OPEN ACCESS

GAVIN PUBLISHERS

International Journal of Nursing and Health Care Research

Ford LA. Int J Nurs Health Care Res 5: 086.

DOI: 10.29011/IJNHR-086.1000086

Research Article

Homeless Families Return to Mainstream Society

Lark A. Ford*

School of Nursing, University of Texas Health Science Center at San Antonio, Texas, USA

***Corresponding author:** Lark A. Ford, School of Nursing, University of Texas Health Science Center at San Antonio, 7703 Floyd Curl Drive San Antonio, TX 78229, USA. Tel: +1-2105670838; Email: fordl2@uthscsa.edu

Citation: Ford LA (2019) Homeless Families Return to Mainstream Society. Int J Nurs Health Care Res 5: 086. DOI: 10.29011/IJNHR-086.1000086

Received Date: 25 April, 2019; **Accepted Date:** 20 May, 2019; **Published Date:** 27 May, 2019

Abstract

The purpose of this descriptive study was to examine the perception of readiness for discharge from a transitional living center of six homeless adult family members with cardiac conditions. Three constructs formed the framework for this study: (a) being homeless, (b) undergoing severe stress, and (c) being ready for discharge. Four data collection instruments used for this study included (a) a 10-item, Self-Perceived Stress Scale to assess perception of stress over a one-month time period; (b) a pencil-and-paper, self-description of respondents' cardiac health condition over time; (c) a retrospective, medical chart review on each respondent; and (d) a one-hour, face-to-face interview with each study volunteer. Findings showed that all of the homeless participants experienced high levels of stress, yet those participants who resided in the transitional living center in their early and later months experienced higher levels of stress than those participants who resided in the transitional living center between 12 to 18 months. One key theme emerged regarding their perception toward readiness for discharge: being safe and securing housing. The adult members' overall perception regarding their health contributed very little to their self-perceptions of being ready for discharge.

Keywords: Being homeless; Readiness for discharge; Undergoing stress

Introduction

Around the world, more than 100 million people are homeless and homelessness is a growing public health concern [1,2]. According to the Stewart B. McKinney Act, U.S.C. §11301 of 1994, A person is considered homeless who lacks a fixed, regular, and adequate night-time residence, and requires a primary night time residency that is: 1) a supervised, publicly or privately operated shelter designed to provide temporary living accommodations; 2) an institution that provides a temporary residence for individuals intended to be institutionalized; or, 3) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings [3]. In the early 1980s, most homeless people were men. In today's world, people experiencing or at risk for homelessness also include women with two children under the age of 5 [1,2,4]. Homeless people are a heterogeneous population whose diverse health needs are poorly met [1,2,4]. This vulnerable population's specific health needs differ from those of the general population [1]. People who are homeless suffer from disproportionately high rates of chronic and infectious diseases, such as *Human Immunodeficiency Virus* (HIV), Acquired Immune-Deficiency Syndrome (AIDS), hepatic diseases, cardiovascular disease, and diabetes. In this regard, homeless populations experience higher mortality rates and lower life expectancies than housed populations [1,2,4].

Family homelessness has emerged as a serious challenge in the United States [5] and presents considerable barriers to the maintenance of family processes [6]. It is critical to understand families' readiness to change their lifestyle status from homelessness toward re-engagement into mainstream society given the importance of these processes to individual and family well-being. Readiness to change is defined as a commitment and motivation to make health-related, behavioral, or lifestyle changes [7]. Core areas that focus on readiness include undergoing changes that can improve and build on an individual's basic life-skills, such as education, financial counseling, and parenting skills.

Other areas include the improvement in one's physical and mental health status. Maycock, et al. [8] suggested that, for some, reentry into society or moving out of homelessness involves access to and engagement in drug treatment services and participation in education and training. Kurtz, et al. [9] found that young people resolved their homelessness through support from family, friends, and professional helpers.

Purpose

Based on these conditions and factors, the purpose of this qualitative, descriptive study was to examine the perception of adult members of homeless families regarding their readiness to return to mainstream society after being homeless and residing in a transitional living environment. The selected adults were those diagnosed with cardiac conditions or at risk for such medical conditions as hypertension (blood pressure greater than 120/80 mm Hg), and/or hypercholesterolemia/elevated cholesterol level (level higher than 240 mg/dL), and living as a family.

Background

Homeless individuals or families are in dire situations when faced with challenging job markets, a shortage of affordable housing, and restricted access to health care and possible domestic violence [10]. Individuals or families who are not classified as being homeless may become homeless due to an unforeseen loss of a job or by developing a catastrophic illness. Despite numerous programs and initiatives for the homeless, findings suggest conflicting results of success and unsuccessful outcomes of homeless persons being able to reenter mainstream society, even after participating in those initiatives [8,11].

National Statistics: Report from the U.S. Department of Housing and Urban Development (HUD) indicates that 610,000 people experienced homelessness on any given night in the United States [3]. In 2011, the National Center on Family Homelessness reported that 31% of this population represented families. In a given year, 3.5 million persons will experience homelessness and 1.35 million are children [12]. Among homeless women, 60% parent children under the age of 18, and among homeless men, 41% are fathers with children under the age of 18 years.

Homeless Women: Upshur et al. [13] reported that women are at greater risk for homelessness and show a high prevalence for using alcohol and illegal drugs-5 to 14 times higher than the general population of women. These researchers reported that homeless women with alcohol or drug abuse disorders with prolonged episodes of homelessness did not seek assistance from addiction services. Reasons included lack of motivation to quit using alcohol or drugs, poor mental health, emotional distress, and depression.

Homeless Families: In 2011, in an unprecedented event, the U.S. government recognized that homelessness was a human rights concern and that the government had an obligation to address this issue. According to America's Youngest Outcasts, a report on homelessness among American children compiled by the National Center on Family Homelessness [14] indicated that more than 1.6 million children, or 1 in 45, are homeless annually in America-approximately 30,000 children each week and more than 4,400 each day. The average length of time for people being homeless was 6 months [12]. A 2008 U.S. Conference of Mayors Report indicated that 19 of the 25 cities studied reported an increase in homelessness from year 2007. Stimulated in part by this acknowledgement, an increase may occur in programs to meet the health needs of the homeless over the next decade [10].

Homelessness in Texas: In Texas, according to the U.S. Department of Housing and Urban Development, 29,615 people were classified as homeless in 2013, or 12 out of every 10,000 persons in Texas [12]. In San Antonio, Texas, the number of homeless individuals and families is growing; 31% of these were classified as families.

Transitional Living Centers for Homeless People

Transitional living centers for homeless persons included providing transitional housing and three meals a day. These transitional living centers also focused on providing residents with employment and financial counseling, education, training, and health care. The average length of stay for residents in these centers was between 21 to 24 months.

Significance

This study was important because the increasing population of homeless individuals and families across the country has continued to multiply, as well as the health needs for this vulnerable population. The Centers for Disease Control and Prevention [15] reported that in 2002, 12.3% of the general worldwide population perceived their own health status as poor. In 2009, the health status of homeless persons was much lower than the general population [10]. Poor physical health was associated with poverty in general, but seemed to be more pronounced among those who were without homes. Additionally, poor physical health was associated with higher rates of tuberculosis, hypertension, asthma, diabetes, and HIV/AIDs, as well as higher rates of medical hospitalizations [16].

In a national study, 73% of homeless adults reported at least one unmet health need [1]. The most commonly reported unmet needs of homeless adults were inability to (a) access needed medical or surgical care (32%), (b) purchase prescription medications (36%), (c) receive mental health care (21%), (d) acquire eyeglasses (41%), and (e) access dental care (41%).

Cost of Health Care for the Homeless: According to the National Coalition for Homelessness [10], the 2007 U.S. Census Bureau calculated that 45.7 million Americans (15.3% of the

population) were without any form of health insurance. In 2007, 26.8 million people (18.1%) who worked part-time or full-time during the previous year were uninsured including 21.1 million full-time workers. Of the 45.7 million uninsured Americans, 34.6 million identified as part of a family. Homeless people experienced worse levels of physical and mental health than the general population [17]. Among the homeless, the three leading causes of death were (a) cardiovascular/heart disease, (b) chronic lower respiratory diseases, and (c) cerebrovascular disease. These major causes accounted for 75% of all deaths occurring in the United States [18].

Cardiovascular/heart disease was a major cause of mortality in adults between 45 and 64 years old and this health condition was three times more common in the homeless aged 25 to 44 years when compared to an age-matched sample in the general population [18]. Increased cardiovascular mortality rates in the homeless were attributable to a complex relationship between traditional and less traditional risks [19]. These risks included the pervasive, immeasurable, psychosocial stressors linked to the daily challenges of obtaining the necessities of life including food, shelter, and safety. These challenges along with a decrease in access to health care resulted in an increased prevalence of and/or poor control of the traditional risk factors and other co-morbidities [19]. Long-term solutions that address the links between homelessness and cardiovascular disease are associated with measures that prevent homelessness and/or reverse the trends in our health care system that creates disparities among the poor and homeless population. Other prevalent health conditions among the homeless were drug and alcohol dependence, mental illness, physical trauma, and dental cavities.

Morbidity and Mortality: Homeless persons were at a higher risk for morbidity and mortality from both chronic and episodic illness than the general population [20,21]. The risk of homeless persons being hospitalized were twice as high for men than women [20]. Substance-using **homeless** persons frequented emergency departments and hospitals more often than the general population [22]. However, little is known about the ways in which the homeless are affected when this population seeks care for Substance Abuse Treatment (SAT). O'Toole et al. [22] surveyed 266 homeless and 104 non-homeless substance-using adults who were sequentially admitted to an urban hospital medical service. The homeless respondents were younger, had less than a high school education, were uninsured, and experienced additional health-related issues, which included hepatitis B and C.

Reflexivity

What motivated me to explore the topic of homeless families is having had one of my family members experience homelessness without me having full knowledge that it had occurred. As the proverbial statement goes, "Anyone could be on the brink of homelessness if faced with a serious illness or loss of a job." This was the case with my family member. She was 37 years old at the time of her death, a single mother, with a high school education and sole source of income for her 8-year-old son. She was pursuing a career in health care as a Certified Nursing Assistant when she became seriously ill with flu-like symptoms. Her illness became more serious and she was hospitalized until her death 6 months later. Her spouse was unable to maintain a full-time job while caring for his son and visiting his hospitalized wife. His son reportedly felt secure because he was with his father and did not realize until years later that he had been living in poverty and a state of homelessness when he and his father would sleep at a different location every night. Just when I thought being homeless could not affect anyone in my family, it did. This was, in part, what motivated me to become more aware of transitional living centers for other families and the services that are provided.

Conceptual Framework

The conceptual framework that informed this study was located at the intersection of the three constructs: (a) being homeless, (b) undergoing severe stress, and (c) being ready for discharge.

Being Homeless: Being homeless describes an individual in a supervised, publicly or privately-operated shelter designed to provide temporary living arrangements (including hotels and motels) paid for by the federal, state, or local government programs for low-income individuals, or by charitable organizations, congregate shelters, and transitional housing. Homeless people are unable to acquire and maintain regular, safe, secure, and adequate housing, or they lack a fixed, regular, and adequate nighttime residence [3]. In addition, homeless people are particularly at risk for stress. For this study, being homeless refers to an adult family member, who is the sole source of income for the family and has a confirmed cardiac/heart condition such as hypertension and/or hypercholesterolemia/elevated cholesterol level and living in a transitional living center.

Undergoing Severe Stress: Stress is defined here as a non-specific response of the body to any demand for change [23]. Stress is the state manifested by a specific syndrome that consists of all non-specifically induced changes within a biologic system. Stress has its own characteristic form and composition, but no particular cause. Human beings cannot go through life without stress. "Stress is as much a part of life as breathing and eating" [24]. Homeless people are faced with a combination of internal and external stressors that trigger other mediating factors such as high blood pressure that affect their ability to focus on transitioning or returning to mainstream society from a homeless status. Additional stressors include residing in unfamiliar surroundings such as temporary shelters that are overcrowded, noisy, and lack privacy, as well as economic inadequacies-all contributing factors [23].

Mediating factors may include other physiological changes such as headache and nutritional deficiency. The state of homelessness increases the likelihood of families separating that can further compound stress placed on them. Life changes, whether they are positive or negative, require people to expend energy to adapt to change.

Chronic psychological stress is associated with the body losing its ability to regulate the inflammatory response. Inflammation is partially regulated by the anti-inflammatory hormone, cortisol that protects the body from prolonged periods of inflammation. When cortisol is not allowed to serve its function of impeding the inflammatory process, then inflammation can get out of control [24,25]. Just as cortisol protects the body from inflammation, the production of cortisol is also related to stress. Cortisol also affects the immune system, whereas the immune system affects stress. Prolonged stress alters the effectiveness of cortisol to regulate the inflammatory response because it decreases tissue sensitivity to the hormone. Specifically, immune cells become insensitive to cortisol's regulatory effect. In short, inflammation is thought to promote the development and progression of many diseases [26].

Two syndromes occur in response to stress. The first occurs as a Local Adaptation Syndrome (LAS); the second occurs as a general adaptation syndrome [23]. The LAS is a short-term, localized response to a specific stressor such as a response of body tissue to trauma, illness, or other physiological changes [24]. For example, when a person places his hand on top of a hot stove, a localized pain response occurs with an immediate reflex that removes one's hand from the hot surface. The manner in which an individual respond to a stressful situation is mediated by such factors as personality, perception of stressors, and one's coping abilities. Factors influencing one's response to stressors include the intensity of the stressor; that is, the greater the magnitude of the stressor, the greater the stress response; the scope in which the stress encompasses a person's total well-being, the greater the scope of the stress, the greater the response to the stress; and, lastly, the duration and the number of stressors an individual face [23,24].

The GAS is defined as a physiologic response of a person's whole body to stress. The GAS emerges when people experience stress or illness. The GAS reflects a general response that occurs in various parts of the body. The GAS consists of three stages: (a) the alarm reaction, (b) the resistance stage, and (c) the exhaustion stage. The alarm reaction stage causes the body to react physiologically-increasing hormone levels, heart rate and cardiac output, respiratory rate, oxygen intake, and mental energy. The resistance stage begins as a person adapts to his/her stressors. The third stage of adaptation may occur and manifest as exhaustion; during this stage, the body is drained of energy and can no longer defend itself against the stressor. Either the stress is reduced or the person dies. Selye's LAS and GAS and the other constructs that informed this study (being homeless and being ready for change) formed the elements for this study's conceptual framework. The phenomenon of undergoing/engaging change is critical to one's survival and thriving. Health is defined here as the state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity [27]. Health is a state of equilibrium among the subsystems of the holistic person. Included in a person's health are one's beliefs about the quality of his/her life, ability to find meaning in life, and ability to maintain a positive, future orientation [24].

Being Homeless and Undergoing Severe Stress: For this study, the stressors of interest focus on the phenomenon of being homeless and experiencing the stress of a heart condition. This confirmed health condition is verified through elevated blood pressure/ hypertension and/or elevated cholesterol level/ hypercholesterolemia. The release of cortisol hormones when a person is emotionally stressed may damage one's arteries and lead to heart disease. These hormones can increase an individual's blood pressure by causing one's heart to beat faster and the arteries to narrow [26]. For a homeless person to show full and successful readiness for discharge from a transitional living center, the person must show stabilization or reduction in physiological measurements of blood pressure/ hypertension and/or cholesterol levels. Controlling high blood pressure and cholesterol can cut a person's risk for experiencing heart disease or undergoing a heart attack or stroke [18]. Hypertension is defined when a person has a systolic blood pressure above 120 mm Hg and a diastolic blood pressure above 80 mm Hg [28]. A cholesterol level is considered elevated when levels exceed 240 mg/dL [28].

Being Ready for Discharge: Readiness means being prepared. Readiness for discharge means (a) attaining the right conditions and ensuring that the essential resources are in place to support the change process, (b) securing a clear vision and objectives for the intended change, and (c) achieving the motivation to engage in change and make it work [29]. Prochaska, et al. [29] identified five stages associated with change: (a) pre-contemplation-people at this stage usually have no intention of changing their behavior and typically deny that they have a problem, (b) contemplation-people start acknowledging that they have a problem and begin to think seriously about changing their behavior, (c) preparation-most people make preparation to change their behavior within the next month or so, (d) action-people make a constructive effort to change their behavior. For example, a person removes all the desserts or sweets from his/her house toward the goal of losing weight, and (e) maintenance-this occurs over time and is a critically important stage. Over time refers to the length of time spent by the homeless adults residing in the transitional living center.

Successful Transition: To be ready for discharge from a transition living center, the individual must have returned to a normal level

of stress through self-management of their high blood pressure and self-perceived status of a safe, structured, and supportive living environment, which in turn, facilitates the reduction of stress to normal levels. Successful transitioning out of a state of homelessness and into mainstream society will occur only if all services and resources offered in the transitional living center meet the real needs of the homeless adults and their families. Resources must be used by the homeless adult member and their families as shown through their active use of services.

Failure to Transition: Failure of this process occurs when services and resources are unused and/or are inappropriate to meet the needs of the homeless adult member and his/her family. Failure may also occur when services are available and appropriate but not used.

Research Questions

Based on the purpose, background, and conceptual framework, three research questions were posed.

Research Question 1: How do homeless adult members perceive readiness for discharge when compared with a transitional living center criterion of readiness?

Research Question 2: How do homeless adult members perceive their readiness for discharge over time?

Research Question 3: What is a homeless adult member's perception of stress and its relationship to his/her health condition with regard to readiness for discharge?

Operational Definitions/Key Terms

Being Homeless: Being homeless is defined as A person who lacks a fixed, regular, and adequate nighttime residence; and has a primary night time residency that is: 1) a supervised publicly or privately operated shelter designed to provide temporary living accommodations; 2) an institution that provides a temporary residence for individuals intended to be institutionalized; or, 3) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings [3]. For this study, the adult homeless person's perception was assessed through a self-developed, self-description questionnaire that was obtained during an audio-recorded one-hour interview. Being a member of a homeless family has similar characteristics as defined for a homeless person. A homeless family consists of at least one adult and one minor child 18 or under, or a disabled child over the age of 18 who still requires parenting by an adult member.

Undergoing Severe Stress: Severe stress is defined as a response to emotional pressure suffered for a prolonged period over which an individual perceives he or she has no control [25]. Severe stress will be assessed through a score on a 10-item psychological instrument entitled the Perceived Stress Scale used for measuring the perception of stress [25]. A total score 13 or greater on the Perceived Stress Scale (PSS) is indicative of higher levels of stress; a total score of 12 or less is indicative of lower levels of stress [25].

Transitional Living Center: A transitional living center is a facility that provides residents with employment and financial counseling, education and training, parenting skills, and medical services that facilitates successful reentry into mainstream society. It is transitional in that it expects the adult members to actively participate in the counseling and medical services provided by the Center. Reentry includes (a) permanent housing for the family, (b) access to health care and active participation on part of the family members, and (c) outreach services to ensure full return and integration into mainstream society. The adult homeless member's participation in outreach services will be assessed with a self-developed questionnaire administered face-to-face over a one-hour recorded interview.

Being Ready for Discharge: Readiness is defined as (a) a homeless adult's successful management of two physiological measures, lower blood pressure and cholesterol levels, within an acceptable range as documented by a primary care physician, (b) full-time employment of 30 hours or more per week or attending school as a full-time student, and (c) maintaining a minimum wage employment for at least 6 consecutive months. Readiness will be assessed by the team members' review of the resident's record for documented blood pressure and/or cholesterol level readings, completion of life-skills training classes as documented in the resident's record, and the resident's responses about readiness for discharge through a one-hour recorded interview.

Limitations

This study included several limitations that are acknowledged:

- Limitation due to setting. The setting for this study was one of the 20 transitional living center/shelters in San Antonio, Texas. These other shelters did not provide the broad range of educational services such as wellness programs, financial planning, and parenting counseling, coupled with a policy that allowed families to remain up to 24 months. While it is possible that other shelters may have provided similar services, only one transitional living center was considered for this study and used. This limitation due to setting is acknowledged.
- Limitation due to access to study participants. The study was limited due to the number of residents living in the Center and their accessibility. During the time of this study, 37 homeless adults were residing in the Center. Gaining access to the residents was challenging at times due to several activities occurring simultaneously for the residents. Recruitment of residents for the study could only be achieved through my weekly visits to the medical clinic and attending the monthly residential meetings. The medical clinic was opened one-day

per week with limited operational hours. In addition, residents were required to attend weekly classes that were held on the same day and time that the medical clinic was opened. This procedural limitation due to access to study participants was acknowledged.

Assumptions

This study assumed that:

- Study participants would continue to maintain their eligibility as residents in a transitional living center during the study's data collection period.
- Adult homeless members' attendance records to the various services offered at a transitional living center reflect regular, complete attendance for all educational and health services and that the member would attend each session for the full duration.

Review of Literature

Introduction

This study's focus was residents' perceived readiness for discharge from a transitional living center. This is a complex experience made even more so when an adult living in a center also lives with a serious health condition and who sees him/herself as the family wage earner. This complex, but common, profile links the phenomena of being homeless with being sick and undergoing the stress that is also common to a non-resident wage earner. I examined these factors as perceived by the adults presumably readying themselves for discharge. This comprehensive literature review spanned the 1900s and the years between 2000 and 2015 and included studies located in CINADL, ESCBO, ProQuest, and PubMed. I used the following key words: being homeless; having heart disease and being homeless; undergoing stress and being homeless; and showing readiness for discharge from the homeless persons' perspective, and from the institutions' perspectives. Selye's [23] theory of stress and Cohen and Williamson's Perceived Stress Scale [25] were part of this research.

Being Homeless

Being homeless means being unable to acquire and maintain consistent, safe, secure, and adequate housing or lacking a fixed, regular, and adequate nighttime residence [3]. The National Coalition for the Homeless [10] indicated the top five reasons for homelessness include (a) unemployment/loss of job, (b) inability to pay rent/mortgage, (c) physical/mental disabilities, (d) substance abuse/addiction, and (e) altered family relationships. Home foreclosure also contributes to being homeless, either due to the homeowner's inability to pay his/her mortgage, or because renters are evicted due to property owners not paying the mortgage. Homeless people are at the greatest risk for illness and have higher death rates than the general population [30]. Alcohol and drug use are commonly associated with the experience of homelessness [31,32]. Fazel, et al. [31] and others cited the major reasons for homelessness are an interaction between individual and structural factors. Individual factors include poverty, family problems, and mental health and substance abuse problems, whereby the availability of low-cost or affordable housing is the key structural determinant to homelessness.

Toro, et al. [33] conducted a comparison study of two samples of homeless adults. One was a sample of homeless adults in Poland (n=200), and the other was a sample of homeless adults in the United States (n=219). The researchers recruited and interviewed homeless adults from various shelters located in the United States and Poland. The only difference in the sampling population was that the researchers recruited homeless adults from shelters and soup kitchens across the United States, whereby this was not the case in Poland. In Poland, there are limited soup kitchens. However, the study identified some similarities and several differences. In both countries, homeless adults were males with dependent children, dealing with out-of-home placements and experiencing high levels of physical health problems [33]. The differences recognized among the homeless adults in Poland were that homeless male adults were older, experienced longer episodes of homelessness, and reported less satisfaction after they sought help from supporters. On the other hand, in the United States, the homeless adult males were younger and experienced higher rates of physical and mental health conditions [33].

In the United States, people experiencing or at risk for homelessness are typically women with two children under the age of 5 [1]. Sixty-three percent of women who are homeless have experienced some kind of domestic violence as an adult [10]. When a battered woman decides to leave an abusive situation, she might not have anywhere else to go but the streets. It is much more difficult to find housing when there is a history of abuse [10] because of poor credit and rental and employment histories related to their abuse.

Homeless Families: Families with children are among the fastest growing segments of the homeless population [5,34,35]. The typical homeless parent is a young, unmarried mother with two or three children, who grew up in poverty and typically experienced or witnessed domestic violence at some point in her life, never completed high school, and in many cases dropped out of school because of pregnancy [5]. The typical fathers were aged 35 years old, high school graduates, and unmarried [5]. Children who experience homelessness have an increased risk for negative outcomes in several developmental areas, the most frequent being high rates of physical and mental health problems that may have an impact on their ability to learn [35,36]. Major characteristics associated with families experiencing homelessness include a lack of affordable housing, extreme poverty, and exposure to violence. Over 30% of America's three million homeless people

are members of families. For each homeless family, many more families are living at the edge of homelessness [34].

While numerous programs intend to mediate these and other risks by offering services to families experiencing homelessness, a plethora of research exists that addresses the ways in which psychosocial needs are being addressed in these existing programs [8,37]. Yet, while both homelessness and poverty among families continue to increase, programs designed to assist those families who require shelters have been reduced by 10% per year, or to less than 20 days on average living in a shelter. The Federal Homeless Emergency and Rapid Transition to Housing (HEARTH) Act of 2009 signaled a new shift in homelessness policy and shifted funding away from shelters and onsite supportive services to more rapid re-housing initiatives [34]. Even though the 2009 HEARTH Act represented one way of providing quick housing, studies have shown that homeless families require time and supportive services to rebuild their financial independence through education counseling and training in employment skills [6,38,39]. However, some programs, such as the Federal Aid to Families with Dependent Children (AFDC) Program, reportedly have been criticized for deficiencies in providing basic survival resources for poor families [40].

Perceptions of Being Homeless: Families experiencing homelessness face a number of risks associated to their psychosocial health and well-being [39]. Well-being is defined as a state of one's satisfaction with material, social, and the human aspect of one's life and can be measured both objectively and subjectively [41]. "Men who are homeless experience pervasive psychological stressors that diminish their ability to cope and navigate life problems" [42]. As such, men have a tendency to avoid professional counseling to alleviate their stressors. Homeless mothers/women experience higher rates of major depression disorders compared with the general population [43]. Children living with a depressed parent have experienced poor medical and mental health, as well as poor educational outcomes [43]. Thomas, et al. [41] and others explored the meaning and experience of well-being in the everyday lives of 20 homeless participants. The study revealed that health contributed very little to homeless participants' perception of well-being. Homeless people perceive that keeping safe, being positive and feeling good, connecting with others and the ability to participate in normal life activities were the key contributors to well-being [41]. Thusly, services that provide a homeless person with opportunities to experience social inclusion that cultivates a sense of community and cultural connections may improve the well-being of a homeless person. However, it is difficult to draw any conclusion on this study based on its small sample size.

Mental Illness and Homelessness: Mental illness is the third largest cause of homelessness for people who are single. One estimate is that between 20 to 25% of the homeless population have some type of mental disorder [10]. Homeless women comprise an important portion of the homeless population who encounter multiple life stressors including mental illness, substance abuse, and trauma [35]. Women who are homeless may experience difficulty gaining shelter and/or health care [13,35]. Homelessness among female veterans is a national concern, but few studies have been conducted to show the differences between women and male veterans [44]. The number of homeless youths in the United States has reached an all-time high, and this represents a growing social problem. Homeless youth are at-risk for experiencing a broad range of negative life-outcomes, such as school dropout, the development of mental health problems, use/abuse of illicit substances, suicidality, and even early mortality. Young children who experience homelessness are more likely to have developmental delays and experience physical and mental health problems when compared with children in stable housing [36,45].

Undergoing Severe Stress

Families experiencing homelessness are under considerable stress. Those living in temporary shelters are stressed due to having to adjust to being in places that are overcrowded, noisy, and lack privacy [46,47]. The state of homelessness increases the likelihood of families separating, thus compounding the stress. Social stressors include unemployment, unstable housing, and problems with family, friends, and/or significant others [48]. Physiological stressors faced by homeless children and adolescents include depression, post-traumatic stress disorder, anxiety, and substance abuse [49]. Being homeless is an unhealthy circumstance that promotes illness and reduces one's well-being. Severe stress can trigger major health issues that are prevalent among the homeless [17,21]. Selye's [23] research on stress is applicable here and well-documented. Two types of stress responses as described by Selye include the Local Adaptation (LAS) and General Adaptation Syndromes (GAS).

Local Adaptation Syndrome: The LAS is a short-term process. It provides a localized response to a specific stressor that can restore or return a person's body to a state of homeostasis. For example, a person cuts his/her finger while picking up a piece of broken glass. The finger heals quickly using the body's natural defenses for healing.

General Adaptation Syndrome: However, if the person's body is compromised, such as being malnourished, undergoing physical pressure, or experiencing chronic fatigue, the entire body becomes mobilized by the GAS. The GAS is a physiologic response of the whole body to stress and it can take much longer in returning one's body to a full state of homeostasis [24]. If the body cannot fight these stressors, a person can die.

Being Homeless with Heart Disease and Undergoing Stress

Cardiovascular disease is one of the leading causes of death and accounts for 75% of the deaths occurring in the United States [17,18].

Homeless adults are at a greater risk of developing heart disease and increased rates of mortality. In a study conducted over a 5-year period (1988-1993), in comparing the mortality rates among homeless adults living in Boston, results showed that heart disease and cancer were the leading causes of death in persons who were between the ages of 45 to 64 years old [50]. In a study conducted among 426 low socioeconomic community-dwelling citizens and 287 homeless males over a 15-year period in Philadelphia, researcher results indicated that the prevalence of smoking and hypertension among the homeless males was comparable with low socio-economic community-dwellers, and both groups were at risk of developing coronary artery disease [51].

Being Homeless with Hypertension

Homeless individuals have a higher rate of hypertension when compared to the general population [52]. It has been shown that therapeutic lifestyle changes have the potential to decrease the morbidity and mortality associated with hypertension, through such interventions as smoking cessation and nutrition classes, physical activity, and exercise; yet, therapeutic lifestyle changes may be difficult for homeless people to implement due to conflicting priorities [52]. Homeless people consider shelter as a key priority in life. In a study conducted with 14 homeless participants, the participants viewed therapeutic lifestyle changes as being too restrictive when it came to nutrition, exercise, and educational resources. In general, homeless people often have more difficulty implementing healthy lifestyle changes due to limited meal choices, poor access to exercise equipment, and being unable to access health-related educational resources [52].

Readiness to Change/Being Ready for Discharge

A precursor to readiness for discharge is readiness to change. Readiness to change is defined as a commitment and motivation to make health-related, behavioral, or lifestyle changes [22]. Readiness is described as being prepared-having the right conditions and resources in place to support a change [29]. Core areas that focus on readiness include undergoing changes that can improve and build on an individual's basic life-skills, such as education, financial counseling, and parenting skills. In a study conducted with 43 homeless adults (25 males, 16 females, and 2 transgendered individuals) with mental disorders, researchers found that after 18 months of being assigned to a transitional housing project, the "Majority" of the participants reported positive changes across multiple domains [53]. Key themes included (a) feeling secure and proud, (b) adjusting to living alone, and (c) developing meaningful activity. Maycock, et al. [8] identified two factors associated with moving out of homelessness and reentering society: access to and engagement in drug treatment services and participating in education and training.

Discharge/Termination Criteria: Data collected from 217 families participating in a Transitional Housing Program that provided well-designed services over a 2-year period to 560 individuals showed that program participants who successfully completed the Hawkeye Area Community Action Program (HACAP), achieved greater gains in income than those participants who did not complete the program [54]. Successful completion was also credited to a strong working relationship between the case manager and program participant [54].

Limited literature was available in the material reviewed for this study that addressed discharge criteria from a transitional housing program. However, termination criteria were well documented. The primary cause for participants not completing a program was due to participants' noncompliance and/or rule violations [54,55]. Termination criteria included (a) bringing mood-altering substances onto the property; (b) coming onto the property under the influence; (c) bringing people who were not residents in the house without staff permission; (d) failing to adhere to curfew guidelines; (e) stealing, gambling; or participating in illegal activity; (f) damaging property belonging to the Center; (g) carrying out acts or threats of physical violence; (h) failing to maintain full-time employment or be enrolled in an educational program; and (i) failing to attend weekly classes (N. Bracken, personal communication, May 18, 2015).

Successful Transition: Kurtz, et al. [9] and others conducted a qualitative research design study that primarily involved interviewing 12 formerly runaway and homeless youths (3 males and 9 females). The research question explored in the study was "How do runaway and homeless adolescents navigate the troubled waters of the adolescence - leaving home prematurely; living in high-risk environments; and engaging in dangerous behaviors - to make successful, developmental transitions into young adulthood?" Based on their results, the researchers found that the runaways and homeless youth resolved their homelessness through help from others-family, friends, and professional helpers-and perceived such attributes as caring, trustworthiness, strong boundaries and holding youth accountable, concrete assistance, and counseling. These were considered the most important attributes in making a smooth transition into young adulthood. Other studies have shown that transition homes improve the chances for a successful reintegration into mainstream society for women recovering from additions and for ex-criminal offenders who were released from prison [35,55]. More than just a structured living environment, transition homes provide on-site support from a full-time staff and life-skills development including communication skills, job-related skills, and ways of coping with conflict resolution.

In a study conducted on criminal offenders who were released from prison after serving their term, Washington State implemented a program called the Reentry Housing Pilot Program (RHPP) that provided housing assistance to high-risk/high-need offenders leaving prison that did not have a place to live. This pilot program included five different counties located in the state of Washington. Findings from this pilot program, involving a total of 181 high-risk offenders/participants, revealed that the RHPP program was successful in reducing new convictions by 22% and readmission to prison for new crimes by 36%. Results of this study also revealed that long periods of homelessness increased the risk of recidivism two times the rate for new convictions and readmission to prison when compared to those participants in stable housing [55].

Successful Transitional Living Centers: Safe and secure housing is considered by individuals as the foundation for homeless people to prepare and actively engage in the process of reentry into society [22,44,55-57]. Housing interventions, inclusive of supportive services such as employment, parenting, and educational counseling may be effective in reducing the return of such high-risk behaviors as drug and substance abuse [55]. Successful transitional living centers can be most effective when they offer the following services: (a) safe, stable living conditions; (b) basic life skill-building, including consumer education and instruction in budgeting and parenting skills; (c) interpersonal skill-building, including enhancing young people's abilities to establish positive relationships with peers and adults; (d) educational/vocational opportunities; (e) mental health care, to include counseling; and (f) physical health care, including routine physical examinations, health assessments, and emergency treatment.

However, documented cases of failure have occurred despite well-coordinated services and efforts toward successful reentry into society. New York's Greenlight Project provided a 60-day reentry program to prisoners who were scheduled to be released from jail within one year. The Project provided such services as employment, education, health care access, and family counseling, with an emphasis on housing. However, one year after the release of the prisoners, participants recidivated at a higher rate than prisoners who had not participated in the project [58]. The cause of recidivism by these participants is still under examination questioning whether the increase in recidivism was due to the limited period for the reentry initiative or the lack of motivation by the participants to change their way of life [58].

Health Care Costs for the Homeless: According to the Interagency Council on the Homeless, President Obama's Fiscal Year 2014 (FY 2014) Budget included a considerable funding commitment of $5.3 billion targeted for homeless assistance, a 21.1% increase over the previously enacted fiscal year budgets. Two such programs included the Health Care for the Homeless Program and Projects for Assistance in Transition from Homelessness. The Health Care for the Homeless Program is aimed at providing (a) primary health care and substance use treatment, (b) emergency care for homeless people who are referred to hospitals for in-patient care services, and/or (c) other health-related needs to assist homeless people who are experiencing difficulty in accessing health care. The Projects for Assistance in Transition from Homelessness Program provided financial assistance to states to support services for homeless individuals who have serious mental illness and substance abuse disorders. Operating both of these programs is costly. At (Table 1) is a breakdown of budget for the homeless by fiscal year.

Fiscal Year	Budget ($) in Millions
2010	236
2011	280
2012	296
2014	384

Table 1: Budget for the Homeless and in Transition by Fiscal Year.

Summary

Review of the literature revealed that homelessness is a growing concern and challenge in the United States [2,20]. While several studies discussed the magnitude of homelessness and the impact of unmet health care needs [1,10,20,47,59], a gap in literature for this study became apparent. The studies aforementioned included small to moderate sample sizes that only addressed housing issues and did not include physiological/health considerations. Based on this limited information or substantiated research, a need exists to address the ways in which those who are homeless perceive their health/medical condition as preparation for readiness for discharge or return into mainstream society.

Methods

Setting

This study's data were collected between April and June 2015 at a transitional living center (Center) that had been providing services and housing to homeless families for over 30 years in San Antonio, Texas. In the past, transitional housing locations were often referred to as halfway houses. This Center was characterized as an interfaith ministry whose goal was to help the homeless families become more self-sufficient toward independent living on their own. Transitional housing is defined as affordable, supportive residential quarters designed to provide housing and appropriate support services to persons who are homeless or on the brinks of becoming homeless. The Center required (a) its families to have custody of at least one minor child, equal to or under the age of 18, or a disabled child over the age of 18, who still require parenting by an adult; (b) the adults must complete criminal background checks; the head of the household must be working or attending school for at least 30 hours per week; (c) the family must meet with case managers regularly to establish short- and long-term

goals; and (d) the adults must attend weekly life-skills classes on money management, parenting, and conflict resolution.

When a family entered the Center, a case manager assessed the needs of the family to find programs that matched the family's circumstances. Services provided through transitional housing facilities varied from substance abuse treatment to psychological assistance, job training, and domestic violence assistance. The assistance provided varied, but it was generally affordable. The only requirement of a homeless family residing in the Center was to pay $100 per month that went toward rent and utility services. The Center housed a maximum of 40 homeless families over a 2-year period who showed a commitment to gaining self-sufficiency. Residential members' commitment was defined as adherence to all admission criteria, as well as agreement to attend weekly classes of the Center. The Center noted that it promoted the viability of the family as a whole. The average number living in a Center was 200. In 2011, 298 residents (93 adults and 205 children) lived there. During data collection, 117 residents lived in the Center (37 adults & 80 children; N. Bracken, personal communication, May 18, 2015).

The Center's free health and dental clinics opened in August 2000 and were staffed by medical, dental, and dental residents under the supervision of medical and dental faculty from the University of Texas Health Science Center at San Antonio (UTHSCSA). The facility included two physical examination or treatment rooms in the medical clinic and two dental chairs in the dental clinic. The health clinic was open between 5:30 p.m. until 8:00 p.m. once per week. Five student-run free clinics were supervised and operated by UTHSCSA. However, out of the five clinics, the Center was the only facility that provided residential housing to homeless families.

Research Design

I used a mixed qualitative and quantitative descriptive design for this study. The qualitative portion focused on respondents' description of their health status experience, over time, in the Center and their perception of readiness for discharge from the Center. I collected data during a one-on-one interview for one hour with each study volunteer. For a husband and wife team, only the major breadwinner for the family was interviewed. For the quantitative portion, all respondents were asked questions derived from a standardized data collection instrument to assess self-perceived stress. Furthermore, I conducted a retrospective chart review to examine changes in the participants' cardiac health condition over the previous year.

Population and Sample

Thirty-seven families comprised the population of the Center in the spring of 2015. During the data collection period, I had access to 15 families. Of the 15 families, 9 families (60%) met my inclusion criteria that included at least one family member with a heart condition admitted between January 2012 and May 2015. Given the focus on readiness over time, I sorted the population into three groups of respondents: (a) those that met the inclusion criteria and were in their first 6 months at the Center-five families met this criteria; (b) those who were in the second 6 months at the Center-five families met this criteria; and (c) those who were in their third 6 months at the Center-five families met this criteria.

Sample Type and Number

From this population, this study's final sample included six families-two families in the Center from less than 6 to12 months, two between 12 to 18 months, and two between 18 to 24 months for six out of the total population. Of the 15 families, 9 adult members (60%) were interviewed, 3 adult members were used for the pilot study, 6 adult members for the full study, and 3 adult members did not keep their scheduled appointment.

Inclusion Criteria: Participants included adult "Wage-Earner" members who were diagnosed with some form of cardiac disease, such as hypertension and/or hypercholesterolemia. All participants had resided in the Center during one of the three specified time periods and were educated at a junior level or higher in school education. I used a self-developed checklist to ensure that inclusion criteria of respondents were met (Appendix A).

Exclusion Criteria: I excluded any non-English-speaking and deaf respondents due to the unavailability of translation services or interpretive resources. I also excluded any volunteer participants who indicated they were unable to read at a fifth-grade level. The participants' educational and reading level was determined at the time they completed the data collection questionnaire background information for adult family members.

Data Collection Instruments

The study's data collection instruments included a Perceived Stress Scale (PSS), an interview protocol, and an instrument related to the retrospective chart data.

Perceived Stress Scale: The PSS was the most widely used psychological instrument for measuring the perception of stress [25]. The PSS was a 10-item, self-report questionnaire that measured a person's evaluation of the stressfulness of situations in the past month of their lives (Appendix B). Items on the PSS were designed to tap the extent to which unpredictable, uncontrollable, and overloaded respondents found their lives to be [25].

Sample Items: Participants were asked these 10 questions during the interview process. During the one-hour interview, each of the study participants were offered the following guidance regarding the Likert rating on the PSS:

I have a couple of questions that deal with the level of stress

you have experienced over this last month. I will ask you the questions and there is a scale with the following ratings. Zero (0) meaning that this level of stress never occurs; one (1) meaning that this level of stress almost never occurs; two (2) meaning that this level of stress occurs sometimes; three (3) meaning that this level of stress occurs fairly often; and four (4) meaning that this level of stress occurs very often. I only need you to address your level of stress that has occurred starting from last month until now (today).

Assessed were aspects of stress that included (a) actual environmental experiences; (b) subjective evaluations of the stressfulness of a situation; and (c) the affective, behavioral, or biological responses to environmental experiences or their subjective evaluations [25]. The PSS asked study participants about their feelings and thoughts that had occurred during the last month. Sample items on the scale included such questions as "In the last month, how often have you been upset because of something that happened unexpectedly?" "In the last month, how often have you felt nervous and stressed?"

Validity: "PSS scores were moderately related to responses on other measures of appraised stress, as well as measures to potential sources of stress as assessed by event frequency" [25]. The only available verification of validity of the instrument was provided verbally by Dr. Sheldon's assistant (C. Detrick, personal communication. June 19, 2015), who indicated that the instrument achieved acceptable levels of validation.

Predictive Validity: The intent of predictive validity is to assess the operationalization ability to predict something will occur [25]. The PSS predicted both objective biological markers of stress and increased risk for disease among persons with higher perceived levels of stress.

Reliability: I used the coefficient alpha to assess reliability. The normal span of values ranged between .00 to +1.00; higher values reflected a higher internal consistency [60]. The reliability for the 10-Item PSS had a "Good internal consistency" with a coefficient alpha of .78 [25].

Scorability: PSS-10 scores were obtained by reversing the scores on the four positive items (e.g., 0=4, 1=3, 2=2, etc.) and then summing across all 10 items. Items 4, 5, 7, and 8 were the positively stated items. Scores ranged from 0 to 40; the higher the score, the greater the stress. A total score of 13 or higher is indicative of higher levels of stress, a score of 12 or less is indicative of lower levels of stress. The scoring of the PSS instrument was validated by Dr. Sheldon's assistant (C. Detrick, personal communication. June 19, 2015). In 1983, Louis Harris and Associates collected data using the 10-item PSS on a large sample group of 2,387 respondents living in the United States [61]. These data provided mean stress scores (Table 2).

Category	*N*	*M*	*SD*
Gender			
Male	926	12.1	5.9
Female	1,406	13.7	6.6
Age			
18-29			
30-44	645	14.2	6.2
45-54	750	13	6.2
55-64	285	12.6	6.1
65 & older	282	11.9	6.9
	296	12	6.3
Race			
White			
Hispanic			
Black	1,924	12.8	6.2
Other	98	14	6.9
	76	14.7	7.2
Another minority	50	14.1	5
Note. L. Harris Poll information on 2,387 respondents in the United States [61].			

Table 2: Norm Table for the Perceived Stress Scale 10-Item Inventory.

The PSS 10 items were easy to understand and the response alternatives were simple to grasp. In each case, respondents were asked how often they felt a certain way [25].

Utility: PSS took 15 minutes to complete and was reportedly appropriate for participants who can read at the fifth-grade level.

Cost: PSS was free and easily downloaded from the Internet. The cost to respondents was one hour of their time.

Interview Protocol/Self-Developed Questionnaire: The interview protocol included two data collection instruments. I developed the interview questions using the conceptual framework of my study. The first section, the Data Collection Instrument, Background Information for Adult Family Members, was designed to provide background and demographic information on the participant. Because I was interested in the cardiac/heart condition of a participant, this particular instrument was used to document specific information regarding that aspect of a participant's medical history. I asked each question to the participant and documented responses with pencil and paper and recorded the information with an audiotape recorder.

The second instrument was the Data Collection Instrument, Interview with Adult Family Members (Appendix C). The purpose of this self-developed interview questionnaire was to document the participant's perception regarding his/her readiness for discharge from a transitional living center. Sample items for the interview included such questions as

- How long have you been homeless? What were the circumstances that led you to become homeless?
- What was it like for you at the beginning of your time at the transitional living center? How do you feel about your current situation?
- What has changed for you over time regarding your cardiac physical health status?

Trustworthiness: Participants were provided an opportunity to review their transcripts for accuracy at least 2 weeks following their interview. I provided participants with a copy of their written transcript for their review. The participants reviewed and returned their transcripts on the same day.

Dependability: Dependability refers to evidence being consistent and stable [60]. Inter-rater or inter-coder agreement occurs when several observers, raters, or coders reviewed the same information [62]. I used two coders and trained them using my self-developed codebook. The codebook included 60 items. The inter-coder agreement was 70% or higher. All disagreements were discussed until there was at least a .70 consensus reached.

Scorability: Participants' responses to the open-ended interview questions were recorded in narrative form and also coded. Each participant was assigned a numerical identifier (i.e., 1, 2, 3, etc.) and the paper copies of the interview protocol were color-coded to include the Informed Consent.

Utility: The open-ended interview data collection instrument took 45 minutes, allowing the participant time to answer each question thoroughly.

Cost: The cost to respondents was one hour of their time. I spent 20 hours per participant in interviewing, transcribing, and reviewing transcripts. The cost of the printed-paper copies was 64 cents per each color copy and the audiotape recorders were $49 each (two tape recorders were purchased).

Procedures

Access to Study Participants: Prior to approaching potential participants, I followed the following procedures. First, I held a preliminary face-to-face meeting with the Vice President of Programs at the Center on March 13, 2015 to check if the facility could be used for the study. I followed this up with a formal letter to that Vice President and access was granted on April 7, 2015. I requested access to review the files of residents and to identify those adult members who met the inclusion criteria for the study (Appendix D). I provided a Letter of Introduction to each resident at the residential family center meeting on April 25, May 28, and June 25, 2015 (Appendix E). Following the residential family center meeting, the participant and I set a date and time to meet. The study participants reviewed and signed the Informed Consent on their scheduled interview date (Appendix F). Finally, I held all interview sessions at the transitional living center in a room that separated the participant from other residents in the Center.

Protection of Human Participants: My application received approval from the Fielding Graduate University (FGU) Institutional Review Board (IRB) in April 2015. Approval by the University of Texas Health Science Center at San Antonio was not required. Homeless adult members' participation in the research study was not anonymous, due to participants being recruited openly following the monthly residential family center meeting. Those adult members who attended the meeting received a copy of my Letter of Introduction and heard my presentation about the study.

All participants' responses were kept confidential. I interviewed each adult family member individually. Participants were assigned a numerical identifier, and their interview questionnaire was color-coded for ease of access. During the interviewing process, participants were promised that their name would not be disclosed or identified in the study. As noted, participants would only be identified by their numerical identifier. Participants were informed that they were free to decline participation, or if they felt uncomfortable answering any question, they did not have to, and they could withdraw at any time without penalty. This information was reiterated prior to the Informed Consent being signed. The Informed Content was signed at the time of the participant's one-on-one interview with me. All residents received a copy of their signed Informed Consent. I transcribed all of the interviews. After the audiotaped interviews were recorded and the semi-structured interviews concluded, I placed all of the data/information in a binder and transported them from the Center in my private vehicle to my home residence.

Conduct of a Pilot Study: After approval to conduct the study by the FGU, I requested and received a list of demographics from the Director of Case Managers at the Center. The list included the total number of residents residing in the Center, by gender, and the total number of children. As noted, at the time of this pilot study, there were 37 families residing at the Center (36 females, 1 male, and 80 children). I also requested a breakdown for the length of time that each family member had been residing in the Center, as this information was not initially available.

For purpose of the pilot study, three homeless adult members were selected covering three specified times (6, 18, & 24 months).

I conducted the pilot study over 3 days (May 18, May 28, and June 1, 2015). I interviewed the adult family members once for one hour that provided adequate time to ask and receive answers on all of the interview protocol questions. All of the interviews were conducted in a private, secured area in the Center away from the other residents. The only individuals in the room during the interview were the participant and me. The room provided adequate spacing, seating, and lighting. The criteria of a data collection instrument were assessed during the pilot study and the results were reported under the section on Data Collection Instruments. The lessons learned from the pilot study included the following:

Gaining Access to Participants: Gaining access to the participants was the most difficult part. At the beginning of this study, a change occurred in leadership among the Case Managers in the Center. Under this new leadership, I was only allowed to interview residents by appointments. I was not permitted to conduct any open recruitment, or be in the Center without the presence of a Case Manager when interviewing residents. The Case Manager was not present in the interview room, but accessible in the Center in case any issue developed with the resident. This issue was resolved after I met with the Vice President of Programs. The Vice President of Programs felt that my attendance to the residential family center meeting would alleviate the problems in gaining access to the residents. On May 28, 2015, I attended and presented at the Center. Four of the six residents immediately volunteered for the study with a confirmed date and time for us to meet for an interview. The two remaining participants were interviewed on June 25, 2015.

Interview Protocol/Self-Developed Questionnaire: The one-hour face-to-face interview was adequate with each participant; individual interviews were completed between 40 to 45 minutes. The PSS, 10-item, self-report questionnaire was appropriate and only took 15 minutes to complete. I completed the face-to-face interview and PSS questionnaire with each participant within 60 minutes. I recommended no changes to my interview protocol for the full study.

Data Management

I transcribed the interviews by listening to the audiotape and creating a written transcript. Next, I cleaned the written transcript by listening to the audiotape twice more to confirm accuracy of my transcription. Using my conceptual framework and the transcript, I analyzed, parsed, and numbered each interview response for the participants' description of how they perceived their readiness for discharge from the Center. Each statement was coded against my self-developed codebook (Appendix G). The parsed statements were color-coded and reflected the participants' responses to each question. Each research question was coded with a specific color.

The categories derived from my conceptual framework formed my three constructs of being homeless, undergoing severe stress, and being ready for discharge. Three major category schemes were developed: (a) the participant's perception of readiness for discharge as it compared with the Center's criteria, (b) the participant's perception of readiness over time, and (c) the participant's perception of stress as related to his/her heart condition.

Data Analysis

My plan was to analyze the data from the PSS using the Non-Parametric ANOVA Kruskal-Wallis Test to determine if there were any significant differences by the reduced length of time of the participants living in the Center. Based on the small sample size, I hypothesized that there would not be any significant differences between the participants' responses to the PSS as they related to their length of time in the Center.

The qualitative data were obtained from open-ended interview questions. I used thematic and content analysis to examine the qualitative components of the data.

Findings, with Analysis, Interpretation, and Discussion

Here, I begin with a discussion of the intended and final sample. Next, I present the findings from my data. Results of the data were captured using two methods. Quantitative data were analyzed from the PSS. Analysis of the PSS included participants' responses to the 10-item stress scale in relation to the participants' length of time at the transitional living center and their responses to the four items that were reversed in coding. Qualitative data were analyzed through a semi-structured, self-descriptive questionnaire and resident interviews and revealed three overarching constructs that formed my conceptual framework of (a) being homeless, (b) undergoing severe stress, and (c) being ready for discharge.

Intended and Final Sample

The intended and final sample for the full study was six participants-two residents from each specified timeframe (6, 18, and 24 months) who resided in the transitional living center. Thirty-seven families comprised the population in the Center. During the data collection period, 15 families were living there. Of the 15 families, 9 adult members (60%) met the inclusion criteria with a heart condition with either hypertension or an elevated cholesterol level who were admitted between January 2012 and May 2015. Three of the nine adult members were used for my pilot study. Six adult members were used for my full study. I had three other adult family members volunteer for the full study; however, they did not keep their scheduled appointment. Those adult members who volunteered to participate agreed upon a date and time for me to meet with them.

Length of Time at Center: The six participants for the full study included (a) two residents who lived in the Center for less than

6 months, (b) two residents who lived in the Center between 12 to 18 months, and (c) two residents who lived there between 18 to 24 months. (Table 3) summarizes the length of time for each participant in the study.

Length of Time (months)	Frequency	Percent
Less than 6	2	33
12	1	16.7
13	1	16.7
17	1	16.7
24	1	16.7
Total	6	100

Table 3: Summary of the Length of Time in the Center for Each Participant.

I had trouble in recruiting volunteers for the study despite weekly visits to the Center that included visits to the health clinic located in the Center, attendance at the monthly residential family center meetings, and support by the Vice President of Programs, Case Managers, and health clinic staff. This Center was restrictive with regard to families' available time. Families were required to prepare and eat meals at a specified time as well as complete their daily chores and attend the mandatory weekly classes that occurred during the evening hours. The best time for me to meet with participants for this study occurred on Thursday evening between 5:30 p.m. to 9:00 p.m.

Demographics: The mean age for the study group was 34, with an age range of 23 to 45. The educational level for the study group included one participant with a high school equivalent GED, two participants with a technical vocation, and three participants with some college education.

A prerequisite for entry into the Center was that families had children. The average number of children for each participant in the study was two. Children's ages ranged from 1 to 16. The marital status for the study group varied: Four participants were separated from their spouse, one was single, and one was widowed. Studies have identified that the typical homeless parent is a young, unmarried mother with two to three children under the age of 5, had never completed high school, and in most cases dropped out of high school due to pregnancy [5,35]. In this study, all of the participants were women who had graduated from high school, several participants had completed 2 to 3 years of college, and all were serving as the primary breadwinner for their family.

Quantitative Findings

In this section, I examined the data obtained from the PSS that addressed the participants' level of stress (Appendix H). Each participant was asked the 10-item questionnaire from the PSS (Appendix B). Scoring of the PSS was obtained by reversing responses to the four positively stated items in questions number 4, 5, 7, and 8 and then summing across all scale items. As noted earlier, the Likert Scale for the reversed items would read 0 = 4; 1 = 3; 2 = 2; 3 = 1; 4 = 0). A total score of 13 or greater on the PSS was indicative of higher levels of stress; a total score of 12 or less was indicative of lower levels of stress. I used the non-parametric ANOVA Kruskal-Wallis Test to determine if there were any significant differences by the reduced length of time of the participants in the Center. There were no significant differences ($p<=0.05$).

Interpretation and Discussion: Higher levels of stress were noted among residents who lived in the Center for less than 6 months, as well as those residents who lived in the Center over 18 months. Residents living in the Center over 12 months, yet less than 18 months, revealed lower levels of stress when compared to those less than 6 months and those over 18 months. It is a common assumption among health researchers that stressful life events are not, in and of themselves, sufficient causes of pathology and illness behavior [25]. However, prolonged periods of stressful events are assumed to increase the risk of disease if the event is considered as threatening or demanding, and the coping resources are insufficient to address the threat or demand [25].

The adult members in this study were faced with multiple internal and external stressors that triggered other mediating factors to their well-being such as a health condition of hypertension/high blood pressure. Here, three of the six participants had a confirmed diagnosis of high blood pressure/hypertension, and one had a confirmed diagnosis of high blood pressure and an elevated cholesterol level as documented through review of their medical record. Three of the new arrivals to the Center denied having any form of cardiac/heart disease, such as hypertension or high cholesterol; these individuals had lived there for less than 6 months. One of the three participants who denied any form of cardiac/heart disease indicated a recent diagnosis of arthritis. Even though arthritis was not one of the medical conditions associated with the inclusion criteria, the medical condition of arthritis, in itself, is a chronic disease and one of the leading causes of disability associated in old age [24]. The age of this specific participant was 32, and she was already inflicted with a chronic disease at this young age. The debilitating effects of arthritis can place an impact on an individual's knees, hips, and spine and can limit an individual's physical mobility.

Lack of physical mobility, which may include limitations in exercising, can have a direct effect on an individual's cardiovascular system that can lead to cardiac/heart disease due to a sedentary lifestyle because of the detrimental effects of immobility. This participant was included in the study based on possible future alterations or changes that could occur in the individual's health if a strict medical health regime was not implemented early on to ensure full physical mobility. Stress is an important mediator that

can link stressful events to poorer health and health practices. All participants experienced various levels of stress as based on their PSS scores. Factors that can affect blood pressure include race, social environment, and emotional distress [63]. It was suggestive only to associate the participants' state of being homeless, their current environment, and/or their perceived level of stress as contributing factors to their hypertension/high blood pressure.

Qualitative Findings

In this section, I examined and analyzed the respondents' responses to the semi-structured, self-descriptive, open-ended interview questions. The three research questions analyzed were:

Research Question 1: How do homeless adult members perceive readiness for discharge when compared with a transitional living center criterion of readiness?

Research Question 2: How do homeless adult members perceive their readiness for discharge over time?

Research Question 3: What is a homeless adult member's perception of stress and its relationship to his/her health condition with regard to readiness for discharge?

Perceived Readiness for Discharge Compared with the Center's Criteria

The Center's criteria for residents' readiness for discharge was based on participants' successful completion of the 2-year program. Participants were required to save 30% of their monthly earnings as a form of financial security; to attend weekly classes, and to be gainfully employed. The Center provided several services to facilitate the residents toward transition out of their state of homelessness. However, the Center placed the responsibility on the resident. When participants were queried regarding the Center's discharge criteria, they indicated that they were unaware of them. In comparison, they considered themselves ready for discharge when they compared the 2-year program. In this regard, while the respondents focused on one set of criteria, the Center focused on another. For the resident, being ready for discharge meant having a job, being free from debt, and securing a place to live. However, the two participants who lived in the Center for less than 6 months were more focused on getting settled and feeling secure in the Center. One participant shared two major goals that she wanted accomplished prior to her discharge/transition from the Center: One was to divorce her husband and the other was to buy a home. She noted, "I do not want to live in Section 8 housing or an apartment."

Three participants expressed concern regarding their ability to afford health insurance when they transitioned. One with health insurance had 7 months remaining in the Center before her scheduled discharge. All respondents' perceptions regarding readiness for discharge were focused on their current state of homelessness and having a place to live. They openly shared the circumstances that led to their state of homelessness. They identified with one of the top five reasons for becoming homeless: (a) unemployment/ loss of job, (b) inability to pay their rent/mortgage, (c) physical/ mental disabilities, (d) substance abuse/addiction, or (e) family relationships. One respondent shared that she had been abandoned by her spouse, leaving her and their children with no money. Two of the respondents had been in abusive relationships and indicated that "They had nowhere to go"; these respondents lacked any type of family support. The emotions revealed by participants were strong and their perceptions of homelessness came across in many forms. Respondents expressed how it felt being homeless with such statements as (a) "I am very sad," (b) "I am angry," and (c) "I was lost." Several respondents' facial expressions of sadness were quite evident during the interview.

Interpretation and Discussion: In the Center, security meant having 30% of a resident's budget saved every month to ensure the availability of funds toward moving into housing upon discharge/ transition from the Center. In order to have these funds, individuals must be working. Two of the participants indicated that they were looking forward to changing their current employment. For example, H.Z. indicated that she had 33 hours of prerequisites completed toward entering a nursing program and was eager to make the transition. Her only concern was having enough time remaining in the Center to complete her education. L.S. indicated that she was returning to school in the fall to become a medical secretary. She indicated that she had been a certified nursing assistant when she was 19 years old and enjoyed taking care of people. However, she stated she hurt her back and could no longer work in that role. She had one year remaining at the Center and was looking for some type of employment where she could afford health insurance.

The Center required residents to work or be enrolled in school for at least 30 hours a week. Residents had the opportunity to switch jobs and/or enroll in school at their own discretion. The question remaining was "Is there enough time for a resident to save and secure funds for housing and be able to afford health insurance for their family with only 12 months remaining in a transitional living center?" (Table 4) summarizes the discharge criteria for the Center and respondents' perception.

Participant's Readiness for Discharge Over Time

Participants had lived in some type of temporary shelter prior to being approved for residency at the transitional living center. When the participants were asked how they perceived their readiness for discharge over time, the following quotes were made by the participants:

- I now have a place to live. I know I must stay here for the full time (two years) at the Transitional Living and Learning Center and I am okay with this (L. S.).

- It has been fun. They have been helping me. I haven't and didn't know all the help that is out here (F.V.).
- I am not used to it yet. I am used to living my own life, having my own apartment, being on my own. I am not used to having others pay my bills (S.T.).
- I feel like, I do not even know the words - I feel secure here (F.V.).
- I have a place to live; a place for my son to sleep. I am trying to be as normal as possible (L.S.).

Center Criteria for Discharge	RES 1	RES 2	RES 3	RES 4	RES 5	RES 6
LOT in Center	L = Less than 6 mos.	L = Less than 6 mos.	L= 12 mos.	L = 24 mos.	L = 13 mos.	L = 17 mos.
Physiologic Measures			Yes	Yes	Yes	Yes
↓ Blood Pressure	No results	No results				
SBP > 120 mmHg	No results	No results	No	No	Yes	Yes
DBP > 80 mmHg	No results	No results	Yes	Yes	Yes	Yes
↓ Cholesterol level	No results	No results	Yes	Yes	No results	No results
Chol > 240 mg/dL	No results	No results	Yes	Yes	No results	No results
Social Measures						
All bills paid Educational/ Work Skills	No	No	Yes	Yes	No	Yes
Gainfully employed or in school	Yes	Yes	Yes	Yes	Yes	Yes
Parenting Skills Family and child security	Yes	Yes	Yes	Yes	Yes	Yes
Universal Imperatives	27	29	12	22	1	11
PSS score						

Note. From a physiological perspective, successful transition from the Center includes a decrease in blood pressure and cholesterol levels and being stress free. From the Center's perspective regarding a successful transition, a resident must complete the full 2-year program, be financially secure, and be either gainfully employed or enrolled in school. From the respondents' perspective regarding a successful transition, they perceived feeling safe and secure for themselves and their family. The letter "L" denotes length of time in the Center. Universal imperatives refer the Perceived Stress Level scale and the score achieved by the resident.

Table 4: Summary of Center Criteria for Discharge and Respondents' Perceptions.

Interpretation and Discussion: These responses were consistent with those found in the residents' responses. Studies showed that individuals living in transitional housing have reported positive outcomes across multiple domains [53]. Some key themes included (a) feeling secure and proud, (b) adjusting to living alone, and (c) developing meaningful activity. Table 4 showed that Resident 4 was ready for discharge. Participants' perception of stress as it relates to heart condition. When participants were asked how they perceived their level of stress in relation to their heart condition, such as hypertension following discharge from the Center, two of the six participants openly expressed concern based on lack of health insurance. Chronic diseases or illnesses and stress may cause someone to lose work and not have the financial means to support his or her family [25,64].

Three Participants had a History of Hypertension: Two had a confirmed diagnosis of hypertension prior to entry into the Center; one had hypertension for 4 years and the other over 13 years. The one specific participant with hypertension for 13 years was diagnosed with this heart condition in 2002. In 2013, this participant's highest blood pressure reading was recorded at 190 over 110; this is a serious case of hypertension. This resident entered the Center in the summer of 2013. This participant's blood pressure, at the time of data collection, was 138 over 78 on the date of our interview - a considerable improvement. This finding may suggest one effective outcome of the Center's program. A primary criterion in my conceptual framework regarding successful discharge from the Center was a decrease in participants' blood pressure readings. This specific participant was scheduled to transition from the Center within a few weeks of my interview. However, she said she was worried as she knew she would be unable to receive health care in the clinic after discharge due to her lack of health insurance. The aftercare services do not provide medical coverage.

Another participant experienced both hypertension and an elevated cholesterol level; both of these heart conditions were long-standing and were being controlled with medication. At the time of my interview, this participant had a blood pressure reading of 119 over 73 and a cholesterol level of 199. Both of these readings were considered normal and suggests an effective result of the Center's interventions. Another area of concern or stress involved the participants' desire to change jobs or start formal schooling with less than 12 months remaining in the Center. For people experiencing homelessness, a stable source of income and opportunities to build assets are necessary for securing and maintaining housing [3]. Security is a feeling of certainty that everything is all right and that all of one's basic needs are met. Maslow's hierarchy of needs suggests that safety and security must be achieved prior to meeting love and belonging [24].

Interpretation and Discussion: Homeless mothers/women experience higher rates of major depression disorders compared with the general population [43]. It was evident during the interview that all of the women had experienced some form of depression. A respondent expressed being sad and having no family support. This particular respondent had experienced loss of family support on several levels. She had been married for only 3 days when her spouse was arrested, jailed, and later deported. Once she was no longer with her husband, she moved back home with her biological father and stepmother. The respondent shared that she and her stepmother did not get along, and the participant was asked to leave that home. Finally, the respondent indicated that she had located and made contact with her biological mother. This respondent lived with her biological mother for one week and then left due to her biological mother's alcoholism. Homeless people feel displaced, sad, angry, alone, and hopeless. Many of the women who participated in this study expressed all of those emotions. These respondents' emotional accounts were consistent with those found in the literature [8,39,64].

Women are at a greater risk for homelessness due to the need to escape physical and mental abuse and domestic violence in their household. A participant shared that she had to abandon her abusive relationship, and this was how she became homeless. The respondent stated, "I have been homeless for one month. My husband was abusive to me and my children." This participant was not working and had three children ages 1, 2, and 8 years old. This respondent was indeed living in a stressful situation, yet her blood pressure was within the normal range (below 120 mm Hg and below 80 mm Hg). Stressful events may increase the risk or threat of a disease when coping resources are insufficient to address the threat [25]. This participant's entry into the Center was timely based on her stressful situation.

Summary

Concerning the three research questions, the residents' perceived readiness for discharge were incongruent with the Center's criteria. The Center focused on the residents completing a 2-year program, being financially secure, and gainfully employed or in school as key factors toward being ready for discharge, while the respondents' major foci were being safe and secure. Residents over time experienced higher levels of stress when approaching completion of the 2-year program. Residents' perceived feeling secure, having order and structure in their lives, and obtaining housing upon discharge as their priority. Residents valued the importance of having good health; however, it was not perceived as a key contributing factor toward discharge from the Center.

Summary, Conclusions, and Recommendations

Summary

The purpose of this descriptive study was to examine the perception of readiness for discharge and return to mainstream society after being homeless and residing in a transitional living center (Center) among selected adult members of homeless families. The selected members in this study were diagnosed with a cardiac/heart condition that included a medical condition such as high blood pressure (readings greater than 120/80 mm Hg), and/or elevated cholesterol levels (level higher than 240 mg/dL). The conceptual framework was developed around three major constructs: (a) being homeless, (b) undergoing severe stress, and (c) being ready for discharge from a transitional living center. The final sample for this study included six participants who had resided in the Center during the following timeframe: Two participants resided there for less than 6 months, two participants resided there between 12 to 17 months, and two participants resided there between 18 to 24 months. Even though participants lived in the Center during the three specified periods of time, a missed opportunity existed for interviewing residents who resided at the Center between 6 to 12 months; I did not have any participants volunteer to participate in the study during that timeframe.

Homeless people are in a dismal situation when faced with finding employment, affordable housing, and access to health care. Family homelessness is one of the fastest growing segments of the homeless population. In America, more than 1.6 million children or one in 45 are homeless annually. In 2013, there were 30,000 people who were classified as homeless living in Texas. In the city of San Antonio where my study was conducted, 30% of the homeless were classified as families. San Antonio had 20 shelters available for homeless people at the time of data collection. However, these shelters only provided short-stay living accommodations, ranging from one day to a week, for homeless individuals or families. The Center where my study was conducted was the only facility in San Antonio that allowed families to reside up to 24 months and that is why I selected that facility. The preconceived idea that the typical homeless parent is a young, unmarried mother with two or three children, who had never completed high school, and may have

dropped out of school because of pregnancy is not necessarily the case based on the outcome of this study. In this study, the mothers were mature adults, served as the primary breadwinner of their family, well-educated, and gainfully employed with a career-oriented focus. The mean age of the women participating in this study was 34 years, and all were high school graduates with at least 2 to 3 years of college. However, all of the women were impacted by certain life-altering changes that caused overwhelming stress to their lives.

Such life-changing stressors included either the death of spouse or family member, being divorced or separated, being fired from work, and/or experiencing some type of personal injury/illness. The biggest stressor conveyed by all of the participants was their goal of providing a safe and secure environment for their children. The PSS questionnaire showed that residents were more stressed in the early months and later months during their time in the Center when compared with the period between these two time periods. All the residents participated in the same weekly life-skill classes at the Center regardless of their length of time in the Center. An opportunity may exist to develop individualized programs for residents at various stages of their readiness for discharge while residing in a transitional living center. Due to the small sample size, it is debatable if the specific length of time in the Center was related to a measure of stress. However, a Harris Poll conducted in 1983 with 2,387 respondents showed that normal stress levels based on gender, age, and race were not reflective of homeless people with a medical condition [25].

The medical clinic that was open one day a week at the Center was visited by the adult members with their children. Health visits by the adult members in the Center were limited. Three of the six study participants had regular visits to the medical clinic due to their health condition of having high blood pressure. However, health services were not available to residents after they were discharged from the Center. Residents were required to seek health care outside the Center. It has been demonstrated that therapeutic lifestyle changes have the potential to decrease the morbidity and mortality associated with hypertension through such interventions as smoking cessation and nutrition classes, physical activity, and exercise. However, therapeutic lifestyle changes may be difficult for homeless people to implement due to conflicting priorities [52]. Homeless people perceived having shelter as a key priority. For the participants in this study, being secure, experiencing order and ensuring structure to their lives, and obtaining housing were their most important factors. With regard to the participants' health condition, their level of stress due to their homelessness may have been a contributing factor to their high blood pressure, but their heart condition was not the cause of their homelessness.

Conclusions

Based on a review of findings, the following conclusions were made. The Center selected for this study provides a valued service to the residents living there. The Center has a well-designed 2-year plan to track residents' progress; however, the plan is not resident centric in that the Center's criteria for discharge (success) were not fully known to the respondents. Based on the thematic data, quantitative and qualitative, residents experienced and perceived increased levels of stress upon transitioning out of the Center. The PSS was chosen based on its simplicity for interpretation and adequately measured the degree of stress in the residents' lives, yet there were limited questions regarding the health of the residents. It was surprising to find participants who were within 2 weeks of transitioning from the Center with higher levels of stress than those participants just entering the Center. In this regard, the Center appears in need of individualized plans to address the varied and specific health requirements of residents. Based on this summary and conclusions, the following recommendations are offered.

Recommendations

- Replicate this study with a larger sample size including more participants in each of the varied, specified period of less than 6 months, 6 to 12 months, 13 to 18 months, and 18 to 24 months.
- Create individualized plans in the transitional living center aimed at targeting residents who are just entering the program and a separate plan for residents who are at one year and beyond from discharge from the Center.
- Design a Perceived Stress Scale with items appropriate for a vulnerable population, such as homeless persons, and develop measures to link ongoing assessments of stress with interventions used to address health and cardiac-related conditions.
- Orient residents on entry into the transitional living center of the Center's goals for successful transition.
- Recommend a cut-off time for residents changing jobs or returning to school when there is less than 12 months remaining on their contract in the transitional living center.
- Address aftercare services upfront to residents to ensure that the physical, emotional, social, and environmental needs are met by the resident prior to discharge.
- Examine community approaches to post-discharge health care.

Appendixes (A-H)

Appendix A

Data Collection Instrument

Background Information for Adult Family Members

Purpose: The purpose of this document is to provide background about the adult family members who were selected as part of this study.

Instructions: Please provide an answer to items 1.1., and 1.2. For the remaining items, please insert a check mark (√) in the space provided. Leave no blanks. Please return this form with your signed copy of the Information Consent document.

Scoring: Obviously, there is no right or wrong answer to any of the items.

Part 1:

1.1. Age _____;

1.2. Sex: Male _____; Female _____

1.3. Heart Disease (check mark -√) (Yes or No)

Hypertension: Yes: _____ No: _____

(High blood pressure) Length of time I have had hypertension: Years: ____ Months: ____

High cholesterol level: Yes: _____ No: _____

Length of time I have had a high cholesterol level: Years: _____ Months: _____

3. Race/ethnicity (check mark - √)

American Indian or Alaska Native _____

Hawaiian or Another Pacific Islander _____

Asian or Asian American _____

Black or African American _____

Hispanic or Latino _____

Non-Hispanic White _____

Other _____ (please specify)

1.4. Marital status (check mark - √)

Married _____

Divorced _____

Widowed _____

Separated _____

Never been married _____

Other _____ (please specify)

1.5. Current job situation:

Right now, I am working at a job for wages: Yes: _____ No: _____

I work as (identify job type): _____

I work (number of hours per week): _____

I have worked at this current job for: Weeks: _____ Months: _____

1.6. Educational level (check mark - √)

Never attended school _____

Attended Grades 1 through 8 (Elementary) _____

Attended Grades 9 through 11 (Some High School) _____

Attended Grades 12 or GED (High School Graduate) _____

Attended College 1 to 3 years (Some College or Technical School) _____

Attended 4 years of College or more _____

Thank You for Completing This First Part of the Study!

Appendix B

Data Collection Instrument

Perceived Stress Scale

Perceived Stress Scale

Purpose: The purpose of this Perceived Stress Scale Data Collection Instrument is to elicit information from homeless adult members regarding their feelings, thoughts and stressors during the last month.

Confidentiality Agreement: By signing the Informed Consent document and by participating in this interview, you indicate your willingness to participate in this study and understand the agreement concerning confidentiality.

Instructions: There is no right or wrong answers. Your thoughtful and full responses to the questions are appreciated. This scale asks you about your feelings, thoughts, and stressors during the last month. I will ask you each of the questions, and then I will indicate your response by circling how often you felt or thought a certain way.

Perceived Stress Scale

0=Never 1=Almost Never 2=Sometimes 3=Fairly Often 4=Very Often

1	In the last month, how often have you been upset because of something that happened unexpectedly?	0	1	2	3	4
2	In the last month, how often have you felt you were unable to control the important things in your life?	0	1	2	3	4
3	In the last month, how often have your felt nervous and “stressed”?	0	1	2	3	4
4	In the last month, how often have your felt confident about your ability to handle your personal problems?	0	1	2	3	4
5	In the last month, how often have you found that things were going your way?	0	1	2	3	4
6	In the last month, how often have your found that you could not cope with all the things that you had to do?	0	1	2	3	4
7	In the last month, how often have you been able to control irritations in your life?	0	1	2	3	4
8	In the last month, how often have your felt that you were not on top of things?	0	1	2	3	4
9	In the last month, how often have you been angered because of things that were outside of your control?	0	1	2	3	4
10	In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	0	1	2	3	4

Format of Interview: 1.Face to face _____ 2.Go To Meeting____ 3.Telephone_____ 4.Skype_____ 5.Focus group__ ___ Respondent does; do not___; request a summary of the study.	Start time: _____ End time:_____ Total time:_____(In minutes)

Appendix C

Data Collection Instrument

Interview with Adult Family Members

Purpose: The purpose of this interview protocol is to document adult members' perception with regard to their readiness for discharge from a transitional living and learning center.

Confidentiality Agreement: By signing the Informed Consent document and by participating in this interview, you indicate your willingness to participate in this study and understand the agreement concerning confidentiality.

Instructions: Over the next one hour, I invite you to share your perceptions. I am interested in learning how you see yourself being ready for discharge from this Center.

Scoring: There is no right or wrong answers. Your thoughtful and full responses to the questions are appreciated.

Part 1: Background Information (completed by participant)

Part 2: Interview Items

Open-Ended Questions: Being Homeless

RQ 2.1: How long have you been homeless?

How did this happen?

What circumstances have contributed to being homeless?

What is this like for you?

What is it like for your _____ (insert each member name)?

RQ 2.2: So, what was it like for you during the beginning (first six months)?

- People during the 1st six months at the transitional living center
- People during the 6th until 18th month at the transitional living center
- People during the 18th until 24th month at the transitional living center
- So, what was it like for other members in your family?
- During their first six months?

RQ 2.3. Since your time in the Center, have your feelings changed?

When?

How?

So, after all this time, do you feel ready for discharge?

If so, what got you there?

If not, what happened - what prevented this from happening?

Open-Ended Questions: Undergoing Severe Stress

RQ 2.4: What is the adult members' perception of stress? (This questionnaire will be given at the start of the interviewing process - when I first meet with the family member).

- 10-Item Questionnaire from the Perceived Stress Scale

RQ 2.5: Has being here been tough on you? How so, please describe.

What services at the transitional center are being provided to you?

What services at the transitional center are you using?

How have you managed your heart condition while being here? How so, please describe.

How have you managed your high blood pressure while being here? How so, please describe.

How have you managed your high cholesterol level while being here? How so, please describe.

Open-Ended Questions: Readiness for Discharge

RQ 2.6: Since being here, have you seen a change in your blood pressure readings? If so, is your blood

pressure readings the same; or lower or higher?

Since being here, have you seen a change in your cholesterol levels? If so, is your cholesterol level the same; or lower or higher?

How have the services that were provided at the transitional center assisted you?

What stressors do you feel that you have resolved?

What stressors still exist for you?

How do you perceive that you will cope with those existing stressors?

How does the transitional center determine that you are ready for discharge?

What do you think of these criteria for determining if you are ready for discharge?

How do you perceive yourself as ready for discharge from the transitional center?

So, how do you stand when thinking about these criteria items for discharge from the Center?

Appendix D

Letter to Vice President of Programs, San Antonio Metropolitan Ministries, Inc.

Spring 2015

Ms. Anna Vidaurri

Vice President of Programs

San Antonio Metropolitan Ministries, Inc.

5454 Blanco Road

San Antonio, TX 78216

Dear Ms. Vidaurri:

I am currently a doctoral student completing my dissertation at Fielding Graduate University located in Santa Barbara, California. My research study is entitled, Health Factor Readiness to Successful Reentry Among a Sample Group of Homeless Families Return to the Mainstream Society. I would like to conduct my study among a group of adult family members residing at a Transitional Living and Learning Center. The adult family members selected for this study must have a documented health history of heart disease. The heart disease health condition may include adult family members identified with either high blood pressure, diagnosed with coronary heart disease, being overweight, and/or having an elevated blood cholesterol level. Upon approval by the Institutional Review Board (IRB) of Fielding Graduate University, I would like to start my data collection during the month of April 2015. My goal is to complete my data collection by mid-May 2015.

Attached is a Letter of Introduction for the families residing at the SAMM Transitional Living and Learning Center to participant in this research study. Request that a copy of this Letter of Introduction be provided to each family during your monthly residential meeting. I will require between 9 to 15 research participants for my study. Three family members will be used as part of my Pilot Study. The remaining number of participants will serve as my sample group of families for my dissertation. I only require one adult member per family to meet my inclusion criteria. I am most interested in the family member that meets my inclusion criteria who is the "Wage-earner or bread-winner" for the family. This research study will require one hour of the participant's time. I will conduct a one-on-one interview, gaining approval by the selected family member to audio/tape record his/her responses to my interview questions.

Those adult family members identified who meet the inclusion criteria and selected for this study will be contacted by me. I will coordinate a date and time to conduct the individual interviews with the selected participants. All interviews will occur at the Transitional Living and Learning Center in a secured and protected area. Adult family member's participation in this research is confidential. Their participation will not be anonymous; however, their responses will not be attached to them. In the written dissertation, no respondent will be identified by name. Participants' are free to decline participation or if they do agree they can redraw at any time without penalty. If they choose to be a part of this study, I will provide each adult family member with an informed consent form which will require their signature. Enclosed is a copy of the Informed Consent Form.

If you have any questions, please do not hesitate in contacting me at (XXX) XXX-XXXX. I greatly appreciate your time and opportunity to conduct my research study at your facility.

Sincerely,

Lark A. Ford, MA, MSN, RN

Doctoral Student

Fielding Graduate University

Appendix E

Informed Consent for Homeless Adult Family Members

Summer 2015

Dear Study Participant (Insert Name):

I am writing to you to request your participation in a research study I am conducting as a doctoral student at the Fielding Graduate University School of Human and Organizational Development, Santa Barbara, California.

This mixed, part descriptive, part quantitative study focuses on your views of being ready for discharge from a transitional living and learning center.

The study involves you for one session for one hour. During the hour, I will talk with you about your situation and your time at the Center and your views about your health.

The Institutional Review Board of Fielding Graduate University retains access to signed informed consent forms. The information that you provide will be kept strictly confidential. Your responses will be kept confidential as they will not be attached to any name. While others may know that you are participating in this study, no will know what you say.

You will be assigned a number that I will use to track any quotes that might be included in the final research study. You will have the opportunity to review the typed notes of your responses and make corrections, additions or subtractions. No one will know what responses may be attributed to you. I will be the only person conducting the interview with you and recording your responses. So what you say will be confidential.

All the related research materials and any documentation related to this study will be kept in a secure file cabinet and available only to me as the principal investigator. I will destroy the files after three years after the completion of the study. The results of this research will be published in academic journals, books, or papers.

I hope that you consider this an important study and view your contribution as a positive one to the advancement of research in this field. I believe that the risks to you are minimal; there is only a small chance that you may experience some uneasiness in sharing the circumstances that brought you here to the transitional living and learning center. At any time during my interview, if you feel uncomfortable, please do not hesitate in letting me know.

You may withdraw from this study at any time without negative consequences. Should you

withdraw, your data will be destroyed and eliminated from the study.

This study is voluntary and there is no obligation to participate. There is no financial remuneration for participating in this study. You may request a copy of the study's summary by indicating your interest on this form.

If you have questions at any time, you may contact me by phone at XXX-XXX-XXXX, or by email at laford@email.fielding.edu

Two copies of this Informed Consent form have been provided. Please sign both, indicating that you read, understood, and agreed to participate in this research. Return one copy to me and keep the other one. The Institutional Review Board of the Fielding Graduate University retains access to signed informed consent forms.

_____

Name of Participant (please print) Telephone Number

_____

Signature of Participant Date

_____ _____

Yes, please send a summary of the study results to me at:

_____

Street Address

City, State, Zip

THANK YOU FOR COMPLETING THIS FIRST PART OF YOUR PARTICIPATION IN THIS STUDY!!

Appendix F

Letter of Introduction

Dear Resident of the SAMM Transitional Living and Learning Center,

I am a doctoral student at Fielding Graduate University located in Santa Barbara, California and I would like to invite you to participant in research study that I am conducting at a Transitional Living and Learning Center between April and June, 2015. My research study is evaluating how you perceive your health readiness toward discharge from a Transitional Living and Learning Center. Research studies are done to answer a question. I have several questions that I will ask you. In addition, I would like to tape record your responses so that I can capture all of your responses. The time commitment for this study will require one hour of your time during the interview process. All interviews will occur at a Transitional Living and Learning Center in a secured and protected area. Adult family member's participation in this research is confidential. In my written dissertation, you will not be identified by name. You are free to decline at any time during this study without penalty.

The reason that I want to know about your health readiness toward discharge from the Transitional Living and Learning Center is based on the lack of research studies that have addressed this matter. An individual's health and well-being are very important. Poor health can reduce the quality of life of among individuals, as well as increases the risks for many other serious chronic diseases and premature deaths, such as coronary artery disease.

Taking part in the research study is voluntary. I am looking for participants with the following known health condition:

Diagnosed with a heart condition, such as coronary artery disease (pain in your chest when exercising or walking upstairs that goes away with rest)

High blood pressure of 120/80 or higher

High cholesterol level of 240 or higher

If you are interested in participating in this research study, please contact me by April 30th, 2015 at the following number: (XXX) XXX-XXXX - please leave your name and telephone number so that I may return your call or E-mail: laford@email.fielding.edu

Sincerely

Lark A. Ford, MA, MSN, RN

Doctoral Student

Fielding Graduate University

Appendix G

Homeless Families Return to Mainstream Society Code Book©

Lark A. Ford, MA, MSN, RN

Interview Protocol	CODE
Age	
18-29	1.1
30-44	1.2
45-54	1.3
55-64	1.4
65 & older	1.5
Sex	
Male	2.1
Female	2.2
Heart Disease	
Hypertension	3.1
Elevated Cholesterol	3.2
Length of time with high blood pressure (write out)	3.3
Length of time with elevated cholesterol (write out)	3.4
Race/Ethnicity	4.1
American Indian or Alaska Native	4.2
Hawaiian or Pacific Islander	4.3
Asian or Asian American	4.4
Black or African American	4.5
Hispanic or Latino	4.6
Non-Hispanic White	4.7
Other	4.8
Marital Status	5
Married	5.1
Divorced	5.2
Widowed	5.3
Separated	5.4
Never been married	5.5
Other	5.6

Current Job	Spelled-out
Educational Level	
Attended Grades 1 through 8 (Elementary)	7.1
Attended Grades 9 through 11 (Some High School)	7.2
Attended Grades 12 or GED (High School Graduate)	7.3
Attended College 1 to 3 years (Some College or Technical School)	7.4
Attended 4 years of College or more	7.5
RQ1: How do homeless adult members perceive readiness for discharge when compared with a transitional living center criterion of readiness?	
Probe questions:	
How long have you been homeless?	8.1
How did this happen?	8.2
What circumstances have contributed to you being homeless?	8.3
What is it like for you?	8.4
What is it like for your family members?	8.5
RQ2: How do homeless adult members perceive their readiness for discharge overtime?	
Probe questions:	
So, what was it like for you during the beginning?	9.1
People during the 1st six months at the transitional living center.	9.2
People during the 6th until 18th month in the transitional living center.	9.3
People during the 18th until 24th month in the transitional living center.	9.4
So, what was it like for other members in your family?	9.5
Then how did these feelings, ideas change overtime?	9.6
When?	9.7
How?	9.8

RQ 3: What is a homeless adults members' perception of stress and its relationship to his/her health condition with regard to readiness for discharge?	10.1
Probe questions:	10.2
Has being here in the Center been tough on you?	10.3
How - describe?	
How have the services that were provided at the transitional center assisted you?	10.4
How have you managed your high blood pressure?	10.5
Have you noticed a change in your blood pressure?	10.6
When?	10.7
How?	10.8
How have you managed your high cholesterol level?	10.9
Have you noticed a change in your cholesterol level?	10.1
When?	10.11
How?	10.12
What stressors do you feel that you have resolved?	10.13
What stressors still exist for you?	10.14
How does the transitional center determine that you are ready for discharge? What do you think of these criteria for determining if you are ready for discharge?	10.15
So, how do you stand when thinking about the criteria for discharge from the transitional center?	10.16

Appendix H

Shelter/Perceived Stress Study

Kruskal-Wallis Non-Parametric Test for Differences in the Perceived

Stress Score and Items by Reduced LOT in Center

Ranks				
		Reduced LOT in Center	N	Mean Rank
	pssc Perceived Stress Score - Computed	0 LT 6 Mo.	2	5
		1 12 - 13 Mo.	2	2.5
		2 17 - 24 Mo.	2	3
		Total	6	
	Pss01 In the last month, how often have you been upset because of something that happened unexpectedly?	0 LT 6 Mo.	2	4
		1 12 - 13 Mo.	2	4
		2 17 - 24 Mo.	2	2.5
		Total	6	

	Pss02 In the last month, how often have you felt that you were unable to control the important things in your life?	0 LT 6 Mo.	2	4.75
		1 12 - 13 Mo.	2	2.5
		2 17 - 24 Mo.	2	3.25
		Total	6	
	Pss03 In the last month, how often have you felt nervous and stressed?	0 LT 6 Mo.	2	5.5
		1 12 - 13 Mo.	2	2.75
		2 17 - 24 Mo.	2	2.25
		Total	6	
	Rpss04 Reversed: In the last month, how often have you felt confident about your ability to handle your personal problems?	0 LT 6 Mo.	2	5
		1 12 - 13 Mo.	2	2.75
		2 17 - 24 Mo.	2	2.75
		Total	6	
	Rpss05 Reversed: In the last month, how often have you felt that things were going your way?	0 LT 6 Mo.	2	3.5
		1 12 - 13 Mo.	2	3.5
		2 17 - 24 Mo.	2	3.5
			Total	6
	Pss06 In the last month, how often have you found that you could not cope with all of the things that you had to do?	0 LT 6 Mo.	2	5
		1 12 - 13 Mo.	2	2.75
		2 17 - 24 Mo.	2	2.75
		Total	6	
	Rpss07 Reversed: In the last month, how often have you been able to control irritations in your life?	0 LT 6 Mo.	2	4.5
		1 12 - 13 Mo.	2	2.25
		2 17 - 24 Mo.	2	3.75
		Total	6	
	Rpss08 Reversed: In the last month, how often have you felt that you were on top of things?	0 LT 6 Mo.	2	3.75
		1 12 - 13 Mo.	2	3
		2 17 - 24 Mo.	2	3.75
		Total	6	
	Pss09 in the last month, how often have you been angered because of things that were outside of your control?	0 LT 6 Mo.	2	5.5
		1 12 - 13 Mo.	2	2.75
		2 17 - 24 Mo.	2	2.25
		Total	6	
	Pss10 in the last month, how often have you felt difficulties piling up so high that you could not overcome them?	0 LT 6 Mo.	2	4
		1 12 - 13 Mo.	2	3.25
		2 17 - 24 Mo.	2	3.25
		Total	6	

Test Statistics[a,b]			
	Chi-Square	df	Asymp. Sig.
pssc	2.059	2	0.357
pss01	0.968	2	0.616
pss02	1.591	2	0.451
pss03	3.712	2	0.156
rpss04	2.25	2	0.325
rpss05	0	2	1
pss06	2.25	2	0.325
rpss07	1.591	2	0.451
rpss08	0.25	2	0.882
pss09	3.603	2	0.165
pss10	0.25	2	0.882
a. Kruskal Wallis Test; b. Grouping Variable: lotr			

References

1. Bagget TP, O'Connell JJ, Singer DE, Rigotti N (2010) The unmet health care needs of homeless adults. A national study. American Journal of Public Health 100: 1326-1333.
2. Laird G (2007) Homelessness in a growth economy: Canada's 21st century paradox: A Report for the Sheldon Chumir Foundation for Ethics in Leadership.
3. National Alliance to End Homelessness (2008) Legislative updates: McKinney-Vento reauthorization.
4. Gaetz S (2012) The real cost of homelessness: Can we save money by doing the right thing? Toronto, Canada: Canadian Homelessness Research Network Press. Pg N: 1-19.
5. Swick KJ (2004) The dynamics of families who are homeless: Implications for early childhood educators. Childhood Education 80: 116-121.
6. Mayberry LS (2014) Families experiencing housing instability: The effects of housing programs on family routines & rituals. American Journal of Orthopsychiatry 84: 95-109.
7. Henwood BF, Hsu H, Dent D, Winetrobe H, Carranza A, et al. (2013) Transitioning from homelessness: A "Fresh-Start" event. Journal of the Society for Social Work and Research 4: 47-57.
8. Maycock P, Corr ML, O'Sullivan E (2011) Homeless young people, families and change: Family support as a facilitator to exiting homelessness. Child & Family Social Work 16: 391-401.
9. Kurtz PD, Jarvis S, Lindsey EW, Nackerud L (2000) How runaway and homeless youth navigate troubled waters: The role of formal and informal helpers. Child and Adolescent Social Work Journal 17: 381-402.
10. National Coalition for the Homeless (2009) How many people experiences homelessness.
11. Mares AS, Rosenheck R (2010) Twelve-month client outcome and service use in a multisite project for chronically ill homeless adults. Journal of Behavioral Services & Research 37: 167-183.
12. Coalition for the Homeless (2014) State of the homeless 2014 turning point: Amidst unprecedented homelessness - a new focus on housing can turn the tide.
13. Upshur CC, Weinreb L, Cheng DM, Kim TW, Samet JH, et al. (2014) Does experiencing homelessness affect women's motivation to change alcohol or drug use? The American Journal on Addictions 23: 76-83.
14. National Center on Family Homelessness (2011) America's youngest outcasts 2010.
15. Centers for Disease Control and Prevention (2014) Percentages of persons whose health status was assessed as □Poor.□ OECD Health Statistics 2014.
16. Kushel MB, Vittinghoff EE, Hass JS (2001) Factors associated with the health care utilization of homeless people. Caring for the uninsured and underinsured. JAMA 285: 200-256.
17. Wright NMJ, Tompkins CNE (2006) How can health services effectively meet the health needs of homeless people? The British Journal of General Practice 56: 286-293.
18. Heron M (2013) U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. National Vitals Statistics Report 62: 1-97.
19. Jones CA, Perera A, Chow M, Ho I, Nguyen J, et al. (2009) Cardiovascular disease among the poor and homeless - what we know so far. Current Cardiology Review 5: 69-77.
20. Beijer U (2009) Homelessness and health: Analysis of mortality and morbidity from a gender perspective. Stockholm Sweden: KarolinskaInstitutet.
21. Wiersma P, Epperson S, Terp S, Lacourse S, Flinton B, et al. (2010) Episodic illness, chronic disease, and health care among homeless persons. South Medical Journal 103: 18-24.
22. O'Toole TP, Conde-Martel A, Gibbon JL (2007) Where do people go when they first experience homelessness? A survey of homeless adults in the USA. Health and Social Care in the Community 15: 446-453.
23. Selye H (1956) The stress of life. New York, NY: McGraw-Hill.
24. Linton AD (2012) Introduction to medical-surgical nursing. St. Louis, MO: Elsevier-Saunders.
25. Cohen S, Williamson G (1988) Perceived stress in a probability sample of the United States. In: Spacapan S, Oskamp S (Editors). The social psychology of health Newbury Park CA: Sage 6: 31-67.
26. Carlson M, Dragomir C, Earls F, Farrell M, Macovei O, et al. (1995) Effects of social deprivation on cortisol regulation in institutionalized Romanian infants. Society for Neuroscience Abstracts 218: 12.
27. World Health Organization (1974) International health regulations (1969): Second annotated edition. Geneva, Switzerland: Author.
28. Go AS, Mozaffarian D, Roger VL, Benjamin EJ, Berry JD, et al. (2014) Heart disease and stroke statistics - 2014 update: A report from the American Heart Association. Circulation 129: 28-292.
29. Prochaska JO, Norcross JC, Diclemente CC (1994) Changing for good. New York, NY: Avon Books.
30. Cheung AM, Hwang SW (2004) Risk of death among homeless women: A cohort study and review of literature. CMAJ 170: 1243-1247.
31. Fazel S, Geddes JR, Kushel M (2014) The health of homeless people in high-income countries: Descriptive epidemiology health consequences, and clinical and policy recommendations. The Lancet 384: 1529-1540.

32. Mcquistion H, Gorroochurn P, Hsu E, Caton CR (2014) Risk factors associated with recurrent homelessness after a first homeless episode. Community Mental Health Journal 50: 505-513.

33. Toro PA, Hobden KL, Wyszacki Durham K, Oko-riebau M, Bokszczanin A (2014) Comparing the characteristics of homeless adults in Poland and the United States. American Journal of Community Psychology 53: 134-45.

34. National Center on Family Homelessness-San Antonio. (2011) New report: Homeless children on the rise.

35. Ponce AN (2014) Homelessness, behavioral health disorders and intimate partner violence: Barriers to services for women. Community Mental Health Journal 50: 831 - 840.

36. Wilson AB, Squires J (2014) Young children and families experiencing homelessness. Children and Youth Services Review 44: 145-151.

37. Lee SS, August GJ, Gerwirtz AH, Klimes-Doughan B, Bloomquist ML, et al. (2010) Identifying unmet mental health needs in children of formerly homeless mothers living in a supportive housing community sector of care. Journal of Abnormal Child Psychology 38: 421-432.

38. Henwood BF, Cabassa LJ, Craig C, Padgett D (2013) Permanent supportive housing: Addressing homelessness and health disparities? American Journal of Public Health 103: 188-192.

39. Holtrop K, McNeil S, McWey LM (2015) "It's a struggle but I can do it. I'm doing it for me and my kids": The psychosocial characteristics and life experiences of at-risk homeless parents in transitional housing. Journal of Marital and Family Therapy 41: 177-191.

40. Page S, Larner M (1997) Introduction to AFDC. The Future of Children Welfare to Work 7: 20-27.

41. Thomas Y, Gray MA, McGinty S (2012) An exploration of subjective wellbeing among people experiencing homelessness: A strengths-based approach. Social Work in Health Care 51: 780-797.

42. Nguyen CM, Liu WM, Hernandez JO, Stinson R (2012) Problem-solving appraisal, gender role conflict, help-seeking behavior, and psychological distress among men who are homeless. Psychology of Men & Masculinity 13: 270-282.

43. Bassuk EL, Beardslee WR (2014) Depression in homeless mothers: Addressing an unrecognized public health issue. American Journal of Orthopsychiatry 84: 73-81.

44. Tsai J, Rosenheck RA, McGuire JF (2012) Comparison of outcomes of homeless female and male veterans in transitional housing. Community 48: 705-710.

45. Hinton S, Cassel D (2013) Exploring the lived experiences of homeless families with young children. Early Childhood Education Journal 41: 457-463.

46. Burt M, Aron LY, Lee E, Valente J (2001) Helping America□s homeless: Emergency shelter or affordable housing? Washington, DC: Urban Institute Press.

47. Caton CLM, Wilkins C, Anderson J (2007) Towards understanding homelessness: The 2007 National Symposium on Homelessness Research. People who experience long-term homelessness: Characteristics and interventions.

48. Calcaterra S, Beaty B, Mueller S, Min SJ, Binswanger J (2014) The association between social stressors and drug use/hazardous drinking among former prison inmates. Journal of Substance Abuse Treatment 41: 41-49.

49. Medlow S, Klineberg E, Steinbeck K (2014) The health diagnoses of homeless adolescents: A systematic review of the literature. Journal of Adolescence 37: 531-542.

50. Hwang SW, Orav EJ, O'Connell JJ, Lebow JM, Brennan TA (1997) Causes of death in homeless adults in Boston. Annual of Internal Medicine 126: 625-628.

51. Kim DH, Daskalakis C, Plumb JD, Adams S, Brawer R, et al. (2008) Modifiable cardiovascular risk factors among individuals in low socioeconomic communities and homeless shelters. Family Community Health 31: 269-280.

52. Moczygemba LR, Kennedy AK, Marks SA, Goode JR, Matzke GR (2013) A qualitative analysis of perceptions and barriers to therapeutic lifestyle changes among homeless hypertensive patients. Research in Social & Administrative Pharmacy 9: 467-481.

53. Patterson ML, Currie L, Rezansoff S, Somers JM (2014) Exiting homelessness: Perceived changes, barriers, and facilitators among formerly homeless adults with mental disorders. Psychiatric Rehabilitation Journal 38: 81-87.

54. Richardson BB, Landsman MJ (1996) Community response to homelessness: Evaluation of the HACAP Transitional Housing Program. Final report. Clearinghouse on Elementary and Early Childhood Education 1-113.

55. Lutze FE, Rosky JW, Falconer S (2011) Washington State's Reentry Housing Pilot Program evaluation: Year 3 final report. Spokane: Washington State University.

56. Lee BA, Price-Spratlen T (2004) The geography of homelessness in American communities: Concentration or dispersion? City and Community 3: 3-27.

57. Moore J (2000) Health and home for homeless people in transition. Reviews on Environmental Health 15: 135-148.

58. Wilson JA, Davis RC (2006) Good intentions meet hard realities: An evaluation of the Project Greenlight Reentry Program. Criminology and Public Policy 5: 303-338.

59. Cameron A, Lloyd L (2009) Working across boundaries to improve health outcomes: A case study of a housing support and outreach service for homeless people living with HIV. Health and Social Care in the Community 17: 388-395.

60. Polit DF, Beck CT (2012) Nursing research: Generated and assessing evidence for nursing practice (9th Edition). Philadelphia, PA: Wolters Kluwer, Lippincott Williams & Wilkins.

61. Cohen S, Karmark T, Mermelstein R (1983) A global measure of perceived stress. Journal of Health and Social Behavior 24: 385-396.

62. Neuman WL (1997) Social research methods: Qualitative and quantitative approaches (3rd Edition). Boston, MA: Allyn & Bacon.

63. Kulkarni S, O□Farrell I, Kochar MS (1998) Stress and hypertension. WMJ 97: 34-38.

64. LaGory M, Fitzpatrick K, Ritchey F (2001) Life chances and choices: Assessing quality of life among the homeless. The Sociological Quarterly 42: 633-651.