, 2018

1. **Project Title**: Exploring Help Seeking Intention of Homeless Veterans Attending a Stand Down Event

2. **Principal Investigator:** Tara Vaughn, RN, MPH, MSN, PhD(c)

3. **Participant's Name (Printed):**

   Last Name: _____ First Name: _____

To the Participant:

You are being asked to take part in this study through The University of Texas at Tyler (UT Tyler).

This permission form explains:

- Why this research study is being done.
- What you will be doing if you take part in the study.
- Any risks and benefits you can expect if you take part in this study.

After talking with the person who asks you to take part in the study, you should be able to:

- Understand what the study is about.
- Choose to take part in this study because you understand what will happen

•

4. Description of Project

The purpose of this study is to find out the things that help a veteran who is homeless get help from others. By doing this, we can work to find ways to help veterans get the care they need. You will be asked to privately answer five surveys about your demographic information, history of head injury, social support, faith of your own power, and help seeking (this will take anywhere from 20-30 minutes to complete).

5. Research Procedures

<u>If you agree to be in this study, we will ask you to do the following things:</u>

- You will be asked to complete five surveys where you will answer:
  - Questions about your age, race, benefits you might receive, what you think are good things about getting help and things that make it hard for you to get help
  - Questions about if you have ever had a head injury
  - Questions about the support you get from others
  - Questions about you faith in your power to do well in some situations
  - Questions about how likely you are to seek help and from who

6. Side Effects/Risks

You may become slightly distressed when completing the questionnaires, though we do not expect this to be a common problem. Should you become distressed, immediately notify the researcher, who is a nurse. She will help you and, if you want, she will connect you with a counselor or chaplain who is at this event to help you if you need it.

7. Potential Benefits

Participation in this study may not benefit you personally. The findings from this study will help to understand the needs of homeless veterans, and to develop plan to provide better care for homeless veterans.

Understanding of Participants

8. I have been given a chance to ask any questions about this research study. The researcher has answered my questions.

9. If I consent to participate, I know it means that:

- I am taking part in this study because I want to. I chose to take part in this study after having been told about the study and how it will affect me.
- I know that I am free to not be in this study. If I choose to not take part in the study, then nothing will happen to me as a result of my choice.
- I know that I have been told that if I choose to be in the study, then I can stop at any time. I know that if I do stop being a part of the study, then nothing will happen to me.
- I will be told about any new information that may affect my wanting to continue to be part of this study.
- The study may be changed or stopped at any time by the researcher or by The University of Texas at Tyler.
- The researcher will get my written permission for any changes that may affect me.

10. I have been promised that that my name will not be in any reports about this study unless I give my permission.

11. I also understand that any information collected during this study may be shared as long as no identifying information such as my name, address, or other contact information is provided). This information can include health information. Information may be shared with:

- Other researchers interested in putting together your information with information from other studies
- Information shared through presentations or publications

12. I understand The UT Tyler Institutional Review Board (the group that makes sure that research is done correctly and that procedures are in place to protect the safety of research participants) may look at the research documents. These documents may have information that identifies me on them. This is a part of their monitoring procedure. I also understand that my personal information will not be shared with anyone.

13. I have been told about any possible risks that can happen with my taking part in this research project.

14. I also understand that I will not be given money for any patents or discoveries that may result from my taking part in this research.

15. If I have any questions concerning my participation in this project, I will contact the principal researcher: Tara Vaughn at 361-205-9061 or email tvaughn5@patriots.uttyler.edu.

16. If I have any questions concerning my rights as a research subject, I will contact Dr. Gloria Duke, Chair of the IRB, at (903) 566-7023, gduke@uttyler.edu, or the University's Office of Sponsored Research:

The University of Texas at Tyler
c/o Office of Sponsored Research
3900 University Blvd
Tyler, TX 75799

I understand that I may contact Dr. Duke with questions about research-related injuries.

CONSENT/PERMISSION FOR PARTICIPATION IN THIS RESEARCH STUDY

I have read and understood what has been explained to me. I give my permission to take part in this study as it is explained to me. I give the study researcher permission to register me in this study. I have received a signed copy of this consent form.

Witness to Informed Consent

18. I have discussed this project with the participant, using language that is understandable and appropriate. The participant has verbalized the purpose, expectations, risks and benefits of this study, and has a copy of this consent.

I believe this participant is participating based on informed consent of the nature of this study and its possible benefits and risks. I believe the participant understood this explanation.

_____ _____

Researcher/Principal Investigator Date

Appendix G: IRB Approval, University of Texas, Tyler

THE UNIVERSITY OF TEXAS AT TYLER
3900 University Blvd. • Tyler, TX 75799 • 903.565.5774 • FAX: 903.565.5858

Office of Research and Technology Transfer

Institutional Review Board

July 11, 2018

Dear Ms. Vaughn,

Your request to conduct the study: *Exploring Help Seeking Intentions of Veterans Attending a Stand Down Event*, IRB #Sum2018-159 has been approved by The University of Texas at Tyler Institutional Review Board under expedited review. This approval includes the use of signed informed consent, and your assurance of participant knowledge of the following prior to study participation: this is a research study; participation is completely voluntary with no obligations to continue participating, and with no adverse consequences for non-participation; and assurance of confidentiality of their data.

In addition, please ensure that any research assistants are knowledgeable about research ethics and confidentiality, and any co-investigators have completed human protection training within the past three years, and have forwarded their certificates to the IRB office (G. Duke).

Please review the UT Tyler IRB Principal Investigator Responsibilities, and acknowledge your understanding of these responsibilities and the following through return of this email to the IRB Chair within one week after receipt of this approval letter:

- This approval is for one year, as of the date of the approval letter
- **The Progress Report form must be completed for projects extending past one year.** Your protocol will automatically expire on the one year anniversary of this letter if a Progress Report is not submitted, per HHS Regulations **prior** to that date (45 CFR 46.108(b) and 109(e): http://www.hhs.gov/ohrp/policy/contrev0107.html
- Prompt reporting to the UT Tyler IRB of any proposed changes to this research activity
- **Prompt reporting to the UT Tyler IRB and academic department administration will be done of any unanticipated problems involving risks to subjects or others**
- Suspension or termination of approval may be done if there is evidence of any serious or continuing noncompliance with Federal Regulations or any aberrations in original proposal.

- Any change in proposal procedures must be promptly reported to the IRB prior to implementing any changes except when necessary to eliminate apparent immediate hazards to the subject.
- Expedited approval with signed consent, but with assurance of informed consent through participant verbalization of purpose, expectations, risks and benefits of this study.
- Participant must be given a copy of the consent form.

Best of luck in your research, and do not hesitate to contact me if you need any further assistance.

Sincerely,

Gloria Duke, PhD, RN
Chair, UT Tyler IRB

Appendix H: Biographical Sketch

NAME: Tara Vaughn

POSITION TITLE: Doctoral Student

EDUCATION/TRAINING:

INSTITUTION AND LOCATION	DEGREE	COMPLETION DATE	FIELD OF STUDY
University of Central Oklahoma, Edmond, Oklahoma	B.B.A.	May 1991	Business
University of Oklahoma Health Sciences Center, Oklahoma City, Oklahoma	M.P.H.	May 1993	Public Health
University of Oklahoma Health Sciences Center, Oklahoma City, Oklahoma	M.S.N.	May 2008	Nursing
The University of Texas at Tyler, Tyler, Texas	Ph.D.	May 2019	Nursing

A. Personal Statement

After decades in the Army and time spent working as a RN care manager at the veterans health administration, I have witnessed firsthand the experiences of veterans and the challenges they face. This has led to my desire to research the factors attributing to veteran homelessness and the care of this vulnerable population with the goal of improving homeless veterans' quality of life and reduce the rate of veteran homelessness.

B. Positions

2017 to Present	Clinical Assistant Professor, University of Houston Victoria, Texas
2017 to 2018	Adjunct Clinical Faculty, Texas A&M University, Corpus Christi, Texas
2016 to 2017	Nursing Instructor, Del Mar College, Corpus Christi, TX
2015-2016	Public Health Nurse, Preventive Medicine, William Beaumont Army Medical Center/Fort Bliss, El Paso, TX
2014 to 2015	RN Care Manager, Veterans Health Administration, Corpus Christi, Texas
2014	Public Health Nurse, Tripler Army Medical Center, Oahu, Hawaii
2010-2013	RN Training Support Officer, U.S. Army, Western Medical Area Readiness Support Group, San Pablo, CA
2007 to 2010	RN Post Deployment Health Reassessment Coordinator, U.S. Army, 63rd Regional Support Command, Mountain View, CA

C. Professional Memberships

Sigma Theta Tau, Honor Society of Nursing, Chapter Eta Gamma
Texas Public Health Association
Association of Community Health Nursing Educators (ACHNE)

D. Awards

1996, 2012 2013, 2014	Army Commendation Medal (4)
1993-2015	Army Reserve Component Achievement Medal (7)
2013, 2014	Overseas Training Ribbon (2)
2009, 2010	Excellence in Performance, Post Deployment Health Re-assessment Program, U.S. Army Reserve (2)
2007	Army Achievement Medal

E. Presentations and Publication

Hudson, Camargo, and Vaughn. *Academic and Evidence-Based Practice Literacy Strategies.* 17th World Congress on Clinical Nursing and Practice, Zurich, Switzerland. 2018

"A History of Empowerment: A Review of Nine Concept Analyses Over Time," Poster Presentation, Association of Community Health Nursing Educators (ACHNE), New Orleans, LA	2018
"Scholarly Writing Across the Curriculum in Baccalaureate Education," Podium Presentation, Innovative Teaching and Learning Symposium, University of Houston, Texas	2018
"Tuberculosis in the military: Should we be worried?" Published in Fort Bliss Bugle	2016
"HIV Prevention, Testing, and Treatment in the U.S. Army," Podium Presentation, Lesotho, Africa Defense Force and Lesotho Ministry of Health	2014
"Nursing Education in the United States," Podium Presentation, Benin, Africa Ministry of Defense and Ministry of Health	2013
"Preventing Compassion Fatigue," Podium Presentation, U.S. Army Reserve Post Deployment Health Reassessment Program National Post Deployment Health Conference, Army Reserve, Washington, D.C.	2009