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"I Have a Story to Tell Them": Qualitative Analsysis of Interviews with Formerly Homeless Adults

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"I Have a Story to Tell Them": Qualitative Analsysis of Interviews with Formerly Homeless Adults

Abstract

Background: Adults experiencing homelessness (AEH) make up an underserved community, especially in receipt of occupational therapy (OT) services. While there is growing knowledge on the occupational needs of this community, little is known of the occupational needs of AEH to successfully sustain housing long-term. The primary objective of this study is to describe the lived experiences of adults who have successfully transitioned to stable housing after a long period of homelessness. The secondary objective is to use findings to identify key areas for OT intervention with adults immediately following homelessness.

Method: The participants included five adults 25 years of age and older who have lived experience of homelessness and have transitioned to housing 1 or more years before the start of the study. All of the participants were clients of a community-based organization that provides support services for AEH to maintain stable housing. A thematic analysis of audio-recorded, semi-structured interviews was conducted. Two researchers reviewed the interviews to ensure intra-rater reliability.

Results: These five semi-structured interviews resulted in the following six overarching themes: relationships, environments, routines, health management, trauma, and gaps in services.

Conclusions: Formerly homeless adults (FHA) are an underserved population who may benefit from OT services to successfully sustain housing long-term.

Comments

The authors declare that they have no competing financial, professional, or personal interest that might have influenced the performance or presentation of the work described in this manuscript.

Keywords

homelessness, housing, trauma, routines

Credentials Display

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According to the United States Department of Housing and Urban Development, 582,462 adults were experiencing homelessness in 2022 (U.S. HUD, 2022), a historic high. The causes of homelessness are intersecting and complex and likely the result of factors at the individual (Nishio et al., 2017), policy, and institutional levels (Rukmana, 2020). A growing body of literature finds that the occupational engagement of homeless adults includes survival occupations, such as finding nightly shelter and food (Heuchemer & Josephsson, 2006) and learning and following the rules of securing supports that create challenges to participating in meaningful occupations (Marshall et al., 2017; Marshall et al., 2019). However, when adults experiencing homelessness (AEH) obtain housing, no matter the model or housing philosophy used by support organizations (Semborski et al., 2021), they often continue to experience occupational challenges in their living arrangements, which results in unstable housing (Frederick et al., 2014). In fact, in one of the only studies exploring transitional housing outcomes for individuals (vs. families), 56% experienced a return to homelessness (Wilder Research, 2015).

One factor for this may stem from the fact that after a long period of homelessness, individuals find they have lost valuable life skills necessary for maintaining stable housing, such as financial management and health management occupations (Raphael-Greenfield & Gutman, 2015; Marshall et al., 2017). However, many other factors may contribute to the barriers to sustained housing. AEH have far higher rates of physical and mental disabilities than the general population (Nathalie P. Voorhees Center for Neighborhood & Community Improvement, 2020; Gutwinski et al., 2021). An estimated 25% to 30% of AEH have some form of physical disability, and more than 50% have a history of traumatic brain injury (Stubbs et al., 2020). In addition, 76% to 87% of AEH have a current mental disorder (Gutwinski et al., 2021). Of those with a mental health disorder, more than 33% have an alcohol use disorder, and 22% have a drug use disorder. In addition to the myriad disabilities that put this population at risk, homeless adults must cope with the trauma of homelessness (Raphael-Greenfield & Gutman, 2015). Mental well-being among homeless persons is low, while feelings of boredom and use of substances to cope with boredom are high (Marshall et al., 2019). The Marshall et al. (2021) qualitative study recommends service providers must be knowledgeable of the many chronic health conditions, including substance use disorders, experienced by this community to develop effective interventions.

Literature Review

Transitioning Out of Homelessness

Integrating into housing comes with many challenges. Those interviewed in the Marshall et al. (2017) study worried they were losing crucial life skills related to home maintenance during periods of homelessness. Other research finds that instrumental activities of daily living, such as laundry and meal preparation, were difficult to resume for many, while others found themselves performing these occupations far too frequently (Marshall et al., 2018). Occupational balance is disrupted by both homelessness and reintegration into housing. With a growing number of people experiencing homelessness and awareness of the occupational deprivation and imbalance that comes with homelessness, research exploring occupational therapy's (OT) role in developing and delivering OT interventions has also grown. This research includes occupational therapists' role in working with homeless youth (Aviles & Helfrich, 2006), working in integrated primary care (Synovec et al., 2020), and the impact of an OT leisure craft group for mothers who are homeless (Schultz-Krohn et al., 2021). In a systematic review examining OT interventions in the transition from homelessness, the findings identify that formerly homeless adults (FHA) deal with balancing time dedicated to securing housing with

meaningful activities to support mental health (Marshall et al., 2020a). Another review by Marshall et al. (2020b) explored features and interventions used to address boredom across the homeless experience. Importantly, Marshall et al. (2021) have published competencies for occupational therapists when working with the homeless community and have recently developed an OT framework to support occupational therapists in developing interventions to support AEH throughout the transition processes (Marshall et al., 2023).

Of significance, Marshall et al. (2018) named occupations of productivity, spirituality, and altruism as the most important for AEH following chronic homelessness. Moreover, housing may protect against the harshest elements but does not come with financial security, safety, or community integration. Interventions designed to support clients in their employment goals are uncommon but effective in supporting housing stability, community integration, and abstinence from substances (Marshal et al., 2022). In addition, interventions targeting social connectedness have been found to promote feelings of hope and safety and improve overall mental health (Diduck et al., 2022).

Secure, permanent housing following a period of homelessness promotes health and reduces rates of criminal convictions (Carnemolla & Skinner, 2021). Therefore, it would be an appropriate goal of any OT program that targets this population because of risk factors for unstable housing. Despite the literature describing occupational therapists' roles in working with AEH, more research is needed to understand better the contextual factors that promote stable housing for FHA, which can then be used by occupational therapists to address housing instability. Therefore, the purpose of this paper is to address this gap in research. For increased clarity, the authors refer to FHA as opposed to AEH to distinguish between currently homeless individuals and the target population: those who are housed but have a history of homelessness.

Research Objectives and Questions

The primary research objective of this study was to explore how OT can support adults during the transition period between homelessness and stable, permanent housing. Our research questions are as follows:

1. What physical and social contexts are common among individuals currently successful in maintaining stable housing for 1 to 2 years?
2. How can occupational therapists support FHA immediately following their move into permanent housing?

To answer these questions, the researchers used semi-structured individual interviews with individuals who have moved through the process from homelessness to housing.

Method

Research Design

This exploratory research project used a qualitative design and thematic analysis methods (Braun & Clarke, 2006) to examine the participants' narratives. The study design was submitted to the research team's (both authors) Institutional Review Board and approved. Data collection occurred in a large Midwest urban setting between January and April of 2023. This study was conducted at the homes of participants served by a community-based, non-profit organization or over the phone if a participant had COVID-19 isolation concerns.. Individual, semi-structured interviews were audio-recorded, transcribed verbatim by the primary investigator, de-identified, and then analyzed by the two research team members.

Participant Recruitment

The researchers recruited five participants for this study. This number allowed for a sufficient variety of perspectives and supported the depth of analysis of the research team to perform a focused, case-oriented analysis while also supporting the pragmatic limitations of the exploratory nature of this research (Luborsky & Rubinstein, 1995). Inclusion criteria for this study were as follows: participants must be between 25 and 65 years of age, have a lived experience of homelessness, and currently live in housing with case-management support versus individuals acquiring housing without the use of case-management support systems. Participants may live alone, with family, or with roommates but must have transitioned out of homelessness 1 to 2 years before the start of the interview. Participants must speak and understand English and provide consent. Persons who experienced homelessness for less than 12 consecutive months were excluded from this study. In addition, persons who experienced homelessness as minors and not as adults were excluded from this study.

A case manager at the host organization reached out via email to clients who fit the study criteria. A flier explaining the purpose and background of the study was provided in that email. Clients who were interested in participating in the study were instructed to contact the primary researcher (first author) directly using the contact information on the recruitment flier. Before the start of the interviews, the primary researcher reviewed a written consent form with each participant and obtained their consenting signature. A short demographic survey was conducted verbally, with answers recorded digitally to obtain information about the participants' race, age, gender, employment status, health conditions, total amount of time spent homeless, and time since the last period of homelessness.

Instrument and Procedures

A semi-structured interview protocol was followed. Eleven questions were asked during each interview in the same order for each participant. The interviewer asked follow-up questions when relevant to increase the wealth of information obtained. The researchers developed a list of primary questions based on a literature review of relevant studies and professional experience with AEH. The questions were piloted with a formerly homeless adult. Modifications were made to the interview questions based on feedback from this pilot interview. All of the participants received a $10 gift card of their choice from Target or Amazon.

Data Analysis

This study used Braun and Clarke's (2006) six steps of thematic analysis to systematically analyze transcriptions to form themes of the participants' perceptions and experiences. The first step, familiarizing oneself with the data, includes the transcription process. For this study, both research team members read through the interview transcriptions at least once without searching for themes to get a sense of the breadth and content of the data. Next, descriptive and in-vivo codes were aligned to text by each research team member independent of the other. Then, research team members met to review the codes that each had created, discussing the code's meaning and coming to a consensus as to the meaning of the text and determining the code that best represented that meaning. In the following data analysis stage, codes were then combined and separated into concrete themes by the primary investigator. The fourth step involved reviewing and refining initial candidate themes by collapsing similar themes into overarching themes and separating other themes into smaller subcategories, again using a consensus meeting to finalize themes and categories. The themes were then defined and named. Lastly, the themes and accompanying narrative were written down and organized into tables and appropriate sections.

Techniques for Establishing Trustworthiness

This study used the systematic six-step thematic analysis process described by Braun and Clarke (2006) to achieve trustworthiness of the themes that emerged from the data. Other strategies included credibility in the form of peer debriefing and member checking with the participants, dependability through an audit trail by each researcher in theme development, and transferability using dense description (Nowell et al., 2017). The two researchers initially engaged in prolonged exposure to the data individually, reading the interview transcripts multiple times before beginning the initial process of creating codes. During this time, memos were created as a form of reflection on how researcher bias may inform and influence the coding process (Creswell & Miller, 2000). Individual coding was followed by the researchers coming together to compare codes and their meanings in a consensus meeting. For each code assigned to meaningful text, the researchers either came to agreement or disagreement. When a disagreement between researchers occurred, the researchers engaged in prolonged discussion on the meaning of the text, returning to it when necessary, as well as referring to memos and relevant literature until reaching an agreement. Analysis was an iterative as well as inductive process that worked to ensure emergent themes accurately represented the participants' lived experiences.

Researcher Positionality

The authors of this study are faculty members and a student of a doctoral OT program. We do not have lived experience of street homelessness. Rather, we engaged in critical reflection of data to ensure valid qualitative results and to center the perspectives of the participants in this study. We recognize that our own experiences and biases informed our interpretation of interviews with FHA and have debriefed as a team many times throughout the interpretation and coding process to address these biases.

Results

Participant Demographics

Five participants were recruited for this study. This number allowed for sufficient variety of perspectives and supported deep, case-oriented analysis of the research team while also supporting the pragmatic limitations of the exploratory nature of this research (Luborsky & Rubinstein, 1995). Refer to Table 1 for demographic information of the participants.

Table 1

Participant Demographics

Participant	Age	Race	Gender	Employment	Health Conditions	Total Time Homeless	Time Since Last Homeless
1	41	White	Female	Not Employed	Hepatitis C, Anemia, Epilepsy, High Blood Pressure, Deep Vein Thrombosis	10 Years	2 years
2	51	White, Native American	Male	Freelance	Chronic Cough	15 Years	1.5 Years
3	53	Black	Male	Not Employed	High Blood Pressure, Bipolar, Chronic Obstructive Pulmonary Disease	2 Years	1.25 Years
4	39	Hispanic	Female	Not Employed	Deep Vein Thrombosis, Lymphedema, Depression, Anxiety, Post Traumatic Stress Disorder	15 Years	1 Year
5	40	White	Male	Not Employed	Bipolar	15 Years	1 Year
	Mean: 44.8					**Mean: 11.4 years**	**Mean: 1.35 Years**

Thematic Analysis Findings

Six themes emerged from these semi-structured interviews: relationships, environments, routines, health management, trauma, and gaps in services. Under the theme relationships are four subthemes: community members, family, pets, and service providers. Under the theme environments are three subthemes: one place for daily occupations, protection from crime and weather, and basic necessities. Under the theme routines were two subthemes: staying busy and rest and sleep. Under the theme trauma were two subthemes: feeling "institutionalized" and trauma narratives. The themes health management and gaps in services are stand-alone themes without additional subthemes. All five of the participants spoke about their relationship with community members, the need for basic necessities, protection from crime and weather, traumatic events in their lives, and gaps in services. Only one participant described the sub theme "feeling 'institutionalized," but the subtheme was so powerful that the analysis team agreed to include it.

Relationships

The theme of relationships refers to the participants' social context and how relationships and social networking impacted the FHA's ability to maintain their housing. Every participant mentioned some aspect of a relationship with their neighbors, families, pets, and/or service providers. Most of these relationships were discussed in a positive light. This theme included the subthemes of "community members," "family," "pets," and "service providers."

Community Members. Social engagement with neighbors, as well as reliance on community members, was a powerful subtheme of relationships. Participant 1 shared how much they valued their neighbor but that they were learning from them as well: "I never learned how to cook. My neighbor has been teaching me. Every Sunday, we do, like, a little lesson and hang out, you know? She teaches me a new recipe every Sunday." Participant 1 was thankful for the close relationship she had with her next-door neighbor, who was able to teach her valuable life skills, such as cooking. This same participant went on to describe a relationship with another community member who provided her with financial support to pay phone bills and prescriptions: "Without her, I don't know what I would do. But I feel bad because I feel like I'm just draining her, you know?"

Family. Relationships with family members having an impact on the participants' everyday functioning was not mentioned by all of the participants, but those that did mention it described how it influenced their daily occupations, as described by Participant 5: "But sometimes one of my kids will call me, and they may need something. So, you know, I'll go sit on [avenue] and see what I can come up with." Participant 5 mentioned his relationship with his adult children who still relied on him occasionally. This participant continued to panhandle to provide for himself and his partner while housed, and sometimes his children as well. In contrast, the participants acknowledged their interdependence with family members in assisting them. Participant 4 described the ways her partner cared for her physical needs by taking over household responsibilities when she was sick: "[My partner] doesn't have lymphedema, but he understands like, he's got swollen legs, so he understands like 'alright, she's not feeling good, so I'm going to take over and, you know, do the whole dog thing'" (Participant 4).

Pets. Of the five participants, three owned pets. Those participants related how caring for the pet was a valued occupation and provided purpose to their lives. Participant 1 shared the harrowing story of how she saved a kitten from starving on the street by bottle feeding it, then saved it again years later when her first apartment after being homeless burned down:

> I found him underneath the stairs of a house, there was him and four other kittens, and the mom was dead, and he was the only kitten that was still alive. I bottle-fed him. I've had him ever since the whole building went up in flames. I just grabbed my cat, and we got out of the building. That's all I could do. (Participant 1)

Service Providers. Most of the participants discussed their relationship with case workers and other service providers. Some had positive, ongoing relationships with service providers with whom they had made connections while homeless:

> I receive my mail with them. I still, um, contact them for, like, medical purposes, like if I'm having allergies and the doctor don't want to see me for, like, 3 weeks I just call the [street medicine van] and they come and meet up with me. (Participant 2)

Other participants revealed the challenges they had in their relationship with specific service providers: "It's still like pulling teeth to interact with [my case worker]. Any time I interact with her is when she's on a deadline, and I need to hurry up and sign some papers" (Participant 4).

Environments

Environments is a theme that refers to the contexts and materials that make a home feel safe and comfortable beyond just the physical structure. This theme represents the direct impact that context had on the physical and mental well-being of the participants. In this theme are the subthemes "one place for daily occupations," "protection from crime and weather," and "basic necessities."

One Place for Daily Occupations. Most of the participants discussed how having one single place to complete occupations versus doing these and living from place to place made health management overall much easier. "Having your own space makes a difference… I have a place to keep warm during the day, a place to make my food, a place to lay down. I mean, creature comforts" (Participant 2). Having a single location for cooking, eating, sleeping, and showering was a source of comfort and relief for many of those interviewed. Participant 3 discussed how having a kitchen made health management easier because he needed to take his medication with food:

> You know, as far as to get blood pressure pills and all that, you know, you got to eat, um, because, you know, you got to eat - you can't take them on an empty stomach, especially high blood pressure pills for one, and the rest of them too, you know? You know, I can go into the kitchen and whip something up real fast, so I'm thankful for that. (Participant 3)

Protection from Crime and Weather. The participants also discussed their home as providing protection from crime and/or weather and how this impacted relieving daily stress and worry. Getting housed was a major step toward safety, stability, and protection from the elements for most of the participants. Participant 4 expressed relief in having a security guard present in her high-rise apartment:

> You know, being homeless, that was definitely something - being a woman and being homeless, that was something I dealt with all the time. So being able to have a secure, like, place where I know nobody can hurt me in any way. We have uh, locked doors, a security guy in front, so I know nobody can, you know, bother or harm me. (Participant 4)

In addition, some of the participants expressed gratitude for having a warm place to stay in the winter months, especially for individuals experiencing chronic conditions. Protection from the elements was a source of pain management in some cases, as described by this participant: "My legs used to be so stiff, you know, and uh sitting outside in the cold and stuff, and I used to have pain in my knees too" (Participant 3).

Basic Necessities. Despite the fact that most of the participants identified the positive aspect of being housed, all but one participant also discussed the challenges they faced the first days of being housed in which they had no basic necessities or furnishings in their new home. This participant describes the ongoing financial burden they experienced:

> When a homeless person gets housing, I feel like everybody thinks, like, just solves all their problems. But housing doesn't come with financial stability, you know what I mean? So, like, so I still have no way to pay for regular stuff like toilet paper, and you know, stuff like that. And then outreach places, the ones that help homeless people don't want to help me no more because I'm not homeless, so it's just super frustrating. (Participant 1)

Participant 1 explained the myth that housing solved every problem when in fact financial insecurity was still a major factor in the lives of FHA. In addition to having limited resources for obtaining toiletries, all but one participant explained that they had no furniture to sit or sleep on during their first several days, in one case an entire month, of being housed:

> When we first moved in here, like, just getting the basic necessities. They asked us what stuff we needed, what stuff we wanted, and what we were allowed to have. And they came and brought the stuff like a week after they were supposed to. Like we were here, seven, eight days sleeping on the floor. (Participant 5)

Routines

The theme of routines refers to the activities at or near the home on a daily or near-daily basis that have a special meaning to FHA. Most of the participants discussed ways to keep themselves busy, either to stave off boredom and/or depression or because their routines intrinsically motivate them. Some of the participants also discussed how their rest and sleep routines were affected by their experiences of living outside. There are two subthemes in this theme: "staying busy" and "rest and sleep routines."

Staying Busy. No longer having to address basic survival skills that came with living on the street resulted in days with limited structure, and the participants described being bored and needing ways to stay occupied. Participant 5 discussed how he tried to do something outside of the house every day to prevent further decline in health and as an alternative to substance use.

> Now it's like I'm not shooting anymore, so I'm like, okay, well, I'm having a hard time with my lungs and stuff, so I have to get up, and I have to go do something. I have to get out and go do something every day, whether it's go downtown and panhandle or to the store and take the dogs to the park - something. (Participant 5)

Rest and Sleep Routines. The participants also described the major shift they experienced in sleeping that resulted in a change in the environment. The contextual differences between sleeping on the street and sleeping in a home included the temperature, sleeping surface, and sounds. When asked about

what the first few days in his new apartment were like, Participant 2 discussed the difficulties he had with sleeping because of the changes in auditory stimuli:

> It was a little unsettling. I was used to hearing the traffic going over my head when I was sleeping, you know? And then, over here, it was pretty quiet. And when you're used to noises and then it's kind of quiet you, kind of, you know, want to play some kind of background noise, you know, like, keep the TV going or keep your window open so you can hear the bustle - the hustle and bustle outside. (Participant 2)

There were descriptions from participants of routines of daily living that created unique challenges to their sleep and rest. Participant 4 and her family have strict morning and bedtime routines because they have to wake up early each day to go to a methadone clinic:

> So, I wake up about five thirty, six o' clock, um, wake up, make coffee, get myself ready. The methadone clinics close at eight. The one I go to closes at eight-thirty in the morning, so I have to make sure I'm on that, like, seven thirty bus, so then by four o' clock I start making dinner, everyone's already eaten by eight o'clock, and everybody's in bed by nine. (Participant 4)

Health Management

The theme of health management refers to the activities and contexts related to managing chronic health conditions. This included working to access equitable care, time management skills to make and keep health care appointments, and issues with health literacy. Every participant interviewed reported at least one health condition. Participant 2 explained that they felt that they were currently healthy because of their housing conditions, access to health care providers, and healthy routines. "I mean, I make sure to take my meds. This is because I'm - I have high blood pressure for one, you know. And I take some psych meds, you know?" (Participant 2). While Participant 3 described how provider-based transportation services assisted them in accessing health care:

> Researcher: Good. You go to visit the doctor once a month, you said? Participant 3: Once a month, so, you know. Researcher: Any problems with transportation getting there? Participant 3: No, um, actually, they send me an Uber to pick me up. Once in a while, I'll take the walk. Sometimes, if they have a lot of appointments, that day they'll call me an Uber, but then, yeah, they have vans and can pick people up. (Participant 3)

However, both Participants 4 and 5 expressed frustrations with inadequate or inaccessible health care. In these cases, the participants took responsibility for managing their health but felt as though obstacles were being placed in front of them, which were delaying them reaching their health goals:

> There are only four specialists. And I have yet to see one because I need a referral from a doctor. And he's like, "you have lymphedema." And I'm like, "alright, I need that in writing because I'm saying it but because it's coming out of my mouth; it's not coming out of your mouth." People want proof. (Participant 4)

Trauma

Four of the five participants had narratives that were thick with descriptions of physical and emotional traumas experienced when homeless. The theme of trauma refers to the negative effects of long-

term homelessness on one's behavior, affect, and identity. The participants described how experiences continued to impact their behaviors, including lack of trust, blaming themselves, and low self-confidence. Two powerful subthemes emerged in this theme: trauma narratives and feeling institutionalized. Despite the lack of questions geared toward the participants' experience of homelessness before getting housing, every participant spoke about their experiences of living on the street and how that affected who they are today.

Trauma Narratives. Participant 3 processed his trauma through the lens of spirituality, which resulted in a personal narrative of overcoming his past while staying faithful to his religious beliefs. This narrative was powerful in describing the resilience needed to live on the street as well as dealing with an unknown future:

> It was hard, you know? Waking up in the morning, you know, uh, it was like wondering where your next meal gonna be at, you know, how you going to get money for this, sleeping on the ground. It was a lot of crime here; we be dealing with drugs. I had to hustle a lot for money, you know what I'm saying? Not doing drugs, I mean, because I had to talk to people, and you know, I have a story to tell them. There are days where it gets below zero and it was days like that I was always thinking like, man, I can't wait to get a place. And it seemed like it took a long time, you know, to get to where I'm at now, but I was patient. I was patient. But it was still like holding onto a string; some days I wanted to let go but I was like no, I've got faith, you know what I'm saying? So, I held on, you know. And I needed help, and I held on and I'd pray to God please help me out with this homelessness and with depression and all that. And he did. I made it, I made it. (Participant 3)

Feeling "Institutionalized." The context of homelessness created limits on what occupations the participants could engage in on a routine basis and, with that, a loss of confidence in how to re-engage in typically housed occupations. Participant 4 compared being homeless with being incarcerated, implying that getting housed was like being released from prison:

> Okay, so you know how they say like - this is just an example - like people getting out of jail, right? You're institutionalized? Right? Like, you don't know how to live like a normal person. So, I would say for like the first, it wasn't even weeks, it was like the first three months, I didn't know how like, I - I know the basics. You have to keep your house clean, do the dishes, cook. All that good stuff. But it felt funny. It felt weird. It didn't feel normal because I hadn't done it in so long. (Participant 4)

When asked for more examples, Participant 4 explained how she had lost the ability to sense when she needed to shower, and had to set up a schedule to work her way up to showering regularly:

> Like, at first, I took a shower and I'm like alright, I'm not really dirty today. And the next day I go, I'm not really dirty. Like, I still had that mindset of: you're fine, you're inside so you're not getting dirty, so you really don't need a shower. But then it's like, duh, everybody - normal people shower every day. And then it's like you're not normal, so what do you do? So it went from that to like once a week and I'm trying to push myself to - okay let's do it three times a week and four times a week and I'm still not there to where I'm taking a shower every single day, but it's gotten better. (Participant 4)

Gaps in Services

The final but significant theme that emerged from the narratives of most of the participants was "gaps in services," which refers to the ways in which the system has failed FHA and provides insight into how occupational therapists may be able to affect change. When asked about what supports they wished had been in place when first moving into their new home, the participants gave a variety of answers. Some describe needing access to information:

> Something like, like, to have a, like, a list of food pantries in the area. Um, getting at least like a small voucher for clothing, furniture, something. There should be, I think, but this is just me personally, like when people are transitioning from a long period of time from being homeless to not be homeless, even if they don't want the counseling, throw it out there. You know, try to set them up to talk to somebody because it's hard to get out of that mindset. (Participant 4)

While other participants described access to household equipment to perform independent activities of daily living:

> I mean, at least, some way to prepare food. You know what I mean? Like whether - whether they right away they give you a box and it has pots, pans, silverware, stuff like that? Like, just on your initial move in date or whatever? And with maybe an air mattress in it or something. (Participant 5)

Finally, other participants described needing access to ways to develop skills and strategies to support them in employment and other occupational activities to support a housed life. Participant 2 explained how he wanted a job but had difficulty with building the habits necessary to work a regular job:

> I wish I had a steady job. But uh, after not working a steady job for so long, it's hard to get back into the groove of having a routine - a steady routine and waking up a certain time of day and just, you know, facing responsibility. I've been doing part time things, but I am working towards finding what I want to do full time. (Participant 2)

Discussion

The purpose of this study was to explore the need for OT in community-based settings, which serve FHA, by investigating the environmental and social contexts identified by FHA that influence their ability to maintain stable housing. Based on the results of this study, the following conclusions can be made: the participants have significant histories of trauma that impact their identities, mental well-being, and daily routines. In addition, the participants identified the need for job coaching, mental health services, and support with navigating social services. All of the participants identified one or more chronic health conditions that can be an area for OT intervention. These findings are supported by and build on previous studies.

Trauma-Informed Care

The participants in this study named several traumatic events, from the victimization of violent crime to surviving extreme weather conditions. Principles of trauma-informed care (TIC) recognize the impact of past repeated and significant trauma and provide strategies to weave into daily contexts to prevent further trauma (Substance Abuse and Mental Health Services Administration, 2014). These principles focus on client choice, empowerment, and use a strengths-based approach to supporting clients.

Trauma-informed care principles are critical when working with individuals with a history of homelessness (Diduck et al., 2022; Marshall et al., 2019). Moreover, knowledge of TIC was also recognized as a necessary competency for occupational therapists to support individuals during and following homelessness (Marshall et al., 2021). To best support clients in the transition from homelessness to housed, occupational therapists should become knowledgeable in TIC principles to promote safety and stability throughout the therapeutic process and allow clients as much autonomy as possible during treatment (Diduck et al., 2022).

In this study, the participants recognized how their experiences with homelessness have shaped their daily routines and mental well-being post-homelessness. One participant explained how it took some time to get used to the quiet and still needed to have the television on or a window open to sleep. This is supported by the Marshall et al. (2018) findings that FHA have difficulty adjusting to the new environmental and social contexts associated with housing, relying on keeping the television on for company and stimulation. Based on existing literature and this study's findings, it may be critical for an occupational therapist to recognize this period of adjustment and work closely with a FHA following acquisition to develop individualized interventions to support adaptation to their housed life.

Focus of Interventions

Marshall et al. (2021) identified over 100 competencies that occupational therapists should have when working with homeless individuals. These include knowledge of the many physical and mental chronic conditions and their related interventions that are common in the unhoused community. All five participants in this study named one or more chronic health conditions that occupational therapists must consider when working with FHA. For example, medication management, communication with health care systems, and physical activity are all occupations described by the participants as important that should be addressed in this population. One of the participants discussed the difficulty of having to walk up several flights of stairs to reach her home each day while dealing with a possible chronic lung condition. Occupational therapists can be critical in cases such as this by evaluating client factors and advocating for increased accessibility of the home for their clients.

All but one of the participants in this study were unemployed. One participant described his routine around panhandling to support his family, and another participant described his desire for full-time work. Financial insecurity was brought up by most of the participants. Among the many competencies identified by Marshall et al. (2022) for occupational therapists when working with people across the experience of homelessness, including into transition, was a working knowledge of readiness for and stages of change based on the transtheoretical model (Prochaska & Velicer, 1997). Identifying and understanding where FHA are in their readiness for change may help build a strong therapeutic relationship and establish self-efficacy that behaviors and habits can be changed. Occupational therapists can support clients in building new habits and routines that are supportive of full- or part-time employment, as well as support clients in employment exploration and sustainment of employment opportunities (Marshall et al., 2022). Initial efforts in the literature show occupational therapists being successful when using intervention approaches grounded in a social justice framework developed and recommended by Marshall et al. (2023). This includes interventions targeted at the individual level; however, community and population-level strategies should also be an area for occupational therapists to develop and deliver targeted interventions that embrace and support harm reduction, housing first, and trauma-informed care, among other philosophies (Marshall et al., 2023).

In addition, several of the participants in this study revealed a lack of basic necessities and difficulty navigating community resources. Occupational therapists in this setting can advocate for FHA to receive the items necessary for ADLs and sleep, such as cookware, toiletries, and bedding, on their move-in date. Occupational therapists can also support clients with navigating community resources specific to leisure, work, and volunteer opportunities for improved mental well-being (Marshall et al., 2017). The development and facilitation of peer support groups is another way occupational therapists can support the mental well-being of FHA (Diduck et al., 2022).

Occupational therapists are increasingly working specifically with the homeless community, including FHA; however, clients experiencing or having experienced homelessness access OT services across all practice settings, including but not exclusive to acute care, inpatient acute rehabilitation, skilled nursing, and schools and early intervention (Leflore, 2019). The American Occupational Therapy Association (AOTA) has published a decision guide to support occupational therapists in delivering appropriate and effective care when working with AEH (Synovec et al., 2021). Other literature provides recommendations on how occupational therapists can address the occupational needs of AEH in integrated primary care (Synovec et al., 2020). Based on this study's findings from the participants' narratives, other areas of interventions occupational therapists should consider when working with FHA include environmental adaptations to incorporate into the new home environment, instrumental activities of daily living skills training, medication management, developing daily routine schedules, advocating and networking for social support resources and developing community connectedness. Each of these areas fall in the *Occupational Therapy Practice Framework* (AOTA, 2020) and are well within the OT scope of practice.

Limitations

All of the participants in this study were from the same city and had obtained housing through similar means. This limited the breadth of possible perspectives from FHA. In addition, only individuals who had successfully maintained long-term housing were included in this study; the participants who lost or gave up their housing within 1 year were not included but would be invaluable to hear from them in future studies. This study was limited in that it was focused on how to make the transition to stable housing easier for those already successful in permanent housing rather than learning why individuals are sometimes unsuccessful in permanent housing. Future research might focus on individuals who have transitioned into permanent or temporary housing more recently, as well as include minors and families. Another limitation was the interview questions used were unique to this study and were not tested for reliability or validity. Moreover, only five participants were recruited for this study. While this allowed for a variety of perspectives and supported a deep, case-oriented analysis, it limits the nature of this research and its findings as being exploratory in nature (Luborsky & Rubinstein, 1995) and not generalizable. Further research of other communities and groups is highly recommended.

Conclusion

This study investigated the need for OT intervention programs for FHA and found that OT interventions targeting the physical and mental well-being of clients, employment opportunities, community resources, and much more are desired by FHA. This study also adds to existing literature on how the interaction of environment, relationships, routines, and trauma inform the identities and behaviors of FHA

FHA is a vulnerable population of society that continues to face unstable housing (Wilder Research, 2015) and may benefit from targeted OT services, according to this study. While the small number of interviewees limits the generalizability of this study, the thematic results are concurrent with similar studies targeting formerly homeless populations. The FHA in this study had stories to tell, including the trauma that comes with homelessness and unstable housing, as well as the relationships they have formed with their community and their desires for improved health and well-being. While this is an emerging practice area, occupational therapists are in an excellent position to support FHA in maintaining stable housing through work, leisure, and vocational occupations (Marshall et al., 2021). This evidence may be used to inform the development of future OT intervention programs for FHA.

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