Female veterans and homelessness: a resource guide for occupational therapists

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Female Veterans and Homelessness: A Resource Guide for Occupational Therapists

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This Scholarly Project Paper, submitted by Jamie Schacht and Alison Tonsager in partial fulfillment of the requirement for the Degree of Master of Occupational Therapy from the University of North Dakota, has been read by the Faculty Advisor under whom the work has been done and is hereby approved.

Signature of Faculty Advisor

4/19/17

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Jamie Schacht, 4/19/2017

Alison Tonsager, 4/19/2017
# TABLE OF CONTENTS

LIST OF TABLES..............................................................................................................iv

ACKNOWLEDGMENTS......................................................................................................v

ABSTRACT..........................................................................................................................vi

CHAPTER

I. INTRODUCTION..............................................................................................................1

II. REVIEW OF LITERATURE............................................................................................7

III. METHODOLOGY..........................................................................................................36

IV. PRODUCT....................................................................................................................40

V. CONCLUSION...............................................................................................................42

REFERENCES....................................................................................................................46

APPENDIX.........................................................................................................................57
## LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Table 2.1</td>
<td>21</td>
</tr>
<tr>
<td>2. Table 3.1</td>
<td>37</td>
</tr>
</tbody>
</table>
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We can now do our final victory dance.

-Jamie Schacht

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-Alison Tonsager
Female veterans are the fastest growing subpopulation among the homeless population in the United States (U.S.) (Boothe, 2017). Female veterans report lack of access to gender-specific programs and therapy groups within the United States Department of Veterans Affairs (VA) to meet specific needs post-deployment (U.S. Department of Veterans Affairs, 2015b). Difficulty with reintegration post-deployment has been linked with homelessness among female veterans. There is evidence to support female veterans' over-representation in the homeless population is due to a higher prevalence of risk factors for homelessness as compared to male veterans and females within the general population (Byrne, Montgomery, & Dichter, 2013). There is a lack of literature related to the role occupational therapists working with female veterans; however, there is current literature to support occupational therapy’s role in addressing mental health and reintegration risk factors post-deployment (Cogan, 2014).

A literature review was conducted on topics related to gender differences among veterans, experiences of female veterans, mental illness, homelessness, and occupational therapy services. In the absence of randomized control studies in occupational therapy literature on homelessness among female veterans, this project draws from evidence of the occupational therapy role in mental health, veteran population, and homeless persons. Based on the results of the literature, *Female Veterans and Homelessness: A Resource Guide for Occupational Therapists* was created for occupational therapists working in community-based settings. The Canadian Model of Occupational Performance and Engagement and Canadian Practice Process Framework were utilized to guide the
development of the resource guide. Recommendations for the occupational therapy process include assessment, interventions, re-evaluation, and discharge planning.

The purpose of this scholarly project and the resulting resource guide is to increase occupational therapists’ awareness for the need of gender-specific care for female veterans receiving services in community-based settings. Occupational therapists are qualified to address and treat risk factors for homelessness among female veterans. The resource guide is a positive contribution to providing client-centered care for female veterans reintegrating into civilian life. *Female Veterans and Homelessness: A Resource Guide for Occupational Therapists* is a tool that occupational therapists can utilize to implement gender-specific care and address the risk factors for homelessness among female veterans.
CHAPTER I  

Introduction

The role of women in the United States (U.S.) Armed Forces has expanded throughout history from primarily nursing roles to active military combat (U.S. Army Heritage and Education Center, 2007). Females are the fastest growing sub-population within the military (Kimerling et al., 2015a). As of 2015, females comprise 15.5 percent of the U.S. Active Duty force, representing a larger proportion of the military than ever before (U.S. Department of Defense, 2015). There is an increased need to understand the differences between male and female veterans’ experiences reintegrating into society after service (Rivera & Johnson, 2014). As compared to male veterans, female veterans experience differences in regards to physical health, mental health, perceived access to services, and reintegration issues (DeKleijn, Lagro-Janssen, Canelo, & Yano, 2015; Kimerling, Gima, Smith, Street, & Frayne, 2007; Maiocco & Smith, 2016; Rivera & Johnson, 2014). The unique needs of female veterans are not being met with the current services offered within the U.S. Department of Veterans Affairs (VA), which leads to an increased need for gender-specific services to address the needs of female veterans (DeKleijn et al., 2015; Kimerling et al., 2015a).

Difficulty with reintegration post-deployment has been linked to homelessness among female veterans (Byrne et al., 2013; Washington et al., 2010). Today in the U.S., female veterans comprise eight percent of the current homeless veteran population (Henry, Watt, Rosenthal, & Shivji, 2016). According to the National Health Care for the
Homeless Council (2017), homelessness is the state of an individual who is unable to maintain a safe, permanent place of residence. Female veterans often ‘couchsurf,’ so they do not meet the criteria for ‘homelessness’ according to the U.S. Department of Housing and Urban Development (Boothe, 2017). According to the Cambridge English Dictionary (2017), ‘couchsurfing’ is defined as rotating the place of residence for sleeping within an individual’s social circles due to not having a permanent place of residence. Therefore, current statistics are likely to underreport the actual percentage of female veterans who are homeless (Boothe, 2017). As the population of female veterans continues to increase, the rate of female veterans who become homeless is also expected to increase (Montgomery & Byrne, 2014). There is strong evidence to support the female veterans' over-representation in the homeless population is due to a higher prevalence of risk factors for homelessness as compared to male veterans and females within the general population (Byrne et al., 2013; Washington et al., 2010).

There is a lack of literature related to the role of occupational therapists addressing the needs of female veterans; however, current literature suggests occupational therapy has a significant role in addressing mental health conditions and reintegration issues post-deployment for the veteran population (Cogan, 2014; Gibson, D’Amico, Jaffe, & Arbesman, 2011; Murtagh, 2014). For individuals who are homeless, occupational therapy has been shown to play a vital role in providing meaningful services to establish the skills needed to enhance occupational participation in daily tasks and life roles (Bradley, Hersch, Reistetter, & Reed, 2011; Thomas, Gray, & McGinty, 2011). Based on the existing literature regarding occupational therapy’s role in mental health,
veteran population, and homeless persons, occupational therapists are qualified to address the unique needs of female veterans post-deployment.

The purpose of this scholarly project was to examine gender differences between male and female veterans’ experiences post-deployment and identify gaps in literature related to occupational therapy’s role in addressing needs of female veterans. Due to the high prevalence of homelessness among female veterans, it is evident that gender-specific occupational therapy approaches are needed to identify the unique needs and risk factors for homelessness among this population. The purpose of the resource guide is to provide occupational therapists with resources to address the unique needs of female veterans to identify and treat risk factors for homelessness in community-based settings.

The Canadian Model of Occupational Performance and Engagement (CMOP-E) guided the development of the resource guide, which considers the holistic aspects of occupational performance, occupational engagement, and occupational justice for female veterans’ reintegration into society post-deployment. Occupational performance and engagement involves participation in meaningful occupations, and occupation justice provides all individuals with equal rights and access to meaningful occupations. The CMOP-E is a client-centered model of practice focused on the interactions between the person, environment, and occupations; occupational performance and engagement is the outcome of this interaction (Townsend & Polatakjo, 2013). Furthermore, the interaction highlights female veterans’ occupational performance and engagement issues following deployment and support occupational justice for female veterans by implementing gender-specific services.
This model was also selected to guide the therapy process by using the Canadian Practice Process Framework (CPPF) and the Canadian Model of Client-Centered Enablement (CMCE). The resource guide was created using the eight action points of the CPPF to organize the themes from the literature. Each action point consists of recommended enablement skills to utilize from the CMCE and therapeutic considerations when addressing the unique needs of female veterans. Through the CPPF, the therapist participates in a collaborative relationship focused on doing with the client through enablement. Enablement means providing power, to make possible, and make able by utilizing the valued-based enablement skills in order for all individuals to participate in their daily occupations (Townsend & Polatakjo, 2013). The therapist uses the CMCE to assist with enabling occupation within the intervention process. Change occurs through the use of enablement skills to assist with changes that female veterans often experience re-integrating into society in order to create a positive influence on occupational performance in meaningful daily activities (Townsend & Polatakjo, 2013; Turpin & Iwama, 2011).

**Key Terms and Concepts**

- **Female veteran**: a female returning from deployment overseas as part of the U.S. Armed Forces or deployment to a combat zone as a National Guard and Reservist. She is considered a veteran once she has been honorably discharged from the U.S. Armed Forces and may be a veteran while still actively serving in the Guard or Reserve. A female veteran often has physical and emotional scars of combat (Veterans Affairs Healthcare, 2017).
• **Posttraumatic stress disorder (PTSD):** a significant mental health condition in veterans caused by exposure to actual or perceived death, injury, or violence leading to distressing symptoms that impair daily life functioning. Symptoms can include recurring memories, flashbacks, distressing thoughts, avoidance behaviors, and changes in mood or activity level (American Psychiatric Association, 2013).

• **Military sexual trauma (MST):** is a physical and emotional trauma consisting of unwanted sexual harassment, sexual coercion, or sexual assault occurring within the military setting. MST often leads to a diagnosis of PTSD and related distressing symptoms based on the trauma aspect of the experience; military sexual trauma can contribute to development of mental illnesses such as depression and substance use disorders in female veterans (American Psychological Association, 2013; U.S. Department of Veteran Affairs, 2015a).

• **Poor health:** involves disruptions or negative influences on an individual’s social, physical, and economic environment and personal characteristics and behaviors, resulting in self-perceived poor health (World Health Organization, 2017).

• **Homelessness:** the state of an individual who is not able to maintain a safe, permanent place of residence; an individual whose primary residence is temporary public or private facilities such as a shelter or transitional housing (National Health Care for the Homeless Council, 2017).

• **Occupational engagement:** when an individual is involved, occupied, or participates in a meaningful occupation. This includes the individual’s performance and subjective experience (Townsend & Polatakjo, 2013).
- **Occupational performance**: carrying out and completing an occupation. This occurs from the interaction between the person, environment, and occupation (Townsend & Polatakjo, 2013).

- **Occupational justice**: all individuals having the opportunity, autonomy, and right to participate in meaningful occupations related to health and social inclusion (Townsend & Polatakjo, 2013).

The chapters in this scholarly project include: review of the literature, methodology, product, and summary. Chapter two will examine the review of the literature based on topics related to gender differences among veterans, experiences of female veterans, physical health, mental health, homelessness, and occupational therapy services. Chapter three will discuss the process used to develop the resource guide in relation to the literature review and components of the CMOP-E. Chapter four will provide an outline of the resource guide, *Female Veterans and Homelessness: A Resource Guide for Occupational Therapists*, for occupational therapists working with female veterans in community-based settings. The full resource guide is located in the Appendix. Chapter five summarizes the conclusions, limitations, and further recommendations for the resource guide.
CHAPTER II

Literature Review

Women have an extensive history of serving in the United States (U.S.) Armed Forces. During the Revolutionary and Civil Wars, the majority of females held primarily nursing and administrative roles, while others disguised themselves as males to fight in the warzones. By World War I and II, numerous novel military roles were established for females such as the Army Nurse Corps, Women’s Army Corps, and Women Air Force Service Pilots (WASPS), which increased exposure to combat traumas (Chaumba & Bride, 2010; Murdoch, Polusny, Hodges, & Cowper, 2006b; U.S. Army Heritage and Education Center, 2007). The terrorist attacks on September 11, 2001 were a pivotal changing point that led to a rapid expansion of jobs and roles for women in the military. In 2016, the equal right to choose any military occupational specialty, especially ground combat units that were previously unauthorized, were granted to women in the military (U.S. Army Heritage and Education Center, 2007). As of 2015, females comprise 15.5 percent of the U.S. Active Duty force, representing a larger proportion of the military than ever before (U.S. Department of Defense, 2015). With the role of women in military services rapidly growing, there is a strong need for the traditionally male-dominated U.S. Department of Veterans Affairs (VA) to adapt to the diverse and gender-specific needs of this evolving population (Rivera & Johnson, 2014; Ryan, McGrath, Creech, & Borsari, 2015).
Gender Differences in Veterans

Service members in the U.S. military have higher risks for developing physical impairments and mental health illnesses compared to the general population due to deployment to hostile environments and exposure to military-related trauma (Afari et al., 2015; Seal et al., 2009). According to Afari et al. (2015), veterans who experience combat and violence during deployment are more likely to develop mental illnesses, such as posttraumatic stress disorder (PTSD), as compared to veterans without experiences of combat. PTSD is a significant mental health condition in veterans caused by exposure to actual or perceived death, injury, or violence leading to distressing symptoms that impair daily life functioning. Symptoms can include recurring memories, flashbacks, distressing thoughts, avoidance behaviors, and changes in mood or activity level (American Psychiatric Association, 2013). Gamache, Rosenheck, and Tessler (2003) noted veterans with mental illnesses such as PTSD are at a higher risk for homelessness. Male and female veterans comprise a combined eighteen percent of the homeless population in the U.S.; no significant gender differences are seen in services provided for homeless veterans (Montgomery & Byrne, 2014; Henry et al., 2016).

Researchers have highlighted differences within male and female veterans in regards to experiences while in the military and the difficulties with reintegration post-deployment (Afari et al., 2015; Freedy et al., 2010; Hoglund, & Schwartz, 2014; Ryan et al., 2015). Researchers have found significant gender differences between male and female veterans’ physical and mental health related to types of combat and trauma experiences (Elnitsky et al., 2013; Maguen, Luxton, Skopp, & Madden, 2012; Montgomery & Byrne, 2014; Rivera & Johnson, 2014). First, female veterans are twice
as likely to experience PTSD symptoms compared to male veterans (Afari et al., 2015; Chaumba & Bride, 2010; Freedy et al., 2010; Resnick, Mallampalli, & Carter, 2012; Rivera & Johnson, 2014). Secondly, male veterans have a greater prevalence of high-intensity combat-related trauma experiences compared to female veterans who experience more sexual-related traumas (Afari et al., 2015; Freedy et al., 2010). Thirdly, female veterans report sexual-related traumas more frequently than male veterans. According to the U.S. Department of Veterans Affairs (2015a), one in four female veterans and one in 100 male veterans reported history of military sexual trauma on a national VA health screening in 2014. Fourthly, depression is twice as prevalent in female veterans as compared to male veterans, and post-deployment depression rates were shown to be higher among females as compared to males (Freedy et al., 2010; Resnick et al., 2012).

With the continuing expansion of women serving in the U.S. military, researchers have found differences between perceived access and utilization of services between male and female veterans (DeKleijn et al., 2015; Miller & Ghadiali, 2015; Ryan et al., 2015; Washington, Farmer, Sun Mor, Canning, & Yano, 2015). According to DeKleijn et al. (2015), there is a lack of specialized women's services in VA facilities throughout the country. This causes women to seek care from multiple providers, resulting in fragmented care for this vulnerable population (DeKleijn et al., 2015). Murdoch et al. (2006a) noted 1.7 million female veterans receive all or most medical care outside the VA health care systems, decreasing the recognition and value of their veteran status.

Gamache et al. (2003) explained the difficulties of female veterans’ reintegration after deployment in regards to maintaining employment and finding stable housing.
Female veterans are three to four times more likely to experience homelessness as compared to women in the general population (Gamache et al., 2003; Washington et al., 2010). There is strong evidence to support that female veterans' over-representation in the homeless population is due to a higher prevalence of risk factors for homelessness as compared to male veterans and females within the general population (Byrne et al., 2013; Gamache et al., 2003; Washington et al., 2010). According to Henry et al. (2016), of the homeless veteran population in the U.S., female veterans make up eight percent. As the population of female veterans continues to increase, the rate of female veterans who become homeless is expected to increase (Montgomery & Byrne, 2014). Based on the gender differences in physical health, mental health, perceived access to services, reintegration issues, and rates of homelessness, it is crucial for health care providers to understand the differences between male and female veterans’ experiences within the military and to advocate for gender-specific treatments to ease the transition back into civilian life (DeKleijn et al., 2015; Kimerling et al., 2015a; Miller & Ghadiali, 2015; Resnick et al., 2012).

**Unique Needs of Female Veterans**

**Physical Health**

Female veterans experience increased rates of reproductive conditions that affect physical and mental health as compared to male veterans and females in the general population (Miller & Ghadiali, 2015; Rivera & Johnson, 2014). Compared to females within the general population, female veterans are more likely to experience higher rates of physical health conditions such as breast lumps, abnormal pap smears, premenstrual conditions, and other gynecological issues (Rivera & Johnson, 2014). Resnick et al.
(2012) noted female veterans are at a higher risk of urinary tract infections, pelvic organ prolapse, urinary incontinence, and bladder pain syndrome. The differences in reproductive conditions among female veterans compared to females in the general population are attributed to the changes in women’s roles in combat within the military setting. With an increase in combat experiences, the accumulation of combat-related traumas, combat-related physical injuries, and history of military sexual trauma are contributions to the unique physical health needs in female veterans (Afari et al., 2015; Ryan et al., 2015).

Female veterans experience differences in physical health conditions that also affect mental health (Maguen et al., 2012; Miller & Ghadiali, 2015). According to Miller and Ghadiali (2015), female veteran participants reported worsening mental health symptoms during reproductive cycles, pregnancy, loss of pregnancy, dyspareunia, and pelvic pain. Maguen et al. (2012) highlighted a stronger correlation between physical injury and PTSD symptoms in female veterans to male veterans. The correlation between physical injury and PTSD in female veterans is associated with the increased experiences of combat-related traumas leading to injury among female veterans (Afari et al., 2015; Maguen et al., 2012). PTSD symptoms from military sexual trauma are associated with physical conditions such as headaches, gastrointestinal difficulties, sexual dysfunction, chronic pain, chronic fatigue, obesity or weight loss, and hypothyroidism (Kimerling, Gima, Smith, Street, & Frayne, 2007; U.S. Department of Veterans Affairs, 2010).

**Mental Health**

Female veterans experience differences in relation to trauma and mental health as compared to male veterans (Afari et al., 2015; Maguen et al., 2012; Resnick et al., 2012;
Female veterans experience a higher prevalence of psychiatric conditions including depression, suicide, anxiety disorders, eating disorders, physical aggression, and trauma-related disorders as compared to male veterans returning post-deployment (Afari et al., 2015; Fontana, Rosenheck, & Desai, 2010; Maguen et al., 2012; Rivera & Johnson, 2014). Although both genders experience PTSD post-deployment, male veterans experience higher levels of high intensity combat during deployment as compared to female veterans (Afari et al., 2015).

Female veterans who are diagnosed with PTSD are more likely to have comorbid diagnoses such as substance use disorders, eating disorders, and depression as compared to female veterans without a diagnosis of PTSD (Chaumba & Bride, 2010; Forman-Hoffman, Mengeling, Booth, Torner, & Sadler, 2012). According to Forman-Hoffman et al. (2012), female veterans diagnosed with eating disorders were twice as likely to experience trauma-related PTSD as compared to female veterans who reported no past trauma history. Female veterans who report sexual assault while in the military are three times as likely to be diagnosed with an eating disorder as compared to females who reported no history of sexual assault (Forman-Hoffman et al., 2012).

**Posttraumatic stress disorder.** Tolin and Foa (2006) examined gender differences in reactions to trauma and PTSD prevalence between males and females in the general population. Women are expected to experience more potentially traumatic events (PTEs), twice as likely to develop PTSD after a traumatic event, and more likely to experience sexual trauma than males. Within males and females who experienced similar PTEs such as child abuse, traumatic accidents, and sexual assaults, females were found to have an increased rate of PTSD as compared to males (Tolin & Foa, 2006).
female veterans, stressful military experiences consist of combat-related trauma and military sexual trauma (Mattocks et al., 2012). Traumatic experiences related to PTSD diagnoses in female veterans include sexual trauma during deployment, physical assault, transportation accidents, and combat zone exposure (Schnurr & Lunney, 2012). Combat experiences, including exposure to death, witnessing death, killing of others, and physical injury related to combat, were significantly associated with PTSD in female veterans (Maguen et al., 2012). Due to the expanded combat roles of females in the military and increased risk of trauma-inducing experiences, female veterans are at a higher risk for developing PTSD as compared to male veterans (Resnick et al., 2012; Tolin & Foa, 2006).

**Military sexual trauma.** There is strong evidence for the link between military sexual trauma and the diagnosis of PTSD in female veterans (Chaumba & Bride, 2010; Maguen et al., 2012; Mattocks et al., 2012; Ryan et al., 2015). Military sexual trauma is defined by the VA as physical and psychological trauma consisting of unwanted sexual harassment, sexual coercion, or sexual assault occurring within the military setting (U.S. Department of Veteran Affairs, 2015a). Military sexual trauma often leads to a diagnosis of PTSD and related distressing symptoms based on the trauma aspect of the experience, and military sexual trauma can contribute to development of mental illnesses such as depression and substance use disorders in female veterans (American Psychological Association, 2013; U.S. Department of Veteran Affairs, 2015a).

Military sexual trauma has been linked to high prevalence of PTSD, anxiety, depression, and suicide among female veterans (Kimerling et al., 2007; Maguen et al., 2012; Wolff & Mills, 2016). For female veterans, military sexual trauma is associated
with a higher prevalence of PTSD and depression symptoms, while war exposure and violence were found to be associated with higher prevalence of PTSD and depression in male veterans (Mattocks et al., 2012). According to Murdoch et al. (2006b), military sexual trauma during deployment correlated with higher prevalence and severity of PTSD diagnoses in female veterans. The correlation of PTSD prevalence in males with high-intensity combat exposure and the correlation of PTSD prevalence in females with history of military sexual trauma showed similarities in regards to trauma-inducing experiences (Murdoch et al., 2006b). As reported by Maguen et al. (2012), military sexual trauma is a main contributor to PTSD and depression among female veterans. Chaumba and Bride (2010) noted military sexual harassment and sexual assault were reported by a majority of the female veterans who had diagnoses of PTSD. According to Kimerling et al. (2007), history of military sexual trauma in female veterans correlated with a three times increased likelihood of a PTSD diagnosis as compared to male veterans.

Wolff and Mills (2016) focused on female veterans’ experiences with military sexual trauma; 90 percent of the 52 female participants reported at least one incident of sexual-related trauma during deployment. According to Maguen et al. (2012), 12 percent of the 554 female participants with PTSD and less than one percent of the 6,697 male participants with PTSD in the study reported history of military sexual trauma. Afari et al. (2015) noted 21 percent of the 96 female participants with PTSD and three percent of the 458 male participants with PTSD reported military sexual trauma.

Although the prevalence of military sexual trauma among female veterans appears substantial, validity of the estimates are limited due to possible under-reporting within the
VA setting and reporting trauma experiences outside of the VA system (U.S. Department of Veteran Affairs, 2015a; Wolff & Mills, 2016). Wolff and Mills (2016) focused on examining the experiences of military sexual trauma and utilization of services among female veterans. Reasons for female participants to not report military sexual trauma included pressure to not report, fear of retaliation, and hopeless feelings that there would be no consequences to the perpetrator (Wolff & Mills, 2016). There appears to be a connection between gender-specific traumatic experiences and perceived lack of access to VA services among female veterans (Ryan et al., 2015).

**Access to Services**

Due to the increase of females in the U.S. military, the VA has begun to create specialized women’s services focused on the unique needs of this population including primary care, specialty care, mental health services, and programs focused on female veterans in the homeless population (U.S. Department of Veterans Affairs, 2010; U.S. Department of Veterans Affairs, 2015b). Yet, female veterans report a perceived lack of access to services as compared to male veterans (Chaumba & Bride, 2010; DeKleijn et al., 2015; Kimerling et al., 2015a; Washington et al., 2015). According to Smith (2014), the VA offers programs to address vocational and rehabilitation needs of veterans with a disability, but the programs fail to distinguish differences between male and female veterans’ needs.

Kimerling et al. (2015a) examined access to mental health services among female veterans within the VA. After deployment, half of the participants within the study reported needing to seek mental health service, but only about three-fourths of the participants sought to receive care for their illness. Only half of those who received care
reported the services met their health care expectations (Kimerling et al., 2015a). The VA has focused on creating gender-specific care for women in the military; however, there appears to be a gap in perceived access to services available for female veterans (Chaumba & Bride, 2010; DeKleijn et al., 2015; Kimerling et al., 2015a; Washington et al., 2015).

Reported barriers for female veterans utilizing VA health care services include decreased knowledge of VA eligibility and services, lack of gender-specific services and groups, and inconvenience of VA locations (Hamilton, Poza, Hines, & Washington, 2012; U.S. Department of Veterans Affairs, 2015b; Washington et al., 2015). The VA acknowledges barriers for female veterans that include lack of knowledge about eligibility criteria, barriers in transportation to get to health care appointments, locations of VA Women’s Health Centers, lack of onsite childcare, limited access to women-only clinics and services, the level of VA staff gender sensitivity, stigma on seeking mental health services, and the feelings of being unsafe during appointments and inpatient hospital stays (U.S. Department of Veterans Affairs, 2015b). Gender-related issues reported by female veterans include lack of access to gender-specific programs and therapy groups (Kimerling et al., 2015a; U.S. Department of Veterans Affairs, 2015b). These barriers have led to decreased utilization of VA services by female veterans, which have contributed to PTSD and other mental health conditions being undertreated among female veterans in VA settings (Chaumba & Bride, 2010; Kimerling et al., 2015a).

According to DeKleijn et al. (2015), current VA programs and services need to be adapted to meet the unique needs and preferences of female veterans. Recommendations include providing gender-specific programs related to sexual trauma experiences and
gender-sensitivity training for health care professionals to increase quality of care (DeKleijn et al., 2015; Washington et al., 2015). As stated by Ryan et al. (2015), understanding the link between military sexual trauma and psychiatric conditions in female veterans may assist with utilization of services and providing comprehensive care within the VA healthcare settings.

Reintegration Issues

According to Strong et al. (2014), both male and female veterans reported an average of five out of 11 surveyed psychosocial concerns post-deployment. The top concerns included pain, sleep, cognition, vocational issues, education, finances, relationships, anger, substance abuse, and social support (Strong et al., 2014). Female veterans experience differences in regards to difficulties coping with war experiences and trauma, affecting reintegration into civilian life. Difficulties include reintegrating into the community, completing daily life activities such as driving, maintaining social supports, re-entering life roles of being a parent and family member, and maintaining employment and stable housing (Maiocco & Smith, 2016; Mattocks et al., 2012).

Maiocco and Smith (2016) noted a common theme among female veterans’ experiences after returning from war was the importance of family and interpersonal relationships when reintegrating into civilian life. Participants reported separation from family was a large stressor during deployment and re-connecting with family post-deployment was challenging (Maiocco & Smith, 2016; Mattocks et al., 2012). Female veterans reported a changed viewpoint on the world, life, and themselves post-deployment, which strained previous interpersonal relationships (Maiocco & Smith, 2016). Female veterans reported feeling as though family members would not understand
what they have gone through during deployment and felt it hard to open up to others about those experiences (Mattocks et al., 2012). According to Ponder, Aquirre, Smith-Osborne, and Granvold (2012), social supports have been noted as being a strong protective factor for mental illness among veterans. Female veterans reported difficulties reintegrating into civilian life and utilizing social supports, which led to feelings of isolation. Lack of support and feelings of isolation contributed to lower self-reported quality of life among female veterans (Maiocoo & Smith, 2016; Mattocks et al., 2012).

Females in the mental health setting experience more deficits with loss of life roles and reductions of wellbeing as compared to male veterans (Lipskaya-Velikovsky, Bar, & Bart, 2014). Female veterans experience difficulty reintegrating into the roles of a mother, wife, family member, and student; they reported limited services available to assist with the transitions (Mattocks et al., 2012). Reintegrating into the role of a civilian worker in order to maintain employment and stable housing is a challenge for female veterans (Byrne et al., 2013). Challenges in regards to coping with war experiences and difficulty reintegrating into civilian life are significant risk factors for homelessness among female veterans (Byrne et al., 2013; Washington et al., 2010).

**Homelessness**

Female veterans are the fastest growing subpopulation among the homeless population in the U.S. (Boothe, 2017). Female veterans are 3.6 times more likely to be homeless as compared to women in the general population, and 4.4 times more likely to be homeless as compared to low-income women in the general population (Gamache et al., 2003). There is strong evidence to support that female veterans have a higher prevalence of risk factors for homelessness as compared to male veterans (Byrne et al.,
According to Byrne et al. (2013), the majority of female veterans who are homeless are between the ages of 40 and 59 years old, are African American, and have children (Washington et al., 2010). Female veterans are more likely to utilize housing services with children (Bryne et al., 2013). According to Boothe (2017), 70 percent of female veterans utilizing housing services at Final Salute Inc. in 2016 were single mothers with children. The reasons for the over-representation of female veterans within the homeless population are unknown; however, there are several risk factors connecting female veterans and homelessness (Byrne et al., 2013; Gamache et al., 2003; Washington et al., 2010).

According to Byrne et al. (2013), risk factors for homelessness among female veterans include pre-military adversity, trauma during service, difficulty with interpersonal relationships post-deployment, health issues, and unemployment. Gamache et al. (2003) noted female veterans who are financially unstable might be more likely to join the service, which affects reintegration and financial stability post-deployment. Risk factors for homelessness among female veterans post-deployment include low income, poor self-reported health, lack of utilization of VA services, stress due to separation from family and reintegration into life roles, lack of social supports, unemployment, and having a disability (Byrne et al., 2013; Gamache et al., 2003; Hamilton et al., 2012; Washington et al., 2010). According to Smith (2014), there was a significant difference between employment rates of female veterans with disabilities compared to female veterans without; female veterans with a disability were more likely to be unemployed. Female veterans who are homeless are less likely to have college degrees, be married, have health insurance, and utilize health care services in the VA (Washington et al.,
According to Washington et al. (2010), protective factors among female veterans include having a college degree and being married. Female veterans noted social supports prevented relapse back to psychiatric programs and housing services (Bryne et al., 2013).

According to Byrne et al. (2013), female veterans who are homeless have higher rates of military sexual trauma and mental illness as compared to females in the general population. Compared to non-homeless female veterans, female veterans who are homeless are more likely to report history of trauma, PTSD, anxiety, and substance use (Brignone et al., 2016; Byrne et al., 2013; Washington et al., 2010). Military sexual trauma is associated with a greater severity of PTSD and other psychiatric symptoms among female veterans who are homeless (Decker, Rosenheck, Tsai, Hoff, & Harpaz-Rotem, 2013). There is a strong connection between military sexual trauma and homelessness among female veterans (Brignone et al., 2016; Decker et al., 2013; Washington et al., 2010). Prevalence of military sexual trauma among female veterans who are homeless is twice as high as non-homeless female veterans (Brignone et al., 2016). According to Decker et al. (2013), 41 percent of female veterans who are homeless reported military sexual trauma during service. As stated by Brignone et al. (2016), of the female veterans who identified military sexual trauma during service, 10 percent were homeless within five years post-deployment. Due to the high prevalence of military sexual trauma among female veterans who are homeless, gender-specific programs are needed to identify the risk factors and prevent homelessness among this population (Rivera & Johnson, 2014; Washington et al., 2010).
Table 2.1
Summary of the Unique Needs of Female Veterans

| Physical health | ● Compared to females within the general population, female veterans are more likely to experience higher rates of physical health conditions (Rivera & Johnson, 2014).
|                 | ● There is a stronger correlation between physical injury and PTSD symptoms in female veterans as compared to male veterans (Maguen et al., 2012). |
| Mental health   | ● Female veterans experience a higher prevalence of psychiatric conditions as compared to male veterans post-deployment (Afari et al., 2015; Fontana et al., 2010; Maguen et al., 2012; Rivera & Johnson, 2014).
|                 | ● Female veterans are at a higher risk for developing PTSD as compared to male veterans (Resnick et al., 2012; Tolin & Foa, 2006).
|                 | ● History of military sexual trauma in female veterans correlated with a three times increased likelihood of a PTSD diagnosis as compared to male veterans (Kimerling et al., 2007). |
| Access to services | ● Female veterans report a perceived lack of access to services as compared to male veterans (Chaumba & Bride, 2010; DeKleijn et al., 2015; Kimerling et al., 2015a; Washington et al., 2015).
|                 | ● Female veterans report barriers to utilizing VA services. Female veterans struggle with being able to identify the need to seek assistance, how to seek assistance, and what resources are available (Chaumba & Bride, 2010; Kimerling et al., 2015a).
|                 | ● The unique needs and preferences of female veterans are not addressed by current VA programming (DeKleijn et al., 2015). |
| Reintegration issues | ● Female veterans experience differences in regards to reintegration issues as compared to male veterans. Differences include difficulties coping with war experiences and trauma, completing daily life activities such as driving, maintaining social supports, re-entering life roles of being a parent and family member, and maintaining employment and stable housing (Maiocco & Smith, 2016; Mattocks et al., 2012). |
| Homelessness    | ● Female veterans have a higher prevalence of risk factors for homelessness as compared to male veterans (Byrne et al., 2013; Washington et al., 2010). |
● Prevalence of military sexual trauma among female veterans who are homeless is twice as high as non-homeless veterans (Brignone et al., 2016).
● Compared to non-homeless female veterans, female veterans who are homeless are more likely to report history of trauma, PTSD, anxiety, and substance use (Brignone et al., 2016; Byrne et al., 2013; Washington et al., 2010).
● Risk factors for homelessness among female veterans post-deployment include low income, poor self-reported health, lack of utilization of VA services, stress due to separation from family, reintegration into life roles, lack of social supports, unemployment, history of trauma or military sexual trauma, diagnosis of PTSD, and having a disability (Brignone et al., 2016; Byrne et al., 2013; Gamache et al., 2003; Hamilton et al., 2012; Washington et al., 2010).

Female Veterans Recommendations for Mental Health Services

Koblinsky, Schroeder, and Leslie (2016) examined female veterans’ recommendations for improving services provided in current VA and community-based mental health settings. The female veterans identified barriers and potential solutions to improve quality of mental health care. The themes among the female veterans’ recommendations included focus on therapeutic relationships, the clinical care environment, and the health care system (Koblinsky et al., 2016).

According to Koblinsky et al. (2016), female veterans highlighted the importance of developing a respectable and trustworthy therapeutic relationship with clinicians. Female veterans reported the value of having recognition for the contributions and sacrifices made by women in the U.S. military. Female veterans reported feeling less deserving of care by comparing severity of conditions to other veterans in the VA. In addition, the stigma of seeking mental health services has negatively impacted female veterans by increasing feelings of shame and decreasing self-efficacy. When clinicians provide recognition of the courageous roles female veterans have fulfilled, it helped
reaffirm the female veterans’ worthiness to obtain holistic care. Female veterans recommend clinicians recognize the diverse experiences of each female to individualize treatments and increase therapeutic relationships (Koblinsky et al., 2016).

Female veterans reported solutions to improve quality of care within mental health service settings (Koblinsky et al., 2016). Women reported the importance of educating mental health professions about military culture and providing professionals with sensitivity training on how to process trauma reported by clients. Women reported gender-sensitivity as a concern within mental health settings. The female veterans desired gender-sensitive environments in order to feel safe and respected as veterans (Koblinsky et al., 2016). According to Kimerling et al. (2015b), female veterans reported coping with mental illness and chronic conditions, pain management, sleep, and weight management as priorities for gender-specific care in mental health settings. Koblinsky et al. (2016) noted the female veterans reported a need for implementation of psychoeducation interventions focused on self-expression and empowerment. In addition, peer supports within female-only groups were noted as high importance to the participants. The women reported feeling more comfortable opening up about sensitive topics and relating to others with similar experiences in female-only settings (Koblinsky et al., 2016).

According to Koblinsky et al. (2016), female veterans recommended enhancing ways of promoting and advertising access to mental health services for veterans including utilizing social media and paper advertisements. Female veterans advocated for further community-based programs and effective mental health therapies. By increasing accessibility to programs that target female veterans, improved reintegration into society will be facilitated. Female veterans also recommended hiring more female veterans as
ment health providers in the VA system. Female veteran health care providers would have the personal experience needed to be empathetic to the unique difficulties with reintegration post-deployment (Koblinsky et al., 2016).

Role of Occupational Therapy

Mental Health Practice

The origins of occupational therapy in the U.S. are in mental health; occupational therapy has made significant contributions to the establishment of holistic care provided in mental health settings. Occupational therapy’s ability to view health in the context of occupational performance has been a distinguished characteristic since its inception in the early 20th century (Gibson et al., 2011; Scheinholtz, 2010). Today, occupational therapy practitioners provide services in mental health settings such as hospital inpatient and outpatient, partial hospitalization programs, correctional facilities, assertiveness community treatment teams, psychosocial clubhouses, community centers, homeless and women’s shelters, and senior centers (Brown & Stoffel, 2011). The recovery model is often implemented by occupational therapists in mental health settings to focus on the client’s achievement in full participation in community activities. Community activities include going to school, obtaining and maintaining employment, and living independently (Scheinholtz, 2010).

The scope of occupational therapy practice in the mental health setting consists of individual evaluation, assessment, treatment, therapeutic groups, and discharge planning. Through the process of evaluation, occupational therapists examine the impact of psychosocial dysfunction on occupational engagement to facilitate health and participation in life. Assessment tools are utilized to identify strengths, weaknesses,
needs, and concerns regarding the client’s occupational engagement and performance in daily life activities. Further, occupational therapists analyze environmental and contextual factors that support and hinder the client’s occupational performance (American Occupational Therapy Association [AOTA], 2010; Gibson et al., 2011; Pitts, 2010).

Occupational therapy practitioners are qualified to analyze how mental illnesses affect the ability to successfully participate in everyday occupations. Clinical reasoning is utilized to select which skills, compensatory strategies, or accommodations are needed to increase the client’s occupational performance in daily tasks. Occupational therapists utilize skill development, task adaptations, environmental supports, and participation in meaningful occupations to promote positive health and well-being (AOTA, 2010; Gibson et al., 2011). Occupational therapists utilize prevention methods such as coping strategies to reduce symptoms experienced with mental illnesses. In addition, occupational therapists assist with establishing habits and routines to improve sleep, relationships, physical activity, and participation in meaningful activities (AOTA, 2010).

Occupational therapy provides psychosocial interventions that engage clients in meaningful occupations to increase participation in daily routines, roles, community reintegration, and improve overall health and well-being (AOTA, 2010; AOTA, 2012; Gibson et al., 2011; Pitts, 2010). Key areas of interventions include health and wellness, education, skills training, work, and cognitive remediation and adaptation. Psychosocial interventions utilized to increase community integration and role fulfillment include social participation, activities of daily living (ADLs), instrumental activities of daily living (IADLs), and facilitating development of skills needed for independent living such
as home management, time management, medication management, and utilizing community resources. Occupational therapists aim to provide client-centered interventions in a natural context to increase occupational performance and outcomes (AOTA, 2012; Gibson et al., 2011). Occupational therapists are able to evaluate and adapt the client’s home, school, and work environments to increase optimal functioning during daily tasks. In addition, occupational therapists are able to provide treatment groups, educational programs, and experiential learning to address self-awareness, social and interpersonal skills, assertiveness, stress management, and role development for clients (AOTA, 2012).

Gender-Specific Treatments in Mental Health

There is limited U.S. occupational therapy literature pertaining to gender-specific considerations in mental health settings; however, international research supports the need for gender-specific treatments (Kennedy & Fortune, 2014; Lipskaya-Velikovsky et al., 2014; Taylor, Dorer, Bradfield, & Killaspy, 2010). Kennedy and Fortune (2014) reported a need for individualized services for women in Australian mental health settings. The female participants valued having a variety of activities to choose from that were perceived as having potential benefits, increasing the female participants’ motivation for occupational engagement. The women reported feeling demoralized and felt loss of autonomy when having limited access to desired items. In addition, poor communication between staff members decreased the female participants’ occupational engagement. Greater sensitivity to women’s needs in a mental health setting is vital in order to facilitate participation in occupations (Kennedy & Fortune, 2014).
Lipskaya-Velikovsky et al. (2014) examined gender differences in interventions delivered in a mental health setting in Israel. Researchers reported women benefited from occupation-based activities while men utilized more consultation-related services. The female participants had positive outcomes related to participation in roles and occupations through occupational engagement; the males had a tendency to avoid seeking help when a problem would arise and required consults. The occupational therapists applied establish/restore and create/promote intervention strategies more with men compared to women. According to Lipskaya-Velikovsky et al. (2014), women desired interventions related to habits, performance patterns, and communication skills as compared to men. Interventions targeting the female participants’ routines by organizing meaningful daily activities increased occupational engagement. By considering factors such as gender, occupational therapists are enabled to provide effective client-centered interventions (Lipskaya-Velikovsky et al., 2014).

Taylor et al. (2010) studied female therapy experiences in a mental health setting in London. Therapy benefits identified by the participants included gender-specific treatments, access to female staff, and gender-specific living areas. Participants highlighted female social participation and participation in occupation were significant benefits in the mental health setting (Taylor et al., 2010). In addition, Kennedy and Fortune (2014) found focus on safety to be most beneficial among the female participants in mental health settings. The women reported feeling both physically unsafe among male patients and staff and emotionally fearful of the future with lack of trust in relationships. Gender segregation in mental health settings promotes inadequate services;
it is proposed that gender-specific care promotes safety, occupational engagement, and client-centeredness (Kennedy & Fortune, 2014).

Veterans

According to Plach and Sells (2013), veterans experience challenges in occupational engagement and reintegration into civilian roles after serving in the military. Occupational therapy has fulfilled the role of delivering rehabilitation and reintegration services for military personnel dating back to World War I (Cogan, 2014; Montz, Gonzales, Bash, & Carney, 2008; Murtagh, 2014). According to Montz et al. (2008), occupational therapy provides interventions that address mental and physical health conditions for male and female service members to help improve transitioning into civilian life. Occupational therapists assist military personnel with coping with PTSD conditions, building a social support system, increasing the sense of being a member of their community, and addressing additional post-deployment issues to enable utilization of skills for lifestyle management and restore hope for recovery (Montz et al., 2008; Murtagh, 2014).

According to Brown and Hollis (2013), the practice of occupational therapy fulfills a valuable role in the military context. The role of occupational therapy practice is significant in short and long-term settings by addressing both mental and physical health factors. Occupational therapy focuses on all possible relationships among aspects of a military member's functional performance. Occupational therapists are skilled in completing home modifications, medical equipment consultations, and return-to-work assessments to address physical and mental health needs of veterans. Further, occupational therapy provides skilled interventions to help increase a military member’s
daily functional performances by assessing dynamic relationships between the individual, environment, and occupations to enhance occupational performance (Brown & Hollis, 2013).

Occupational therapy services for veterans require a physician referral and are only covered by TRICARE when it is determined to be medically necessary for the treatment. TRICARE is a health care program provided for active duty, retired soldiers, and families of U.S. military service members (TRICARE, 2016). Cogan (2014) stated occupational therapy’s role is well-established in the military context as a rehabilitation provider for people with physical injuries and disabilities. Regarding VA mental health services, occupational therapists lack recognition to provide skilled services in the VA mental health system (Cogan, 2014). According to TRICARE (2016), occupational therapists are covered as mental health providers in settings such as inpatient, partial hospital programs, substance use disorder facilities, and residential treatment centers. A potential advantage of occupational therapy not being perceived as part of mental health care in the military setting is that the stigma may be reduced when accessing an occupation-based preventive or rehabilitative program (Cogan, 2014).

According to the AOTA’s Societal Statement on Combat-Related Posttraumatic Stress (2009), occupational therapy services benefit military personnel experiencing combat-related PTSD by providing education on strategies to help recovery, improve health outcomes, and enhance quality of life. According to J. Birch, an occupational therapist employed by the VA, female veterans’ integration back into civilian life is challenging due to lack of support systems, spouse assistance, financial support, transportation, and living in low-income housing (Personal communication, January 20,
Occupational therapists utilize strategies such as coping skills, compensatory methods, and adapting daily activities to increase an individual’s experiences of engaging or reengaging in daily life activities (AOTA, 2009).

A significant need for further research exists to establish the impact of occupational therapy services for veterans’ recovery, reintegration, and resilience (Cogan, 2014; Radomski & Brininger, 2014). According to Radomski and Brininger (2014), there is a lack of controlled research studies supporting successful interventions and roles of occupational therapy with military personnel. The main barriers for providing occupational therapy services to military personnel include the payment of services, stigma attached to mental health services, identification of military-connected individuals, and the capacity of the occupational therapy workforce (Cogan, 2014).

Occupational therapy research can help fill existing gaps in the understanding of the effect of deployment on daily life and can be utilized to develop client-centered treatment approaches to increase health outcomes and quality of life for the military population (AOTA, 2009; Cogan, 2014; Radomski & Brininger, 2014).

**Homelessness**

Occupational therapists have demonstrated the ability to work with homeless families and children, youth, women, victims of domestic violence, and persons with mental illnesses (Davis & Kutter, 1998; Helfrich, Aviles, Bandiani, Walens, & Sabol, 2006; Schultz-Krohn, 2004; Thomas et al., 2011). Over one-third of homeless persons reported homelessness either inhibited or restricted participation in occupation; occupational therapists focus on enhancing occupational function, purposeful activities, life roles, and performance skills among homeless persons (Bradley et al., 2011; Lloyd &
Bassett, 2012; Thomas et al., 2011). According to Lloyd and Bassett (2012), occupational therapists can assist individuals to establish the skills needed to re-engage in meaningful occupations and enhance quality of life for homeless persons.

The majority of research on the role of occupational therapy with homeless persons has focused on occupational therapists working directly in homeless shelters (Lloyd & Basset, 2012). Unlike many areas of occupational therapy, ADLs are not the primary focus for this population (Bradley et al., 2011). Occupational therapists address IADLs, promote skill development, and minimize barriers to participation through goal-directed intervention planning (Petrenchik, 2006; Thomas et al., 2011). The main areas of occupational deficits among homeless persons include lack of skills related to money management, maintaining relationships, coping with daily life stressors, employment, leisure activities, and lack of spirituality (Bradley et al., 2011; Thomas et al., 2011; Tryssenaar, Jones, & Lee, 1999). According to Davis and Kutter (1998), females in the homeless population lack the skills needed to address deficits in IADLs and coping mechanisms needed to address traumatic experiences. Females who are homeless demonstrate deficits in money management, budgeting for expenses, participation in leisure activities, awareness of dangerous situations, and awareness of actions to take when needing health care services (Davis & Kutter, 1998).

Occupational therapy interventions within homeless shelters can assist individuals to develop the skills needed to participate in occupations such as employment, banking, budgeting, and healthy leisure activities (Bradley et al., 2011; Thomas et al., 2011). According to Lloyd and Basset (2012), occupational therapists can assist individuals by addressing medication management, health management and promotion, social skills, and
skills needed to monitor mental illness. Coping skills such as stress management, anger management, and assertiveness skills can be established to assist with managing mental illness (Bradley et al., 2011; Thomas et al., 2011). Occupational therapists can assist females in the homeless population by addressing skills related to IADLs to increase independence and establishing coping skills using psychoeducation, stress management, and relaxation training (Davis & Kutter, 1998).

According to Thomas et al. (2011), wellness programs for individuals experiencing homelessness help to establish routines and roles, enhance performance skills and patterns, increase safety, and increase utilization of resources that improve quality of life. Helfrich, Chan, and Sabol (2011) reported life skills training and psychoeducation interventions in a group setting were effective with various cognitive levels of homeless persons with mental illness. Occupational therapy sessions focused on managing the impact of mental illness on occupations including self-care, food management, money management, and community safety (Helfrich et al., 2011). Occupational therapists can provide education and strategies related to skill development to improve wellness and quality of life among homeless persons (Thomas et al., 2011).

According to Lloyd & Basset (2012), there is little research on the role of occupational therapy as part of outreach interdisciplinary teams to prevent homelessness. Occupational therapists can assist with mental health recovery plans focused on re-establishing skills related to life roles and routines, basic household management, health promotion, financial skills, and community living in order to prevent homelessness (Lloyd & Basset, 2012).
Summary

The role of women in the military has expanded throughout history from primarily nursing roles to active military combat. Today, there is an increased need to understand the differences between male and female veterans’ experiences reintegrating into society after service (Rivera & Johnson, 2014; Ryan et al., 2015). Female veterans experience unique differences related to physical health, mental health, perceived access to services, and reintegration issues as compared to male veterans (DeKleijn et al., 2015; Kimerling et al., 2015a; Miller & Ghadiali, 2015; Resnick et al., 2012). First, female veterans experience increased rates of reproductive conditions and a stronger correlation between physical injuries and mental health conditions (Maguen et al., 2012; Miller & Ghadiali, 2015; Rivera & Johnson, 2014). Second, female veterans experience higher rates of psychiatric conditions including PTSD and military sexual trauma as compared to male veterans (Resnick et al., 2012; Tolin & Foa, 2006). History of military sexual assault has been linked to a three times higher prevalence of PTSD diagnosis and increased severity PTSD symptoms in female veterans (Kimerling et al., 2007; Maguen et al., 2012; Murdoch et al., 2006b). Third, female veterans report barriers to utilizing VA services following deployment, contributing to the perceived lack of access to services (Chaumba & Bride, 2010; DeKleijn et al., 2015; Kimerling et al., 2015a; Washington et al., 2015). Female veterans report lack of access to gender-specific programs and therapy groups within the VA to meet specific needs post-deployment (Kimerling et al., 2015a; U.S. Department of Veterans Affairs, 2015b). Fourth, female veterans experience difficulties reintegrating into the community, re-entering into life roles, utilizing social supports, and completing daily tasks post-deployment (Maiocco & Smith, 2016;
Mattocks et al., 2012). Difficulty with reintegration post-deployment has been linked with homelessness among female veterans (Byrne et al., 2013; Washington et al., 2010).

Female veterans have a higher prevalence of risk factors contributing to homelessness as compared to male veterans, leading to an over-representation of female veterans within the homeless population (Byrne et al., 2013; Gamache et al., 2003; Washington et al., 2010). Risk factors for homelessness among female veterans include physical disability, low income, lack of utilization of VA services, lack of social supports, unemployment, trauma history during service, mental illness, and history of military sexual trauma (Byrne et al., 2013; Gamache et al., 2003; Hamilton et al., 2012; Rivera & Johnson, 2014; Washington et al., 2010).

Occupational therapists have the potential to play a significant role in addressing physical and mental health conditions to assist female veterans with reintegration post-deployment (Cogan, 2014; Gibson et al., 2011; Montz et al., 2008; Murtagh, 2014). Occupational therapists are known to provide holistic interventions focused on mental health and psychosocial factors within mental health settings (Gibson et al., 2011; Kennedy & Fortune, 2014; Lipskaya-Velikovsky et al., 2014). Occupational therapists focus on building social supports, establishing coping skills for mental illness, and restoring hope in order to improve occupational performance in veterans struggling with reintegration (Brown & Hollis, 2013; Gibson et al., 2011; Montz et al., 2008; Murtagh, 2014).

Although there is lack of U.S. occupational therapy literature addressing female patients’ needs specifically, international literature suggests that occupational therapists have the skills to evaluate the unique roles and experiences of females in order to provide
gender-specific services in mental health settings (Kennedy & Fortune, 2014; Lipskaya-Velikovsky et al., 2014; Taylor et al., 2010). For individuals who are homeless, occupational therapists have been shown to play a vital role in providing meaningful services in order to establish the skills needed to enhance occupational participation in daily tasks and life roles (Bradley et al., 2011; Thomas et al., 2011). Occupational therapists provide interventions targeted towards establishing skills needed for IADLs, addressing coping skills for mental illness, developing roles and routines, enhancing performance skills, and utilizing resources within the community in order to improve quality of life in individuals who are homeless (Bradley et al., 2011; Davis & Kutter, 1998; Lloyd & Bassett, 2012; Thomas et al., 2011).

**Problem Statement**

Due to the high prevalence of homelessness among female veterans, it is evident that gender-specific occupational therapy approaches are needed to identify and treat risk factors for homelessness among this population. The aim of this scholarly project is to provide a resource guide for occupational therapists working with female veterans in community-based settings. The resource guide will support provision of gender-specific care by identifying and treating risk factors for homelessness among female veterans. Occupational therapy services will include providing gender-specific reintegration services focused on re-establishing life roles and routines, building support networks, identifying emotional deficits, addressing coping skills for mental illness, enhancing performance skills, and utilizing community and health care resource in order to improve quality of life and occupational performance among female veterans.
CHAPTER III

Methodology

This scholarly project sought to identify gaps in current literature related to occupational therapy’s role in addressing the needs of female veterans. The purpose of the literature review was to examine interdisciplinary and occupational therapy literature for information regarding gender differences between male and female veterans’ experiences post-deployment, explore gender-specific services for female veterans, and identify the role of occupational therapy for this target population.

A literature review was conducted by searching numerous online databases including PubMed, CINAHL, ClinicalKey, EBSCOhost, OT Search, PsycInfo, and Sage. Occupational therapy textbooks, government-based websites such as the United States (U.S.) Department of Veterans Affairs (VA), and personal communications with occupational therapists working in VA settings were also utilized. The main topics in the research process included: experiences of male and female veterans, mental health among veterans, homelessness among veterans, and occupational therapy’s role related to gender-specific services, mental health, veterans, and homeless persons.

Each article reviewed was assessed for level of evidence and applicability to the purpose of the literature review. Pertinent articles were organized according to similar topic areas. These topic areas included: gender difference between male and female veterans, unique needs of female veterans, risk factors for homelessness among female
veterans, and occupational therapy’s role related to mental health, veterans, and homeless persons.

The following table summarizes the findings of the literature review and was used to guide the process for developing this scholarly project. The “Xs” indicate research found within the topic areas.

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<th>Table 3.1 Summary of Literature Review Findings</th>
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There was a lack of literature regarding the role of occupational therapy addressing the unique needs of female veterans. The majority research articles were obtained from military-based, mental health, and social work literature. The research revealed female veterans experience a higher prevalence of risk factors for homelessness as compared to male veterans and females within the general population (Brignone et al., 2016; Byrne et al., 2013; Hamilton et al., 2012; Washington et al., 2010). Due to the high prevalence of homelessness among female veterans and the large amount of research

37
outside the profession of occupational therapy, occupational therapy’s role in identifying and treating risk factors for homelessness among female veterans was examined.

Based on the literature review, the authors sought to integrate the research regarding the role of occupational therapy and the unique occupational needs of female veterans. In the absence of randomized control studies in occupational therapy literature on homelessness among female veterans, the scholarly project drew from evidence on the unique needs of female veterans and occupational therapy’s role in mental health, veteran population, and homeless persons. After synthesis of the literature, it was evident that occupational therapy has a role in providing services for female veterans who are homeless or are at risk for homelessness in healthcare settings.

Due to the broad scope of the literature and the lack of existing occupational therapy research, a resource guide for occupational therapists was selected for this scholarly project. An additional literature review was conducted using the aforementioned resources to obtain information related to assessments and interventions to utilize throughout the occupational therapy process. The resource guide was developed in order to present recommendations for the occupational therapy process and therapeutic considerations for gender-specific treatments. The purpose of the resource guide is to provide occupational therapists with resources to address the unique needs of female veterans to identify and treat risk factors for homelessness.

After reviewing several occupation-based models, the Canadian Model of Occupational Performance and Engagement (CMOP-E) was selected as the best model to guide the development and organization of the resource guide. The CMOP-E was selected to highlight post-deployment issues related to occupational performance and
engagement to promote occupational justice, ensuring equal opportunities and access to service provision for female veterans. This holistic, client-centered model allows the occupational therapist to address a wide range of occupational performance and engagement issues throughout the therapy process to identify and treat risk factors for homelessness. This model was also selected to guide the therapy process by utilizing the Canadian Practice Process Framework (CPPF) and the Canadian Model of Client-Centered Enablement (CMCE). The resource guide was created using the eight action points of the CPPF to organize the themes from the literature, and each action point consists of recommended enablement skills to utilize from the CMCE.
CHAPTER IV

Product

The purpose of this resource guide is to provide occupational therapists with resources regarding the unique needs of female veterans. Due to the high prevalence of homelessness among female veterans, it is evident that gender-specific occupational therapy approaches are needed to address the unique needs among this population. The resource guide provides recommendations for the occupational therapy process when working with female veterans in community-based settings. Recommendations support the provision of gender-specific care by identifying and treating risk factors for homelessness. In the absence of randomized control studies in occupational therapy literature on homelessness among female veterans, this resource guide draws from evidence of the occupational therapy role in mental health, veteran population, and homeless persons.

*Female Veterans and Homelessness: A Resource Guide for Occupational Therapists* was developed using the Canadian Model of Occupational Performance and Engagement (CMOP-E). The resource guide is organized into five main sections: assessment, intervention, re-evaluation, discharge, and appendices. The first four sections reflect the occupational therapy process and apply the actions points from the Canadian Practice Process Framework. Each action point consists of recommended enablement skills from the Canadian Model Client-Centered Enablement and suggested approaches for the occupational therapy process. An assortment of recommended assessments and
interventions to utilize with female veterans are categorized into person, environment, and occupation to reflect the main components of the CMOP-E. The appendices consist of tip sheets for occupational therapists and additional resources to utilize throughout the therapy process. Resources include: a checklist of risk factors for homelessness, considerations for the occupational therapy process, resources for occupational therapists regarding military sexual trauma and other experiences of female veterans, and resources for intervention and discharge planning.

The entire *Female Veterans and Homelessness: A Resource Guide for Occupational Therapists* is presented in the Appendix.
CHAPTER V

Conclusion

The purpose of this scholarly project was to examine gender differences between male and female veterans’ experiences post-deployment and identify gaps in literature related to occupational therapy’s role in addressing needs of female veterans. There is evidence to support female veterans’ over-representation in the homeless population is due to a higher prevalence of risk factors for homelessness as compared to male veterans and female within the general population (Byrne et al., 2013). Based on the existing literature regarding occupational therapy’s role in mental health, veteran population, and homeless persons, occupational therapists are qualified to address the unique needs of female veterans post-deployment.

Based on the results of the literature review, Female Veterans and Homelessness: A Resource Guide for Occupational Therapists was created for occupational therapists working in community-based settings. The Canadian Model of Occupational Performance and Engagement (CMOP-E) was selected to highlight post-deployment issues related to occupational performance and engagement to promote occupational justice, ensuring equal opportunities and access to service provision for female veterans. The purpose of the resource guide is to provide occupational therapists with resources to address the unique needs of female veterans to identify and treat risk factors for homelessness. Recommendations for the occupational therapy process include: assessment, intervention, re-evaluation, and discharge planning.
Limitations

There are several limitations to this resource guide. First, the resource guide focuses solely on female veterans and does not address specific needs of male veterans. The United States (U.S.) Department of Veterans Affairs (VA) is a traditionally male-dominated facility, so there is a strong need for the VA to adapt to the diverse and gender-specific needs of female veterans (Rivera & Johnson, 2014; Ryan et al., 2015).

The second limitation is the resource guide focuses on female veterans’ risk factors for homelessness. This is limiting by the female veteran needing to have risk factors for homelessness in order to utilize the resource guide. The risk factors for homelessness are often addressed in mental health settings compared to physical disability settings, limiting the utilization of the resource guide.

The third limitation is the lack of evidence supporting the identified assessments and interventions presented in the resource guide. The resource guide draws from evidence of the occupational therapy role in mental health, veteran population, and homeless persons. However, there is no current evidence for occupational therapy’s role in relation to homelessness among female veterans.

Recommendations

There are several recommendations for further expansion and utilization of the *Female Veterans and Homelessness: A Resource Guide for Occupational Therapists*. First, the resource guide advocates for the role of occupational therapy to address the unique needs of female veterans. Occupational therapists are qualified to address the gender-specific needs for female veterans. The resource guide helps support occupational therapy’s role in addressing gender-specific factors. There is a further need to advocate to
larger organizations such as the VA and American Occupational Therapy Association (AOTA) to increase awareness of the role of occupational therapy addressing the unique needs of female veterans.

The second recommendation includes conducting randomized controlled studies focused on the role of occupational therapy services in identifying and treating risk factors for homelessness among female veterans. There is a need for the evidence-based research regarding occupational needs of female veterans. In addition, research should be conducted on appropriate occupational therapy assessments and interventions that address and treat risk factors for homelessness among female veterans.

The third recommendation includes retaining an updated resource guide for occupational therapists providing services to female veterans. It is vital to incorporate current gender-specific needs, risk factors, statistics, and available resources for female veterans in order to provide quality care for this population. This can be completed by reviewing and updating resources annually.

**Conclusion**

There is a significant need for continued research and implementation of gender-specific services for female veterans among the veteran population. Areas of need to further address include female veterans’ unique differences related to physical health, mental health, perceived access to services, reintegration issues, and rates of homelessness. This resource guide increases awareness and advocates for the role of occupational therapy in utilizing gender-specific resources to support identification and treatment of risk factors for homelessness among female veterans. Occupational therapists can use this guide to implement gender-specific care and address the risk
factors for homelessness among female veterans in community-based settings.

Occupational justice is promoted through occupational therapists utilizing the resource guide and providing equal opportunities for female veterans to receive gender-specific services. Occupational therapists have a potential role in providing gender-specific services to promote occupational performance, engagement, and justice among female veterans.
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Appendix
FEMALE VETERANS AND HOMELESSNESS: A RESOURCE GUIDE FOR OCCUPATIONAL THERAPISTS

JAMIE SCHACHT, MOTS
ALISON TONSAGER, MOTS
SONIA ZIMMERMAN, PHD, OTR/L, FAOTA
# TABLE OF CONTENTS

1. Introduction ................................................................................................................................. 2  
   - Target Population .................................................................................................................. 2  
   - Purpose .................................................................................................................................. 6  
   - Key Terminology .................................................................................................................... 7  
   - Model of Practice ................................................................................................................... 8  
   - Organization of Manual ......................................................................................................... 15  

2. Assessment ................................................................................................................................. 16  
   - Action Point 1: Enter/Initiate .................................................................................................. 17  
   - Action Point 2: Set the Stage ................................................................................................. 18  
   - Action Point 3: Assess/Evaluate ............................................................................................ 19  
   - Action Point 4: Agree on Objectives and Plan ...................................................................... 20  
   - Checklist: Risk Factors for Homelessness ............................................................................. 21  
   - Recommended Assessments ................................................................................................... 22  

3. Intervention .................................................................................................................................. 28  
   - Action Point 5: Implement the Plan ....................................................................................... 29  
   - Action Point 6: Monitor and Modify ...................................................................................... 30  
   - Recommended Interventions .................................................................................................. 31  

4. Re-evaluation ............................................................................................................................... 45  
   - Action Points: 7: Evaluation/Outcome .................................................................................. 46  

5. Discharge ..................................................................................................................................... 47  
   - Action Point: 8: Conclude/Exit .............................................................................................. 49  

6. References .................................................................................................................................... 50  

7. Appendices .................................................................................................................................. 56
The role of women in the United States (U.S.) Armed Forces has expanded throughout history from primarily nursing roles to active military combat (U.S. Army Heritage and Education Center, 2007). As of 2015, females comprise 15.5 percent of the U.S. Active Duty force, representing a larger proportion of the military than ever before (U.S. Department of Defense, 2015). There is an increased need to understand the differences between male and female veterans’ experiences reintegrating into society after service (Rivera & Johnson, 2014). Compared to male veterans, female veterans experience differences in regards to physical health, mental health, perceived access to services, and reintegration issues (Byrne et al., 2013; Kimerling et al., 2015; Maiocco & Smith, 2016; Resnick et al., 2012; Rivera & Johnson, 2014). A summary of the unique needs of female veterans post-deployment is presented in the table below.

Difficulty with reintegration post-deployment has been linked to homelessness among female veterans (Byrne, Montgomery, & Dichter, 2013; Washington et al., 2010). Today in the U.S., female veterans comprise eight percent of the current homeless veteran population (Henry, Watt, Rosenthal, & Shivji, 2016). As the population of female veterans continues to increase, the rate of female veterans who become homeless is also expected to increase (Montgomery & Byrne, 2014). There is strong evidence to support the female veterans’ over-representation in the homeless population is due to a higher prevalence of risk factors for homelessness as compared to male veterans and females within the general population (Byrne et al., 2013; Washington et al., 2010). It is crucial for health care providers to understand these gender differences and advocate for gender-specific treatments to ease the transition back into civilian life (DeKleijn et al., 2015; Kimerling et al., 2015; Resnick, Mallampalli, & Carter, 2012).

Within healthcare settings, female veterans often minimize their roles and contributions within the military. Female veterans often feel less deserving of care by comparing severity of injuries and level of combat exposure to male veterans within the U.S. Department of Veterans Affairs (VA). Therefore, female veterans strongly value recognition for their contributions and sacrifices in the military. It is important for clinicians to recognize and acknowledge the diverse experiences of female veterans to individualize treatments and enhance therapeutic relationships within health care settings (Koblinsky, Schroeder, & Leslie, 2016).

Although there is a lack of literature related to the role of occupational therapists working specifically with female veterans, current literature suggests occupational therapy
has a significant role in addressing mental health conditions and reintegration issues post-deployment for the veteran population (Cogan, 2014; Gibson, D'Amico, Jaffe, & Arbesman, 2011; Murtagh, 2014). For individuals who are homeless, occupational therapy has been shown to play a vital role in providing meaningful services to establish the skills needed to enhance occupational participation in daily tasks and life roles (Bradley, Hersch, Reistetter, & Reed, 2011; Thomas, Gray, & McGinty, 2011). Therefore, this resource guide draws from evidence for the unique needs of female veterans and occupational therapy’s role in mental health, veteran population, and homeless persons.

### Summary of the Unique Needs of Female Veterans

| **Physical Health** | Compared to females within the general population, female veterans are more likely to experience higher rates of reproductive health conditions such as breast lumps, abnormal pap smears, premenstrual conditions, and other gynecological issues (Rivera & Johnson, 2014).

| **Mental Health** | Compared to male veterans post-deployment, female veterans experience a higher prevalence of psychiatric conditions including depression, anxiety disorders, eating disorders, and trauma-related disorders (Afari et al., 2015; Fontana, Rosenheck, & Desai, 2010; Maguen et al., 2012; Rivera & Johnson, 2014).

| **Mental Health** | Female veterans are at a higher risk for developing PTSD as compared to male veterans (Resnick et al., 2012; Tolin & Foa, 2006).

| **Mental Health** | Traumatic experiences related to PTSD diagnoses in female veterans include sexual trauma during deployment, physical assault, transportation accidents, and combat zone exposure (Schnurr & Lunney, 2012).

| **Mental Health** | History of military sexual trauma in female veterans correlated with a three times increased likelihood of PTSD diagnosis as compared to male veterans (Kimerling et al., 2007).
| Access to Services | Female veterans report a perceived lack of access to services as compared to male veterans postdeployment (Chaumba & Bride, 2010; DeKleijn et al., 2015; Kimerling et al., 2015; Washington, Farmer, Sun Mor, Canning, & Yano, 2015).

Female veterans report barriers to utilizing VA services. Female veterans struggle with being able to identify the need to seek assistance, how to seek assistance, and what resources are available (Chaumba & Bride, 2010; Kimerling et al., 2015).

The unique needs and preferences of female veterans are not addressed by current VA programming (DeKleijn et al., 2015). |
<table>
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<tbody>
<tr>
<td>Reintegration Issues</td>
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</table>
| Homelessness | Female veterans are the fastest growing subpopulation among the homeless population in the U.S. (Boothe, 2017).

The majority of female veterans who are homeless are between the ages of 40 and 59 years old, are African American, and are single mothers with children (Boothe, 2017; Washington et al., 2010).

Female veterans have a higher prevalence of risk factors for homelessness as compared to male veterans (Byrne et al., 2013; Washington et al., 2010).

Prevalence of military sexual trauma among female veterans who are homeless is twice as high as non-homeless female veterans (Brignone et al., 2016).

Compared to non-homeless female veterans, homeless female veterans are more likely to report history of trauma, PTSD, anxiety, and substance use (Brignone et al., 2016); |
Byrne et al., 2013; Washington et al., 2010).

- Risk factors for homelessness among female veterans post-deployment include low income, poor self-reported health, lack of utilization of VA services, stress due to separation from family, reintegration into life roles, lack of social supports, unemployment, history of trauma or military sexual trauma, diagnosis of PTSD, and having a disability (Brignone et al., 2016; Byrne et al., 2013; Gamache, Rosenheck, & Tessler, 2003; Hamilton, Poza, Hines, & Washington, 2012; Washington et al., 2010).
Due to the high prevalence of homelessness among female veterans, it is evident that gender-specific occupational therapy approaches are needed to identify the unique needs and risk factors for homelessness among this population. The purpose of this resource guide is to provide recommendations for the occupational therapy process when working with female veterans in community-based settings. Recommendations support the provision of gender-specific care by identifying and treating risk factors for homelessness among female veterans. In the absence of randomized control studies in occupational therapy literature on homelessness among female veterans, this resource guide draws from evidence of the occupational therapy role in mental health, veteran population, and homeless persons.
### KEY TERMINOLOGY

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td><strong>Female veterans</strong></td>
<td>A female veteran is a female returning from deployment overseas as part of the U.S. Armed Forces or deployment to a combat zone as a National Guard and Reservist. She is considered a veteran once she has been honorably discharged from the U.S. Armed Forces and may be a veteran while still actively serving in the Guard or Reserve. A female veteran often has physical and emotional scars of combat (Veterans Affairs Healthcare, 2017).</td>
</tr>
<tr>
<td><strong>Posttraumatic stress disorder (PTSD)</strong></td>
<td>A significant mental health condition in veterans caused by exposure to actual or perceived death, injury, or violence leading to distressing symptoms that impair daily life functioning. Symptoms can include recurring memories, flashbacks, distressing thoughts, avoidance behaviors, and changes in mood or activity level (American Psychiatric Association, 2013).</td>
</tr>
<tr>
<td><strong>Military sexual trauma (MST)</strong></td>
<td>Physical and emotional trauma consisting of unwanted sexual harassment, sexual coercion, or sexual assault occurring within the military setting. MST often leads to a diagnosis of PTSD and related distressing symptoms based on the trauma aspect of the experience; military sexual trauma can contribute to development of mental illnesses such as depression and substance use disorders in female veterans (American Psychological Association, 2013; U.S. Department of Veteran Affairs, 2015).</td>
</tr>
<tr>
<td><strong>Overall poor health</strong></td>
<td>Disruptions or negative influences on an individual’s social, physical, and economic environment and personal characteristics and behaviors; resulting in self-perceived poor health (World Health Organization, 2017).</td>
</tr>
<tr>
<td><strong>Homelessness</strong></td>
<td>The state of an individual who is not able to maintain a safe, permanent place of residence; an individual whose primary residence is temporary public or private facilities such as a shelter or transitional housing (National Health Care for the Homeless Council, 2017).</td>
</tr>
</tbody>
</table>
The Canadian Model of Occupational Performance and Engagement (CMOP-E) was selected for this resource guide based on the central focus of occupational engagement, occupational performance, and occupational justice for female veterans’ reintegration into society postdeployment. The CMOP-E is a holistic, client-centered model of practice focused on the interactions between the person, environment, and occupations. This model was also selected to guide the therapy process by using the Canadian Practice Process Framework (CPPF) and the Canadian Model of Client-Centered Enablement (CMCE). Through the CPPF, the therapist participates in a collaborative relationship with the client focused on doing with the client through enablement. The therapist uses the CMCE to assist with the enabling occupation within the intervention process. Change occurs through the use of enabling skills to assist with change within the person or environment to create a change in occupational performance (Townsend & Polatakjo, 2013; Turpin & Iwama, 2011).

6 Basic Assumptions:

1. Humans are occupational beings.
2. Occupation has therapeutic potential.
3. Occupation affects health and well-being.
4. Occupation organizes time and brings structure to living.
5. Occupation brings meaning to life through the combinational cultural and individual influences on the creation of meaning.
6. Occupations are idiosyncratic. Specific occupations that a person might engage in will vary from person to person.

*Occupational therapy utilizes the six assumptions to provide client-centered interventions focused on re-engagement in meaningful occupations and overall improvement of health and well-being among female veterans.*
Key Concepts

1. Person:
The CMOP-E conceptualized the person as cognitive, affective, and physical performance components with spirituality at the core of the individual.

- **Affective** components of the person involve the feelings and attitudes that affect a person's motivation and self-concept.
- **Physical** components of the person involve the doing performance components of the person such as strength, endurance, and pain.
- **Cognitive** components of the person involve thinking, reasoning, and perception.
- **Spirituality** involves the identity and values of the person, as well as where an individual finds meaning and purpose in one’s life.

*Female veterans who are at-risk for homelessness or are actively homeless often experience difficulty with physical health, mental illness and history of trauma, cognition, and maintaining a sense of identity as a female veteran.*

2. Environment:
The environment involves physical, institutional, cultural, and social contexts.

- **Physical** contexts include physical structures such as the home, workplace, or school.
- **Institutional** contexts include the political and social systems that can either facilitate or set limits on participation in occupation.
- **Cultural** contexts include religious and ethnic factors impacting occupation.
- **Social** contexts include social supports such as family, friends, and community supports.

*Female veterans who are at-risk for homelessness or are actively homeless often experience difficulty maintaining permanent housing, utilizing healthcare and community resources, and maintaining social supports.*
3. Occupation:

Occupation is defined as self-care, productivity, and leisure. Occupation is considered the bridge that connects the person and the environment.

- **Occupational deprivation**: physical, institutional, cultural, and social environmental restrictions resulting in decreased occupational performance and engagement.
- **Occupational alienation**: Individual’s feelings of meaninglessness related to occupational performance.

Female veterans who are at-risk for homelessness or are actively homeless often experience occupational deprivation and occupational alienation due to disruptions within the person and environment post-deployment. Difficulties with occupations include re-integrating into society, establishing daily routines, participating in life roles, and maintaining employment and financial health.

### Core Outcomes of CMOP-E:

- **Occupational Engagement**: participation in occupation.
- **Occupational Performance**: carrying out and completing an occupation; occurs from the interaction between the person, environment, and occupation.
- **Occupational justice**: all individuals having the opportunity, autonomy, and right to participate in meaningful occupations related to health and social inclusion.

The goal of this product is to provide a means for occupational therapists to assist female veterans to engage and participate in meaningful occupations to achieve occupational justice for this population.

(Townsend & Polatakjo, 2013; Turpin & Iwama, 2011)
The Canadian Practice Process Framework (CPPF) consists of eight action points used to guide the therapy process with an emphasis on client-centeredness and the therapeutic relationship. The aim of this process is to enable the client to engage in the therapy process, create meaningful goals, and enhance occupational performance. The therapist assists the client with goal attainment, which is the desired outcome of the process (Townsend & Polatakjo, 2013).

<table>
<thead>
<tr>
<th>Action Point 1: Enter/Initiate</th>
<th>Initial interaction.</th>
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<tbody>
<tr>
<td></td>
<td>A collaborative relationship is established.</td>
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<td></td>
<td>Identify other stakeholders.</td>
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<tr>
<td></td>
<td>Consent for service is obtained.</td>
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<tr>
<td></td>
<td>Occupational challenges are identified.</td>
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<td></td>
<td>Therapist determines if referral is appropriate.</td>
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<thead>
<tr>
<th>Action Point 2: Set the Stage</th>
<th>Gather occupational narrative and occupational history.</th>
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<tbody>
<tr>
<td></td>
<td>Identify occupational issues and goals.</td>
</tr>
<tr>
<td></td>
<td>Build rapport and the therapeutic relationship.</td>
</tr>
<tr>
<td></td>
<td>Negotiate ground-rules and expectations for therapist/client relationship.</td>
</tr>
<tr>
<td></td>
<td>Utilize the Canadian Occupational Performance Measure (COPM) during initial assessment.</td>
</tr>
<tr>
<td></td>
<td>Select frames of reference to organize information and guide selection of assessment strategies.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Action Point 3: Assess/Evaluate</th>
<th>Evaluate the individual’s occupational status, goals, and potential for change.</th>
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<tbody>
<tr>
<td></td>
<td>Evaluate personal, environmental, and occupational factors influencing the client’s occupations.</td>
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<tr>
<td></td>
<td>Utilize standardized and non-standardized assessments for data collection.</td>
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<tr>
<td></td>
<td>All assessment data is interpreted and documented.</td>
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<tr>
<td>Action Point 4: Agree on Objectives and Plan</td>
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<tr>
<td>------------------------------------------------</td>
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<tr>
<td>• Establish a plan using results from the assessments.</td>
<td></td>
</tr>
<tr>
<td>• Facilitate a collaborative process to create and confirm goals.</td>
<td></td>
</tr>
<tr>
<td>• Set objectives in order to achieve the goals.</td>
<td></td>
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<tr>
<td>• Establish the plan, goals, and objectives by collaborating with the client and other stakeholders.</td>
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<tr>
<th>Action Point 5: Implement the Plan</th>
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<tbody>
<tr>
<td>• Implement the plan that both the client and therapist agreed upon.</td>
</tr>
<tr>
<td>• Implement enablement skills.</td>
</tr>
<tr>
<td>• Implement frame of references.</td>
</tr>
<tr>
<td>• Engage client in occupational-based interventions.</td>
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<tr>
<th>Action Point 6: Monitor and Modify</th>
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<tbody>
<tr>
<td>• Monitor client’s progress towards goals and objectives.</td>
</tr>
<tr>
<td>• Complete ongoing evaluation to confirm plan is being implemented appropriately.</td>
</tr>
<tr>
<td>• Implement modifications or changes to the plan.</td>
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<tr>
<td>• Document changes and outcomes during interventions.</td>
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<tr>
<th>Action Point 7: Evaluation/ Outcome</th>
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<tbody>
<tr>
<td>• Utilize assessments to confirm goal attainment and outcomes.</td>
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<tr>
<td>• Identify further occupational issues.</td>
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<tr>
<td>• Establish further actions for services provided.</td>
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<tr>
<td>• Utilize the COPM to determine if goals have been achieved and identify further occupational issues.</td>
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<tr>
<th>Action Point 8: Conclude/ Exit</th>
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<tbody>
<tr>
<td>• Therapist and client mutual agree to conclude services.</td>
</tr>
<tr>
<td>• Educate client on options to receive further services in the future.</td>
</tr>
<tr>
<td>• Provide client with resources for successful carryover of skills learned in therapy.</td>
</tr>
<tr>
<td>• Determine other possible referrals or community resources as needed.</td>
</tr>
<tr>
<td>• Complete a discharge summary.</td>
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</table>

(Townsend & Polatakjo, 2013)
The CMOP-E utilizes the Canadian Model of Client-Centered Enablement (CMCE) to enhance occupational performance and engagement. Through a collaborative relationship, the therapist uses enabling skills throughout the therapy process to provide the client with the skills, techniques, or knowledge needed to perform an occupation (Townsend & Polataki, 2013).

**Adapt:**
- To make fitting to or right for a particular usage or situation.
- To respond to occupational challenges.
- Alter occupations (ex. breaking down tasks to create a just right challenge).
- Alter the environment or select a different environment to enable occupation.

**Advocate:**
- Raise awareness to others of problem issues and promoting the need for the issues to be addressed.
- Lobby or make new options known to key decision makers.

**Coach:**
- Encourage clients to reflect and find personal motivations in desired occupations.
- Develop and sustain an ongoing partnership to help clients produce fulfilling results.
- Draws on communication and collaboration to determine the client’s meaningful occupations.

**Collaborate:**
- Work with the client rather than doing it for them.
- Demonstrate mutual respect by empathizing, developing trust, and communicating with the client.
- Key power-sharing skill.

**Consult:**
- Exchange expertise views and confer with clients, team members, community supports, government personnel, agencies, consumer groups, etc.
- Exchange expertise knowledge for management, education, and research.
- Often replaces direct services and required therapist to gather.
**Coordinate:**  
- Draws on integration skills in which therapists synthesize, analyze, and incorporate a broad range of information pertaining:  
  - Personal factors.  
  - Environmental factors.  
  - Occupations.  
- Coordinate information, people, services, and organizations for multiple roles. Roles include practitioner, case coordinator, and management.

**Design/Build:**  
- Design or build assistive technology or orthotics.  
- Design or build adaptation for the environment.  
- Design and implement programs and services by formulating a plan or strategy.

**Educate:**  
- Understand educational philosophies, teaching methods, and learning principles.  
- Incorporate experiential and behavioral education that emphasize learning through doing.

**Engage:**  
- Engage clients actively in occupations.  
- Address participation as engagement in valued social roles.

**Specialize:**  
- Develop skills and understandings of relevant specialized theories and philosophies.

*(Townsend & Polatakjo, 2013)*
This resource guide is organized into five main sections. The first four sections reflect the occupational therapy process and apply the action points from the CPPE. The appendices consists of tip sheets for therapy and additional resources for occupational therapists working with female veterans.

1. Assessment
2. Intervention
3. Re-evaluation
4. Discharge
5. Appendices
SECTION ONE: ASSESSMENT
ACTION POINT 1: ENTER AND INITIATE

Enablement Skills:

| Collaborate: Verify referral and scope of occupational therapy. |
|----------|---------------------------------------------------------------|
| Design:  Provide a safe and gender-sensitive environment.     |
| Educate: Role of occupational therapy and services provided. |
| Engage:  Utilize discussion to build a therapeutic relationship.|

Complete the following:

- Complete chart review, initial interview, and observation.
- Identify other stakeholders.
- Consent for service is obtained.
- Utilize the Checklist: Risk Factors for Homelessness on page 21 throughout assessment process. The complete Checklist with occupational narrative and goal setting sections is located in Appendix A.
- Consider gender-specific differences for female veterans throughout assessment process. For further gender-specific tips, see Appendix B for 'Considerations for the Occupational Therapy Process.'
- Establish a respectful and therapeutic relationship with the female veteran through collaboration.
- Reassure worthiness to receive care by actively recognizing the contributions, courage, and sacrifices of women veterans.
- Actively listen and have an empathetic understanding of wartime, homeless, and reintegration experiences.
- Occupational challenges are identified.
- Determine if occupational therapy services are necessary.
ACTION POINT 2: SET THE STAGE

Enablement Skills:

**Collaborate:** Set rules, responsibilities, and expectations of the therapeutic relationship.

**Collaborate:** Identify occupational issues and goals for performance and engagement.

**Educate:** Occupational therapy’s ability to advocate for females treatment needs.

**Engage:** Discuss occupational narrative about past and present occupational performance.

**Complete the following:**

- Engage client in discussion about the ground rules for therapy and foster client readiness to proceed.
- Utilize the COPM to assess occupational performance and satisfaction.
- Select and utilize recommended assessments. Recommended assessments to utilize with female veterans can found starting on page 22.
- Identify Frames of References, theories, and frameworks to guide therapy process.
  - Cognitive Theory
  - Cognitive-Behavioral Theory
  - Sensory Integration
  - Transtheoretical Model of Change
  - Psychodynamic Theory
  - Empowerment Theory
  - Trauma-Informed Care
- Build rapport and strengthen the therapeutic relationship with the client.
- Develop the occupational narrative with holistic view of the client.
- Engage client to identify values, beliefs, assumptions, expectations, and desires.
- Collaborate to identify priority occupational issues and occupational goals.
ACTION POINT 3: ASSESS AND EVALUATE

Enablement Skills:

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Collaborate:</td>
<td>Determine perception of occupational issues that has affected occupational performance.</td>
</tr>
<tr>
<td>Coordinate:</td>
<td>Female veteran and team to document assessment findings.</td>
</tr>
<tr>
<td>Educate:</td>
<td>Findings and implications of assessment results.</td>
</tr>
<tr>
<td>Specialize:</td>
<td>Recommended assessments and the ability to interpret female veterans’ occupational issues.</td>
</tr>
</tbody>
</table>

Complete the following:

- Utilize recommended standardized and non-standardized assessments for data collection. Recommended assessments can be found starting on page 22.
- Utilize the Checklist: Risk Factors for Homelessness on page 21 throughout assessment process to identify risk factors for homelessness. See Appendix A for complete checklist with occupational narrative and goal setting sections.
- Participate in power-sharing relationship with client.
- Evaluate the individual’s occupational status, goals, and potential for change.
- Evaluate personal, environmental, spirituality and occupational factors influencing the client’s occupations.
- Analyze and interpret findings.
- Discuss assessment findings with client and other stakeholders.
- Formulate recommendations and identify resources.
- Interpret and document assessment data.
ACTION POINT 4:
AGREE ON OBJECTIVES AND PLAN

Enablement Skills:

<table>
<thead>
<tr>
<th>Adapt:</th>
<th>Treatment plan in order to achieve the goals and objectives.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collaborate:</td>
<td>Establish occupational performance and engagement goals and objectives.</td>
</tr>
<tr>
<td>Design:</td>
<td>Plan to address personal and environmental strengths and challenges.</td>
</tr>
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</table>

Complete the following:

- Utilize the completed *Checklist: Risk Factors for Homelessness* to collaborate on goals and objectives to identify and treat risk factors for homelessness.
- Establishing occupational goals using collaborative decision-making processes and based on evaluation/assessment findings.
- Collaborate to confirm priority occupational issues and established risk factors for homelessness.
- Design and create a plan to achieve goals and objectives.

*See Appendix B for ‘Considerations for the Occupational Therapy Process’ on general assessment considerations when working with female veterans.*
**CHECKLIST: RISK FACTORS FOR HOMELESSNESS**

Below are the major risk factors for homelessness among female veterans. Occupational therapists can use this checklist throughout the assessment process to determine risk factors for homelessness, set goals for the therapy process, and guide intervention planning.

| PERSON | ___ Overall poor health  |
| ___ Physical disability  |
| ___ History of military-related trauma  |
| ___ Diagnosis of PTSD or other mental illnesses  |
| ___ History of military sexual trauma  |

| ENVIRONMENT | ___ Lack of utilization of VA services  |
| ___ Lack of social supports  |

| OCCUPATION | ___ Reintegration difficulty  |
| ___ Lack of daily routines  |
| ___ Difficulty participating in life roles  |
| ___ Unemployment and/or low income  |

*See Appendix A for complete checklist with occupational narrative and goal setting sections.*
Throughout the assessment process, the therapist should utilize the *Checklist: Risk Factors for Homelessness* to determine potential risk factors for homelessness. The purpose of assessments is to further examine areas of concern based on the initial chart review and interview with the client. Below are recommended assessments for occupational therapists to evaluate components of the person, environment, and occupation that are noted to be risk factors for the client. The COPM is recommended to be implemented first within the assessment process to guide further assessments needed. Results from the assessments can be used to identify strengths, weaknesses, and concerns to guide collaborative goal writing and intervention planning.

## Person

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health-Related Quality of Life 14-item Measure (HRQOL-14)</td>
<td>Interview guide provides 14 questions addressing general health, healthy days (the number of days that physical or mental health is not good forms the basis for calculating remaining health days), and days when activities were limited by poor health. Can be used with female veterans to identify health disparities and track population trends.</td>
</tr>
<tr>
<td>Short Form-36 Health Survey</td>
<td>A 36-item survey that examines physical and mental health as well as functional limitations due to ill health. Can be used with female veterans to provide a general health measure.</td>
</tr>
<tr>
<td>General Self-Efficacy Scale</td>
<td>A self-rating scale that assesses an individual's perceived personal competence (self-efficacy or self beliefs) to deal effectively with a variety of stressful situations. Useful with female veterans in order to predict the female's ability to cope with daily hassles and adaptation after stressful life events.</td>
</tr>
<tr>
<td><strong>COPE</strong></td>
<td>A self-report questionnaire that identifies patterns of coping with stress following a traumatic event. Useful to female veterans in order to help identify the female's use of positive or dysfunctional coping responses in regards to a traumatic event.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Routine Task Inventory (RTI-2)</strong></td>
<td>Examines the level of cognitive impairment as it relates to the performance of activities of daily living (ADLs). This can be used with female veterans who have a cognitive impairment in order to measure self awareness (consisting of self-care activities), situational awareness (home and community activities), occupational role disability (e.g. planning, organizing, exerting effort), and social role disability (meeting social expectations when interacting with others).</td>
</tr>
<tr>
<td><strong>Social Adjustment Scale-Self Report (SAS-SR)</strong></td>
<td>Examines the adjustment to social roles. Useful for female veterans to identify problems in social functioning in 6 social role areas: worker (or homemaker or student), marital partner, extended family member, parent, and member of the immediate family, and social and leisure roles.</td>
</tr>
<tr>
<td><strong>Cognition Adaptive Skills Evaluation (CASE)</strong></td>
<td>Examines the cognitive process while performing a task. Useful for female veterans in order to evaluate the individual's functional skills.</td>
</tr>
<tr>
<td><strong>Behavior Rating Inventory of Executive Function-Adult Version (BRIEF™-A™)</strong></td>
<td>Examines the physical and psychiatric disabilities of adults. The questionnaire has nine clinical scales of executive functions that include: inhibit, self-monitor, plan/organize, shift, initiate, task monitor, emotional control, working memory, and organization of materials. Useful for female veterans in order to evaluate executive functioning related to physical and</td>
</tr>
</tbody>
</table>
Millon™ Behavioral Medicine Diagnostic (MBMD™)(2000)

Assesses psychiatric or psychosocial factors that may affect how a patient responds to treatment. The self-report inventory addresses seven domains: response patterns, negative health habits, psychiatric indications, coping styles, stress moderators, treatment prognostics, and management guides. Useful with female veterans by evaluating psychiatric problems and identifying issues with managing health issues.
## Environmental Assessments

### Occupational Self-Assessment (OSA)

Two part self-rating form focused on the individual's occupational competence, values of competence, and impact of the environment on occupational adaptation. Useful with female veterans to determine occupational competence, but also to determine perceptions of the environment. Information can be used to create goals and intervention strategies.

### Interview Questions

Utilize the recommended questions below to address the contextual barriers to occupational participation.

- Tell me about your current physical environment.
- Tell me about your use of healthcare services in the past and present.
- Tell me about your support systems.
- Tell me about your difficulties reintegration back into the community.
- Tell me how your environment has impact your ability to reintegrate back into daily life.
- What are your biggest barriers in your environment and participation in everyday activities?
# RECOMMENDED ASSESSMENTS

## Occupation

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Canadian Occupational Performance Measure (COPM)</strong></td>
<td>Self-structured interview used to track an individual’s occupational performance and satisfaction over time in regards to self-care, leisure, and productivity. Use with female veterans to identify problem areas and deficits in performance and satisfaction to create goals and intervention plans.</td>
</tr>
<tr>
<td><strong>Independent Living Scales (ILS)</strong></td>
<td>Standardized assessment used to measure an individual’s competency in instrumental activities of daily living (IADLs) related to problem-solving, knowledge, and task performance. Use with female veterans to focus on the areas of memory/orientation, managing money, managing home and transportation, health and safety, and social adjustment to set goals and intervention planning for discharge.</td>
</tr>
<tr>
<td><strong>Occupational Performance History Interview (OPHI-II)</strong></td>
<td>Semi-structured interview used to understand an individual’s life narrative by assessing occupational roles, daily routines, occupational behavior settings, activity/occupational choices, and critical life events. Use with female veterans to examine the impact of illness and trauma from critical life events on reintegration issues associated with roles, routines, and behavior settings.</td>
</tr>
<tr>
<td><strong>Role Checklist</strong></td>
<td>Self-report assessing an individual’s occupational roles throughout the lifespan and the value of those roles. Can be used with female veterans to determine values in roles throughout the lifespan, assist with balance between life roles, and facilitate re-engagement into desired roles.</td>
</tr>
<tr>
<td><strong>Street Survival Skills Questionnaire (SSSQ)</strong></td>
<td>Examines the levels of community-related adaptive skills for prevocational evaluation. Can be used with female veterans to provide an objective measure of adaptive behaviors (basic concepts, functional signs, tools, domestic management, health and safety, public services, time, money, and measurement), a baseline to determine the effects of training, and a prediction for community living and vocational placement.</td>
</tr>
<tr>
<td><strong>Transition to Work Inventory (TWI)</strong></td>
<td>Self-administered inventory that provides information on the individual’s career interests during periods of life transitions. Useful for female veterans who are transitioning back into civilian life and starting or going back to a job.</td>
</tr>
<tr>
<td><strong>Workplace Skills Survey (WSS)</strong></td>
<td>Questionnaire to assess nontechnical employability skills related to success in the workplace across all industries and job levels. Useful for female veterans who are transitioning back into civilian life and starting or going back to a job.</td>
</tr>
<tr>
<td><strong>Community Integration Measure (CIM)</strong></td>
<td>A self-report to assess community integration from the client’s own perspective of belonging and participating. Useful for female veterans who experience difficulty with community reintegration.</td>
</tr>
</tbody>
</table>

*See Appendix C for additional information in regards to locating the above recommended assessments.*
SECTION TWO: INTERVENTION
ACTION POINT 5: IMPLEMENT THE PLAN

Enablement Skills:

<table>
<thead>
<tr>
<th>Adapt:</th>
<th>Occupations and environments appropriately.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocate:</td>
<td>Needs of the female veteran.</td>
</tr>
<tr>
<td>Coach:</td>
<td>Use strategies relating to occupational performance issues and occupational therapy goals.</td>
</tr>
<tr>
<td>Collaborate:</td>
<td>Determine preferred interventions and activities to implement in the plan.</td>
</tr>
<tr>
<td>Coordinate:</td>
<td>Manage documentation with the female veteran and other stakeholders.</td>
</tr>
<tr>
<td>Educate:</td>
<td>Risk factors for homelessness among the female veteran population and prevention strategies.</td>
</tr>
<tr>
<td>Enable:</td>
<td>Complete interventions and activities with encouragement.</td>
</tr>
<tr>
<td>Specialize:</td>
<td>Enablement strategies and skills to affect change.</td>
</tr>
</tbody>
</table>

Complete the following:

- Utilize the results from the Checklist: Risk Factors for Homelessness to assist with planning and implementing interventions.
- Utilize frame of references and theories to guide intervention plans.
- Utilize empowerment theory to share control over treatment, empower the client to direct her own care, and get the resources she needs.
- Engage client in occupation-based interventions and activities to achieve goals and objectives.
- Document progress on goals and begin discharge planning.
ACTION POINT 6: MONITOR AND MODIFY

Enablement Skills:

**Adapt:** Occupation and environment to meet needs.

**Coach:** Advocate and discuss issues to other involved stakeholders.

**Collaborate:** Determine if plan or goal modifications are needed.

Complete the following:

- Complete ongoing evaluation to confirm plan is being implemented appropriately.
- Utilize intermittent standardized and non-standardized assessments to monitor progress towards objectives and goals.
- Utilize informal discussions with client or other stakeholders to monitor progress.
- Implement modifications or changes to the therapy plan.
- Document changes during interventions and discharge planning.

*See Appendix B for ‘Considerations for the Occupational Therapy Process’ on general intervention considerations when working with female veterans.*
RECOMMENDED INTERVENTIONS
Interventions provided relate to aspects of the person and focus on overall health, spiritual wellness, cognition, and affective components. Affective components include coping skills related to mental illness, military-related traumas, and military sexual traumas. Interventions can be completed individually or within a group setting.

## Physical and Spiritual Components

<table>
<thead>
<tr>
<th>Enablement Skill</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall Health and Spiritual Wellness</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Coach:</strong></td>
<td>Use with clients with low motivation or self-efficacy to find personal meaning in desired occupations by utilizing principles from the Transtheoretical Model of Change.</td>
</tr>
<tr>
<td><strong>Engage:</strong></td>
<td>Use creative writing and expressive arts to share underlying emotions related to past traumas to enhance feelings of self-acceptance and spirituality. Intervention could include open-ended creative writing, daily journaling, arts and crafts, sculpture, and providing opportunities to express emotions.</td>
</tr>
<tr>
<td><strong>Collaborate:</strong></td>
<td>Develop a daily plan to increase overall health and spiritual wellness through meaningful activities such as meditation, journaling, or daily exercise.</td>
</tr>
<tr>
<td><strong>Educate:</strong></td>
<td>Address healthy habits and ways to implement into daily routines.</td>
</tr>
</tbody>
</table>
## Cognitive Components

<table>
<thead>
<tr>
<th>Enablement Skill</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cognitive Therapy</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Educate:</strong></td>
<td>Patterns of distorted thinking and the negative implications on occupational performance. Intervention could include education on emotionalizing, jumping to conclusions, black-and-white thinking, etc.</td>
</tr>
<tr>
<td><strong>Collaborate:</strong></td>
<td>Identify cognitive distortions related to mental illness and/or trauma.</td>
</tr>
<tr>
<td><strong>Engage:</strong></td>
<td>Examine distorted thinking patterns and engage in healthy, constructive thinking patterns as coping strategies during occupational performance.</td>
</tr>
<tr>
<td><strong>Cognitive-Behavioral Therapy</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Collaborate:</strong></td>
<td>Use Socratic questioning to clarify understandings and beliefs related to thoughts and feelings about mental illness and/or trauma.</td>
</tr>
<tr>
<td><strong>Educate:</strong></td>
<td>Distorted thinking and subsequent behaviors related to past trauma and fears.</td>
</tr>
<tr>
<td><strong>Engage:</strong></td>
<td>Stress inoculation training to educate about stress, the relationship between stress, emotions, and behavior, cognitive restructuring related to stress, and coping skills to address stress management.</td>
</tr>
<tr>
<td><strong>Engage:</strong></td>
<td>Interpersonal skills training to strengthen communication skills and assertiveness skills to enhance confidence in interpersonal relationships.</td>
</tr>
<tr>
<td><strong>Coach</strong></td>
<td>Interpersonal scenarios using modeling, role playing, and direct feedback to apply interpersonal skills to real world situations.</td>
</tr>
</tbody>
</table>
### RECOMMENDED INTERVENTIONS: PERSON

#### Affective Components

<table>
<thead>
<tr>
<th>Enablement Skill</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychoeducation</td>
<td></td>
</tr>
<tr>
<td><strong>Educate:</strong></td>
<td>Symptoms and implications of mental illness, such as PTSD and MST, and the impact on occupational performance. See Appendix B ‘Military Sexual Trauma’ for additional information for occupational therapists about MST.</td>
</tr>
<tr>
<td><strong>Engage:</strong></td>
<td>Use psychoeducation principles related to mental illness and emotional distress in active learning scenarios to discuss and problem-solve barriers to occupational performance.</td>
</tr>
<tr>
<td><strong>Engage:</strong></td>
<td>Discussion focused on trauma history and identifying associated triggers and warning signs.</td>
</tr>
<tr>
<td><strong>Collaborate:</strong></td>
<td>Identify life stressors related to symptoms of mental illness and past trauma.</td>
</tr>
</tbody>
</table>

#### Coping with Mental Illness and Trauma

<table>
<thead>
<tr>
<th>Enablement Skill</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Educate:</strong></td>
<td>Coping strategies and skills to manage emotional distress during occupational performance. Ex. relaxation coping skills, self-regulation sensory techniques, health and wellness strategies, etc.</td>
</tr>
<tr>
<td><strong>Engage:</strong></td>
<td>Explore relaxation coping skills such as meditation, breathing exercises, visualization, progressive muscle relaxation, and yoga to assist symptoms of PTSD and other trauma-related illnesses.</td>
</tr>
<tr>
<td><strong>Engage:</strong></td>
<td>Apply relaxation skills within a control therapy environment prior to a meaningful activity with perceived stress. Ex. apply coping skills while role-playing a conversation about mental</td>
</tr>
</tbody>
</table>
illness with a spouse.

**Engage:**
Use meaningful activities for opportunity to apply learned coping strategies to determine effectiveness and applicability for the individual in life.

**Collaborate:**
Explore self-regulation techniques and create sensory modulation strategies involving sensory components such as calming scents, textures, sounds, and movement.

**Educate:**
Use of health and wellness as coping mechanisms. Education on exercise programs, running, yoga, and nutrition. Consult with other professionals as needed.

**Collaborate:**
Use health and wellness strategies to determine healthy habits and routines to promote ability to coping with mental illness and trauma.

**Design:**
Wellness Recovery Action Plan to identify triggers, early signs, and coping strategies to utilize in order to enhance emotional wellness.

*See Appendix B for ‘Resources for Occupational Therapists’ for additional information and resources regarding experiences of veterans, mental health, homelessness, and trauma-informed care.*
**RECOMMENDED INTERVENTIONS: ENVIRONMENT**

Interventions provided relate to aspects of the environment and focus on educating the impact of physical, institutional, cultural, and social contexts on occupational performance. The interventions assist to enhance the female veterans’ reintegration into civilian life by increasing awareness of community resources and minimizing barriers to occupational performance. Interventions can be completed individually or within a group setting.

### Physical Context

<table>
<thead>
<tr>
<th>Enablement Skill</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adapt:</strong></td>
<td>The environment at home, workplace, or school to promote optimal functioning.</td>
</tr>
<tr>
<td><strong>Coach:</strong></td>
<td>Identify barriers, potential solutions, and resources available within the physical environment.</td>
</tr>
</tbody>
</table>

### Institutional Context

<table>
<thead>
<tr>
<th>Enablement Skill</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Design:</strong></td>
<td>A safe and gender-sensitive environment in the community-based health care setting.</td>
</tr>
<tr>
<td><strong>Adapt:</strong></td>
<td>The community-based setting to fit the recommendations for gender-sensitive care to enhance the therapy process.</td>
</tr>
<tr>
<td><strong>Coordinate:</strong></td>
<td>A child care program associated with the community-based health care setting. This will meet the needs for female veterans with children to receive services.</td>
</tr>
<tr>
<td><strong>Advocate:</strong></td>
<td>Utilize resources within the community to meet specific institutional needs. Ex. support groups and services for substance</td>
</tr>
</tbody>
</table>
use disorders.

**Educate:** What gender-specific health care programs and services are available, eligibility for VA programs, and how to seek and locate health care services available in the community.

---

## Cultural Context

<table>
<thead>
<tr>
<th>Enablement Skill</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Collaborate:</strong></td>
<td>Desired religious practices.</td>
</tr>
<tr>
<td><strong>Engage:</strong></td>
<td>Desired religious practices.</td>
</tr>
<tr>
<td><strong>Educate:</strong></td>
<td>Resources that meet religious needs in the community.</td>
</tr>
<tr>
<td><strong>Advocate:</strong></td>
<td>Utilize resources within the community to meet specific cultural needs.</td>
</tr>
</tbody>
</table>

---

## Social Context

<table>
<thead>
<tr>
<th>Enablement Skill</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coordinate:</strong></td>
<td>Local community female veteran support groups that promotes story sharing and social interaction.</td>
</tr>
<tr>
<td><strong>Coordinate:</strong></td>
<td>Trained peer support staff/volunteer member (ex. former homeless female veteran) to address transition-related challenges such as managing stress, renewing relationships, parenting, employment advise, handling finances, and sharing resources.</td>
</tr>
<tr>
<td><strong>Coordinate:</strong></td>
<td>Programs for veterans and their spouses to promote positive coping strategies to manage conflicts.</td>
</tr>
<tr>
<td><strong>Educate:</strong></td>
<td>Support group resources within the community.</td>
</tr>
</tbody>
</table>

*See Appendix D for additional information regarding interventions focused on the environment.*
RECOMMENDED INTERVENTIONS: OCCUPATION

Interventions provided relate to aspects of the client’s occupational performance and engagement issues. These interventions assist to identify and treat risk factors for homelessness and enhance the female veterans’ reintegration into civilian life. Interventions can be completed individually or within a group setting.

**Self-Care**

<table>
<thead>
<tr>
<th>Enablement Skill</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal Care</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Adapt:</strong></td>
<td><strong>ADLs habits and routines to maximize client’s occupational performance (ex. grooming/hygiene).</strong></td>
</tr>
<tr>
<td><strong>Design:</strong></td>
<td>Daily check-list in order to participate and complete daily activities.</td>
</tr>
<tr>
<td><strong>Design:</strong></td>
<td>Daily schedules to establish daily routines.</td>
</tr>
<tr>
<td><strong>Engage:</strong></td>
<td>Utilize coping strategies and compensatory techniques to complete daily tasks.</td>
</tr>
<tr>
<td><strong>Coach:</strong></td>
<td>Implement empowerment principles to actively participate in meaningful occupations.</td>
</tr>
<tr>
<td><strong>Educate:</strong></td>
<td>Medication management skills to incorporate in daily routines.</td>
</tr>
<tr>
<td><strong>Engage:</strong></td>
<td>Develop a schedule for taking medications to implement into her daily routine.</td>
</tr>
<tr>
<td><strong>Advocate:</strong></td>
<td>Prevent further victimization by establishing healthy, meaningful daily activities and habits.</td>
</tr>
<tr>
<td>Educate:</td>
<td>Awareness of possible physical and mental health issues, when to seek assistance for illness, what actions to take, and how to seek health care resources available.</td>
</tr>
<tr>
<td>Educate and Collaborate:</td>
<td>Healthy habits and routines to prevent further physical disease and mental illness.</td>
</tr>
</tbody>
</table>

**Community Management**

| Educate and Engage:                          | Practice utilizing transportation resources. |
| Educate and Engage:                          | How to develop money management, banking, and budgeting skills. |
| Educate and Engage:                          | How to plan and budget for grocery shopping, housing, child-care, etc. |

| Engage:                                     | Provide resources and ways to seek financial support. |
| Educate:                                    | Awareness of dangerous situations and personal safety within the community. |

| Collaborate:                                 | How to advocate for assistance and services within the community and create plan for utilizing the resources needed. |

*See Appendix D for additional information regarding community resources to assist with intervention planning.*
# Recommended Interventions: Occupation

## Productivity

<table>
<thead>
<tr>
<th>Enablement Skill</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Paid or unpaid work</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Educate:</strong></td>
<td>Employment opportunities, references, and vocational skills.</td>
</tr>
<tr>
<td><strong>Design and Engage:</strong></td>
<td>Implement pre-vocational and vocational training in collaboration with employment services.</td>
</tr>
<tr>
<td><strong>Engage:</strong></td>
<td>Practice workforce skills of assertiveness, decision-making, problem-solving, and time management during meaningful activities.</td>
</tr>
<tr>
<td><strong>Educate and Engage:</strong></td>
<td>Educate on steps to gain stable employment and search through resources with job postings. Examples of resources include newspapers, bulletin boards, and communicating with different businesses.</td>
</tr>
<tr>
<td><strong>Engage:</strong></td>
<td>Practice asking for references from past employment, identifying unique individual skills, and exploring work-related skills for prevocational training.</td>
</tr>
<tr>
<td><strong>Design:</strong></td>
<td>A resume with the client based on previous and unique skill sets.</td>
</tr>
<tr>
<td><strong>Educate:</strong></td>
<td>Dress codes and professionalism presentation for job interviews.</td>
</tr>
<tr>
<td><strong>Engage:</strong></td>
<td>Role-playing activity that provides an opportunity to practice job interviewing skills and help build confidence.</td>
</tr>
<tr>
<td><strong>Coordinate:</strong></td>
<td>Work support group in the community.</td>
</tr>
<tr>
<td><strong>Consult:</strong></td>
<td>With employers regarding appropriate accommodations as required by the Americans with Disabilities Act.</td>
</tr>
<tr>
<td>Educate and Advocate:</td>
<td>How to seek assistance for disability and utilize resources in the community.</td>
</tr>
<tr>
<td>----------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>

**Household Management**

<table>
<thead>
<tr>
<th>Educate:</th>
<th>Home management skills needed for living independently in the community.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engage:</td>
<td>Analyze performance skills of client during occupation-based activities for household management.</td>
</tr>
<tr>
<td>Collaborate:</td>
<td>Identify the benefits of supported housing and developing routines and habits to maintain one’s living space effectively.</td>
</tr>
</tbody>
</table>

*See Appendix D for additional information regarding community resources to assist with intervention planning.*
# RECOMMENDED INTERVENTIONS: OCCUPATION

## Leisure

<table>
<thead>
<tr>
<th>Enablement Skill</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Social Participation</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Collaborate:</strong></td>
<td>Identify current support systems, possible need for additional support systems, and awareness of ways to improve social connections with others.</td>
</tr>
<tr>
<td><strong>Educate:</strong></td>
<td>Client’s family or social supports of the importance of social support from other families, friends, and the community.</td>
</tr>
<tr>
<td><strong>Coach:</strong></td>
<td>Increase awareness of the effectiveness of current interpersonal relationships and ways to enhance relationships with others.</td>
</tr>
<tr>
<td><strong>Engage:</strong></td>
<td>Practice interpersonal and social skills using techniques such as role-playing where the individual and therapist anticipate challenging social situations and practice appropriate responses.</td>
</tr>
<tr>
<td><strong>Educate and Engage:</strong></td>
<td>Family or social support members on information pertaining to mental illness and the risk factors for homelessness. Engage in discussion how it is impacting the client’s occupational performance and role fulfillment.</td>
</tr>
<tr>
<td><strong>Engage:</strong></td>
<td>Group discussion with the client and family/social support members on clarifying roles, the family/support system strengths and weaknesses, and establish relationship values.</td>
</tr>
</tbody>
</table>

## Quiet/Active Recreation

| Engage: | Discuss current or previous recreation interests. |
| **Engage:** | Develop healthy, fulfilling hobbies or other leisure activities through leisure exploration (Ex. art, music, writing, dancing, sports, and yoga). |

*See Appendix D for additional information regarding community resources to assist with intervention planning.*
**RECOMMENDED INTERVENTIONS: OCCUPATION**

### Role Development

<table>
<thead>
<tr>
<th>Engage:</th>
<th>Identify meaningful life roles.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collaborate:</td>
<td>Difficulties and barriers participating in life roles.</td>
</tr>
<tr>
<td>Collaborate:</td>
<td>How to participate and re-establish meaningful, complex life roles. Ex. mother, spouse, family member, student, etc.</td>
</tr>
<tr>
<td>Coordinate:</td>
<td>Groups or classes to address assertiveness, self-awareness, interpersonal and social skills, stress management, and role development for parenting.</td>
</tr>
<tr>
<td>Adapt:</td>
<td>Environment and facilitate interpersonal interactions through role-playing to promote development of roles.</td>
</tr>
<tr>
<td>Educate:</td>
<td>Parenting skills and calming techniques to use with their children.</td>
</tr>
<tr>
<td>Coordinate:</td>
<td>Local support group for single mothers.</td>
</tr>
<tr>
<td>Coach:</td>
<td>How to manage routines and schedules while being a single mother.</td>
</tr>
</tbody>
</table>

*See Appendix D for additional information regarding community resources to assist with intervention planning.*
SECTION THREE:
RE-EVALUATION
**ACTION POINT 7: EVALUATE OUTCOME**

**Enablement Skills:**

**Coach:** Evaluate personal strengths, gains, and weaknesses that impact occupational performance.

**Collaborate:** Determine goals and objectives that have been met.

**Collaborate:** Revise goals based on re-evaluation if further occupational issues exist.

**Engage:** Utilize occupation-based assessment tools to demonstrate progress and determine goal attainment.

**Complete the following:**

- Utilize the COPM to demonstrate progress, determine goal attainment, and identify further occupational issues.
- Utilize recommended assessments to collect re-evaluation data.
- Compare results from initial assessment to current evaluations to evaluate progress.
- Determine goals and objectives met.
- Revise goals for further treatment.
- Refer to Action Point 6: Monitor and Modify on page 30 if continuing services.
- If no additional services are needed, continue to Action Point 8: Conclude and Exit on page 49.
- Document findings and recommendations.

*See Appendix B for ‘Considerations for the Occupational Therapy Process’ on general assessment considerations when working with female veterans.*
SECTION FOUR:
DISCHARGE
ACTION POINT 8: CONCLUDE/EXIT

Enablement Skills:

Collaborate: Establish mutual agreement to conclude services once goals are met.

Educate: Options for resources and services within the community.

Engage: Process of concluding services and providing recommendations.

Complete the following:

- Determine possible referrals or community resources that are needed.
- Provide the necessary resources and handouts prior to discharge.
- Advocate and provide resources for services related to reintegration issues, health care, mental health, MST, and homelessness.
- Ensure that the female veteran is aware of what gender-specific community resources and services are available, eligibility requirements for VA services, and how to locate and seek services within her community.
- Ensure female veterans understands the risk factors for homelessness and how to advocate for needs within the health care system and the community.
- Complete discharge summary with recommendations.
- When possible, complete follow-up sessions following discharge.

See Appendix D ‘Intervention and Discharge Planning’ for resources to assist with discharge.


Fontana, A., Rosenheck, R., & Desai, R. (2010). Female veterans of Iraq and Afghanistan seeking care from VA specialized posttraumatic stress disorder programs: Comparison with male veterans and female war


doi:10.1080/1533256X.2012.647584


doi:10.4276/030802214X14018723138048

doi:10.2105/ajph.2006.092999


APPENDICES
APPENDIX A
CHECKLIST: RISK FACTORS FOR HOMELESSNESS
### Checklist: Risk Factors for Homelessness

**Occupational Narrative:**

### Risk Factors Identified from Evaluation:

<table>
<thead>
<tr>
<th>Category</th>
<th>Risk Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PERSON</strong></td>
<td>___ Overall poor health</td>
</tr>
<tr>
<td></td>
<td>___ Physical disability</td>
</tr>
<tr>
<td></td>
<td>___ History of military-related trauma</td>
</tr>
<tr>
<td></td>
<td>___ Diagnosis of PTSD or other mental illnesses</td>
</tr>
<tr>
<td></td>
<td>___ History of military sexual trauma</td>
</tr>
<tr>
<td><strong>ENVIRONMENT</strong></td>
<td>___ Lack of utilization of VA services</td>
</tr>
<tr>
<td></td>
<td>___ Lack of social supports</td>
</tr>
<tr>
<td><strong>OCCUPATION</strong></td>
<td>___ Reintegration difficulty</td>
</tr>
<tr>
<td></td>
<td>___ Lack of daily routines</td>
</tr>
<tr>
<td></td>
<td>___ Difficulty participating in life roles</td>
</tr>
<tr>
<td></td>
<td>___ Unemployment and/or low income</td>
</tr>
</tbody>
</table>

**Goal Setting:**
CONSIDERATIONS FOR THE OCCUPATIONAL THERAPY PROCESS

**Assessment:**

- Take time to establish a strong therapeutic relationship to understand the whole person. Female veterans are often humble individuals and value developing feelings of trust, respect, and dignity before sharing personal experiences.

- Female veterans often minimize their contributions in the military and often feel less deserving of care by comparing severity of conditions to other veterans in the VA. Focus on identifying meaningfulness of life and enhancing spirituality.

- Respectfully provide recognition of female veterans contributions and sacrifices made by in the military. This helps reaffirm the female veterans’ worthiness to obtain holistic care.

- Recognize the diverse experiences of each female to individualize treatments and increase therapeutic relationships.

- Actively listen and have an empathetic understanding of wartime, homeless, and reintegration experiences.

- Female veterans desire gender-sensitive environments and female-only groups in order to feel safe and respected as veterans. Same gender assistance is often requested for ADLs and sharing MST experiences.

- Be aware that the stigma of seeking mental health services can have negative impact on female veterans by possibly increasing feelings of shame and decreasing self-efficacy.

- It is important to educate mental health professions about military culture and provide professionals with sensitivity training on how to process traumas reported by clients.

- When working with a trauma survivor, be aware that asking questions that reveals details of her trauma may cause further trauma and distress. Avoid unnecessary questions that enforce these memories.

- Do not assume that because a female has history of PTSD and MST that she is not capable of recovery and that these experiences are the only barrier to occupational performance.

- Utilize principles from Trauma-Informed Care. See Appendix B ‘Resources of Occupational Therapist’ for additional resources.

(J. Birch, personal communication, January 20, 2016; Koblinsky et al., 2016)
CONSIDERATIONS FOR THE OCCUPATIONAL THERAPY PROCESS

Intervention:

- Female veterans are often humble and self-reliant. It is critical to focus on enabling skills to do with, not for the client in order to participate in occupation.

- Utilize the empowerment theory to ensure that the client is able to make her own decisions for treatment, direct her own health care, and get the resources she needs.

- Utilize principles from Trauma-Informed Care. See Appendix B ‘Resources of Occupational Therapist’ for additional resources.

- Utilize a strengths-based approach by focusing on strengths in occupational performance.

- Create a collaborative relationship and share control over treatment decisions.

- Female veterans value implementation of psychoeducation interventions focused on self-expression and empowerment.

- Allow for open, constant communication about treatment, progress, goals, and objectives.

- Focus on safety considerations for the client. Women often report feeling both physically unsafe among other male patients and staff, and emotionally fearful of the future with lack of trust in relationships.

- Peer support within female-only groups is highly important to the female veterans. Women report feeling more comfortable discussing sensitive topics and relating to others with similar experiences in female-only settings.

- Have a variety of activities to choose from that will be perceived as having potential benefits; this will help increase motivation for occupational engagement.

- Allow the female veterans to have access to necessary and needed items. Women report feeling demoralized and felt loss of autonomy when having limited access to desired items.

- Focus on habits, performance patterns, and communication skills. Interventions targeting routines by organizing meaningful daily activities will assist in increasing occupational engagement.

- Provide education and understanding about implications and resources available for mental illness and MST.

- When possible, consider co-treating with social workers and mental health providers.

- Consult with other professionals’ throughout the intervention process as needed.

(J. Birch, personal communication, January 20, 2016; Kennedy & Fortune, 2014; Koblinsky et al., 2016; Lipskaya-Velikovsky, Bar, & Bart, 2014).
Military sexual trauma (MST) is defined by the VA as physical and psychological trauma consisting of unwanted sexual harassment, sexual coercion, or sexual assault occurring within the military setting (U.S. Department of Veteran Affairs, 2015).

Quick facts and prevalence:
- According to the VA, 1 in 4 females and 1 in 100 males reported experiencing MST during deployment in a VA National Screen (U.S. Department of Veteran Affairs, 2015).
- History of MST is a main contributor to PTSD and depression among female veterans (Maguen et al., 2012).
- History of MST correlates with a three times increased likelihood of a PTSD diagnosis (Kimerling et al., 2007).
- Validity of the estimates of MST among female veterans are limited due to possible under-reporting within the VA setting and reporting trauma experiences outside of the VA system (U.S. Department of Veteran Affairs, 2015; Wolff & Mills, 2016).
- Reasons for female participants to not report military sexual trauma included pressure to not report, fear of retaliation, and hopeless feelings that there would be no consequences to the perpetrator (Wolff & Mills, 2016).

Female veterans with history of MST often experience:
- Disruptions in daily occupations, routines, and life roles.
- Difficulty coping with emotions and processing the traumatic experience.
- Difficulty with personal relationships.
- Symptoms and/or diagnosis of PTSD, anxiety, and depression.
  (U.S. Department of Veteran Affairs, 2015; Kimerling et al., 2007; Maguen et al., 2012; Wolff & Mills, 2016)

Important considerations for therapy:
- Take time to establish a strong therapeutic relationship to understand the whole person.
- Female veterans are humble individuals and will not share intimate experiences without feelings of trust, respect, and dignity.
- Female veterans often desire gender-sensitive environments and female-only groups in order to feel safe sharing MST experiences.
- Do not assume that history of MST is the only barrier to occupational performance.
- (J. Birch, personal communication, January 20, 2016; Koblinsky et al., 2016)

Additional resources regarding MST can be found at:
- VA National Center for PTSD
- VA Mental Health
  o http://www.mentalhealth.va.gov/msthome.asp
- Make the Connection: Support Network to Connect Veterans
  o https://maketheconnection.net/stories-of-connection?conditions=10
RESOURCES FOR OCCUPATIONAL THERAPISTS

Experiences of Veterans

- Make the Connection: Support Network to Connect Veterans
  - Online support network to connect veterans and families to others with similar stories and situations. The website contains a collection of videos from veterans and family members on stories about recovery and hope related to homelessness, employment, relationships, physical side effects from war, symptoms of mental illness, and many more.
  - Additional information and the collections of support videos can be found at: https://maketheconnection.net/

Mental Health

- Office of Women’s Health, U.S. Department of Health and Human Services
  - The website contains information regarding female veterans and PTSD, MST, intimate partner violence, phone numbers to use when at risk for serious mental health issues, and further resources that may be utilized.
  - Link to the women veterans and mental health resource: https://www.womenshealth.gov/mental-health/veterans/

- PTSD: National Center for PTSD
  - Online support network that educates individuals of the traumatic stress in women veterans. The website contains information regarding women’s changing role in the military, stressors that women face in the military, and what beneficial services and supports that can be provided for female veterans.
  - Additional information can be found at: http://www.ptsd.va.gov/public/PTSD-overview/women/traumatic-stress-female-vets.asp

- U.S. Department of Veterans Affairs: Military Sexual Trauma
  - Provides information about MST, treatment, and MST services provided within the VA.
  - Additional information can be found at: http://www.mentalhealth.va.gov/msthome.asp

Homelessness

- National Coalition for Homeless Veterans
  - Organization focused on ending homelessness among veterans through policy changes, advocacy for funding of federal programs, and providing support and resources to veteran service providers. The website educates on the main topics of...
homeless female veterans, PTSD, MST, housing, employment, child care, female veterans privacy and safety concerns when returning from deployment, and current programs for homeless female veterans.

- Additional information can be found at:

**Trauma-Informed Care**

- **Trauma-Informed Care for Women Veterans Experiencing Homelessness: A Guide for Service Providers**
  - Provides education for service providers about trauma experiences of female veterans and how to provide trauma-informed care.
  - More information and a link to the Women’s Bureau U.S. Department of Labor brochure can be found at: https://www.dol.gov/wb/trauma/
ADDITIONAL ASSESSMENT INFORMATION

More information on the following assessments can be found in:


- Health-Related Quality of Life 14-Item Measure (HRQOL-14)
- Short Form-36 Health Survey
- General Self-Efficacy Scale
- COPE
- Routine Task Inventory (RTI-2)
- Social Adjustment Scale-Self Report (SAS-SR)
- Cognition Adaptive Skills Evaluation (CASE)
- Behavior Rating Inventory of Executive Function-Adult Version (BRIEF-A)
- Millon Behavioral Medicine Diagnostic (MBMD)
- Occupational Self-Assessment (OSA)
- Canadian Occupational Performance Measure (COPM)
- Independent Living Scales (ILS)
- Occupational Performance History Interview (OPHI-II)
- Role Checklist
- Street Survival Skills Questionnaire (SSSQ)
- Transition to Work Inventory (TWI)
- Workplace Skills Survey (WSS)
- Community Integration Measure (CIM)

More information on the following assessments and purchase options can be found at the provided sources.

- Model of Human Occupation: [http://www.cade.uic.edu/moho/default.aspx](http://www.cade.uic.edu/moho/default.aspx)
  - Occupational Self-Assessment (OSA)
  - Occupational Performance History Interview (OPHI-II)

RESOURCES AND SERVICES FOR FEMALE VETERANS

Reintegration and Health Care

- Center for Women Veterans
  - Provides resources and links to services for female veterans related to caregiver support, economic opportunities, health care services, housing, legal assistance, MST, and rural veterans.
  - Provides information regarding location of clinics and services, eligibility information, and other types of services provided through the VA.
  - Resources can be found at: https://www.va.gov/womenvet/resources/index.asp

- U.S. Department of Veterans Affairs: Women Benefits
  - Provides information on VA benefits including disability compensation, pension, education and training, healthcare, home loans, insurance, and vocational rehabilitation and employment. Provides information on how to apply for VA benefits and services.
  - Provides information on Women Veteran Coordinators, Health Care for Women Veterans, and Benefits for Survivors of MST.
  - Additional information can be found at: http://www.benefits.va.gov/persona/veteran-women.asp

- Operation We are Here: Resource for the Military Community and Military Supporters
  - Online support network for female veterans and their families. The website provides several resources regarding assistance for reintegration into society. Additional resources such as counseling, crisis numbers, suicide prevention, peer support, community service organizations, recreation opportunities, and parenting are provided.
  - Additional information can be found at: http://www.operationwearehere.com/Reintegration.html

- Women Veterans Health Care
  - Provides information about eligibility and enrollment in women health care programs within the VA. Provides health and wellness information on disease prevention and healthy lifestyle habits.
  - Resources can be found at: http://www.womenshealth.va.gov/

Mental Health

- U.S. Department of Veterans Affairs: Mental Health Care
  - Provides information about mental health services provided by the VA, how to find care, education on treatment options for mental illness, and information about specialized services for female veterans with mental illness.
Military Sexual Trauma

- U.S. Department of Veterans Affairs: Military Sexual Trauma
  - Provides information that educates the general public, veterans, and family members on military sexual trauma. The website contains information regarding VA services and benefits, articles, programs, and further resources on MST.
  - Additional information can be found at: http://www.mentalhealth.va.gov/msthome.asp

- U.S. Department of Veterans Affairs
  - Online brochure that educates individuals on the disability compensation for conditions related to MST. The website contains information of the VA defining MST, factors that grant veterans disability compensation for MST, risk factors of developing PTSD or alternative mental health disorders as a result of MST, factors that support a disability claim for PTSD as a result of MST, and how to apply for disability compensation.
  - Link to the online brochure for additional information can be found at: http://www.benefits.va.gov/benefits/factsheets/serviceconnected/mst.pdf
  - Information regarding VA state-by-state MST Coordinators can be found at: http://www.benefits.va.gov/benefits/mstcoordinators.asp
  - Information regarding compensation for trauma from MST can be found at: http://www.benefits.va.gov/compensation/index.asp

- Office of Women’s Health, U.S. Department of Health and Human Services
  - Online support network that educates individuals of women veterans and mental health. The website contains information regarding female veterans and PTSD, MST, intimate partner violence, phone numbers to use when at risk for serious mental health issues, and further resources that may be utilized.
  - Additional information can be found at: https://www.womenshealth.gov/mental-health/veterans/
- **Make the Connection: Support Network to Connect Veterans**
  o Online support network to connect veterans and families to others with similar stories and situations. The website contains a collection of videos from veterans on their personal experiences of overcoming MST. In addition, the website offers information defining MST, how MST may affect veterans, and VA treatments provided.
  o Additional information and the collections of support videos can be found at: https://maketheconnection.net/conditions/military-sexual-trauma

- **Stateside Legal: Legal help for military members, veterans, and their families**
  o This support network provides MST resources for women veterans. The website contains information on educating what MST is, MST and Sexual Trauma Treatment Programs that includes women-one treatment programs, VA benefits, and further assistive resources in regards to MST.
  o Additional information can be found at: http://statesidelegal.org/military-sexual-trauma-resources-women
RESOURCES AND SERVICES FOR FEMALE VETERANS

Resources for Veterans Experiencing Homelessness

- Final Salute Inc.
  - Organization focused on meeting the unique needs of homeless female veterans postdeployment by offering services related to awareness, assistance, and aspiration.
  - Mission: provide housing services to homeless female veterans and to prevent homelessness among female veterans.
  - Services provided:
    - Housing Outreach Mentoring Encouragement (H.O.M.E.): provides transitional housing, employment support, and community reintegration support for homeless female veterans and family.
    - Stand-Up for Women Vets: provides professional attire, make-overs, and employment skills assistance for female veterans reintegrating into the workforce.
  - Information about services provided, eligibility requirements, and additional resources can be found at: http://www.finalsaluteinc.org

- National Coalition for Homeless Veterans
  - Organization focused on ending homelessness among veterans through policy changes, advocacy for funding of federal programs, and providing support and resources to veteran service providers.
  - Services provided for veterans on website:
    - Assistance locating organization within the veteran’s area
    - Tips for reintegration issues such as housing, health services, employment, financial, and legal assistance
    - Overview of federal benefits for veterans
    - Section dedicated to female veterans with links to
      - Resources regarding trauma-informed care
      - Department of Labor’s Women Veterans’ Employment website for resources about reintegration into the civilian workforce
      - State-by-state overview of specialized programs for female veterans
  - Additional information and resources can be found at: http://nchw.org/

- National Call Center for Homeless Veterans
  - Additional information can be found at: https://www.va.gov/homeless/NationalCallCenter.asp
  - Or by calling The National Call Center at 1-877-424-3838
Resources for Individuals Experiencing Homelessness

- National Alliance to End Homelessness
  - Non-profit focused on preventing and ending homelessness in the U.S. through policy changes, advocacy, education of leaders, and services throughout the country.
  - Additional information, statistics, and efforts for policy change can be found at: http://www.endhomelessness.org/pages/veterans_overview

VA Homelessness Resources and Services

- Veterans Affairs National Center on Homelessness Among Veterans
  - Focus on ending and preventing homelessness among veterans by implementing policy, education, and research.
  - VA helps Women Veterans brochure https://www.va.gov/homeless/docs/VA_Homeless_Brochure_Womens.pdf

- Community Homelessness Assessment, Local Education and Networking Groups (CHALENG)
  - Focus on uniting homeless service providers, advocates, and veterans toward the goal of meeting the evolving needs of Veterans who are homeless.
  - Services provided include: case management, education on VA benefits, employment services, housing services, and immediate needs such as food and showers services.
  - Additional information can be found at: https://www.va.gov/homeless/nchav/models/crrc.asp

Health Care Services

- Homeless Patient Aligned Care Teams (H-PACT)
  - Provides housing services and healthcare services with an interdisciplinary team approach.
  - Additional information can be found at: https://www.va.gov/homeless/nchav/models/H-PACT.asp

- Health Care For Homeless Veterans (HCHV)
  - Provides outreach, case management, and residential treatment for veterans transitioning to supportive housing services.
  - Information on eligibility and additional information can be found at: https://www.va.gov/HOMELESS/hchv.asp
Housing Services

- **Safe Haven**
  - Community-based supportive housing services for veterans with mental illness and substance use disorders.
  - Additional information can be found at: https://www.va.gov/homeless/nchav/models/safe-havens.asp

- **U.S. Department Of Housing and Urban Development-VA Supportive Housing (HUD-VASH)**
  - Partnership between HUD and the VA that provides supportive housing vouchers to homeless veterans.
  - Information on eligibility and additional resources can be found at: https://www.va.gov/homeless/hud-vash.asp

- **Supportive Services For Veteran Families (SSVF)**
  - Provides case management and supportive housing services to veterans and families who are currently experiencing homelessness or who are at risk for homelessness.
  - Information on eligibility and additional resources can be found at: https://www.va.gov/homeless/SSVF/

Employment Services

- **Homeless Veteran Community Employment Services (HVCES)**
  - Partners with employers to promote hiring of once homeless veterans.
  - Provides veterans with assistance with employment resources, career exploration, and other services related to successful employment.
  - Information on eligibility and additional information can be found at: https://www.va.gov/HOMELESS/HVCES.asp

- **Veterans Justice Outreach Program**
  - Provides assistance to veterans with history within the justice system through outreach services, case management, and assistance locating legal representation.
  - Information on eligibility and additional information can be found at: https://www.va.gov/homeless/vjo.asp

Mental Health

- **U.S. Department of Veterans Affairs: Homeless Veterans**
  - Online support network for veterans with mental illness experiencing homelessness. The website provides information regarding homeless veteran crisis lines, online chats, community mental health services, and programs.
  - Additional information about VA mental health services can be found at: https://www.va.gov/HOMELESS/mental_health_services.asp#one