

Soldiers on the Streets: How Homeless Vietnam Veterans Decide To Seek Healthcare

S Lee, P Willson

Citation

S Lee, P Willson. *Soldiers on the Streets: How Homeless Vietnam Veterans Decide To Seek Healthcare*. The Internet Journal of Advanced Nursing Practice. 2017 Volume 16 Number 1.

DOI: [10.5580/IJANP.47907](https://doi.org/10.5580/IJANP.47907)

Abstract

Information regarding homeless Vietnam veterans (HVV) use of health care services is inconsistent. The purpose of this study was to explore the factors that influence HVV decisions of whether or not to access health care services. Specifically, these authors developed a preliminary theory grounded in data to recognize and improve understanding about experiences and challenges of HVVs seeking health care services. Advanced practice nurses can lead the improvement of HVVs health by understanding the patients' perspectives and patient barriers to care.

Methods: A qualitative research design was implemented to explore the factors that influence HVVs when making decisions of whether or not to access health care services. According to parameters of the study, all participants served the United States military during the Vietnam War. Symbolic Interactionism was used to (a) understand meaning that HVVs attach to the health care setting, to health, and to illness; and (b) to identify the response HVVs apply to things, or symbols, through their interaction with health care providers.

Findings: A preliminary theory was inductively derived from relationships and interactions of HVVs with each other and health care providers. The 6 main categories that contribute to and influence HVVs in their decision-making regarding accessing health care were identified. The prevalent attitudes are that quality of health care is not as important as convenience of the facility or the health care provider.

INTRODUCTION

Advanced Practice Nurses (APNs) are likely to encounter homeless persons with unmet healthcare needs in emergency departments (ED), community clinics, and homeless service centers. Homeless persons have poorer health status than housed patients with a lifetime burden of chronic conditions, mental health problems, and substance use problems. Homeless persons were found to be nearly twice as likely to have unmet medical needs (OR=1.98; 95% CI 1.24-3.16) and ED visits within the past year (2.00, 95% CI= 1.37-2.92) than those with shelter. (1) Military veterans are at increased risk for homelessness when compared to the general population. (2) According to the 2015 Point-in-time Estimates of Homelessness (3), veterans are overrepresented among the homeless population. While veterans account for roughly 10% of the total adult population in the United States (U.S.), they comprise 16% of the homeless adult population.

Health problems of homeless Vietnam veterans (HVVs) are influenced by being part of the "Baby Boomer" generation - Americans born after World War II. This generation is expected to live longer than previous generations because of new and improved medical advancement. (4) Additionally, access to quality health care is associated with a care-giving environment and social interaction between health care provider and client. (5) When HVVs attempt to access health care, barriers may be great and too difficult to overcome. Identifying, recognizing, correcting, and limiting obstacles that fragment health care delivery may improve HVV health and well-being.

HVVs describe their health status as fair or poor, and indicate they have a multitude of health concerns that include physical and psychological problems, Post-Traumatic Stress Disorder (PTSD), anxiety, and alcohol or drug dependencies. Malnutrition, skin disorders, and injuries related to violence are also major health issues, and often are

untreated. (6) Further, homeless veterans were found to be less likely to utilize community health care clinics even though they had medical and psychiatric needs. Homeless veterans report frustration, experiencing high stress levels with community and Veterans Health Administration (VHA) services. For instance, veterans' benefits are needed to receive VHA health care services, and for homeless veterans, signing up for VHA benefits can be excessively difficult and time-consuming. (6)

For this study, a qualitative research design was used to explore the factors that influence HVVs when deciding to access health care services. The aim of this study was to develop a preliminary theory grounded in data to better understand experiences and challenges of HVVs seeking health care. According to parameters of the study, all participants served the U.S. military during the Vietnam War. The Vietnam War was one of our nation's most taxing wars, presenting continuous threats of violence, injury, or death while in combat, while denying servicemen and women the opportunity to discuss their traumatic experiences upon returning home. (7) While Vietnam veterans may have unresolved emotional, physical, and psychosocial needs, most of them are now in their 60's and 70's, which increases needs for healthcare from a plethora of other issues that come with growing older. (8) Data gathered from this study provides information for health care providers to develop and adapt interventions to better meet needs of HVVs.

RATIONALE FOR THE STUDY

The researchers' interest in HVVs stems from experiences as professional nurses having lived in small, rural communities with a large percentage of Vietnam veterans. The researchers became aware that homelessness is a social issue that affects communities across the U.S. Homelessness is comprised of three essential causative factors that, when combined with other events, creates unsafe, unhealthy living. Essential causative factors are unemployment, or not earning a sufficient wage to support one's self; lack of affordable housing; and a breakdown of family and social support systems, possibly from divorce, illness or death of a family member, or as an escape from an abusive relationship. (9)

Homelessness can be quantified by measuring empirical referents of the affected population. That said, estimates of how many people are homeless exist but validity is questionable. A variety of instruments have been employed

to identify and count homeless people, however, these tools are unsatisfactory as it is difficult to track people who do not wish to be seen, are mistrusting of strangers, or are not readily visible. Homeless people hide under shrubs, sleep in cars, or huddle in dark, out of the way areas. To further compound the lack of trust, and because of areas where homeless gather, researchers may ask law enforcement officials to accompany them, which further compounds the issue of homeless people not wanting to be approached and concern that officers will arrest them for vagrancy or loitering. It is understandable, therefore, that information regarding issues and needs of the homeless are inconsistent, thus necessitating improved understanding and assessing of this marginalized population to improve access to health care.

PHILOSOPHICAL FRAMEWORK

Symbolic Interactionism (SI) was the philosophical underpinning for the study, which utilizes a social psychology approach, adjusting analysis based on how people tend to act and interact in the course of daily living while focusing on human experiences. There are three foundational principles of SI, which include meaning, or that human behavior is a response to things or symbols; thought, which is based on a constant process of determining meaning from things themselves; and language, which is thought about, or developed, and used to describe meaning. (10) Even though behavior may be influenced by context, history, and social mores, things or symbols do not determine behavior. The essence of SI is how people interpret circumstances, or use thought processes to apply meaning, and select one course of action over another, which is precisely what this research explains. There is a dynamic relationship among people and society as continuous interpretation and action define each moment and provide a language to better understand actions. (10)

Since meaning is not inherently deduced from symbols, but rather comes from an interaction between person and symbol, people interpret reality based on an individual awareness of reality, which is a continuous process of creating meaning. (10) In other words, there are three truths to every situation -- my interpretation of what happened, your interpretation of what happened, and what really happened. From this concept, inter-relatedness between a person and a symbol allows for multiple social interpretations to emerge. As people develop, important individuals and social institutions influence reference groups and acquired roles. (10) Situations are analyzed to determine

proper behavior as it applies to understanding reality. The process of self-reflection entails “3 me’s”: who the person thinks he/she is, who another person thinks this person is, and who this person really is. This process allows for change as well as stability; as the process continues, actions become more consistent. It is through language that symbolic communication occurs, where meanings are shared, that people become aware of other’s experiences and meanings can be interpreted. Additionally, internal conversations are conducted to attempt to understand reality by defining the current situation a person finds him/herself in and then using that information to determine how to behave. (10)

Research using inductive inquiry and based on SI is thought to be the only way that human complexity can be understood as it allows for an understanding of how people apply meaning to situations where automatic responses are inadequate. (11) For people who have little or no material wealth, other people become very important and those relationships become symbolic. (12) Symbolic Interactionism was used to (a) understand meaning that HVVs attach to the health care setting, to health, and to illness; and (b) to identify response HVVs apply to things, or symbols, through their interaction with health care providers. Through the use of SI, an understanding was gained of HVVs analysis and interpretation of symbols that led to interpretations and subsequent behaviors related to health care decisions.

For veterans, including those who are homeless, status, and rank have meaning. This is found at the group and individual level. Health care professionals are assigned professional status while delivering diagnoses, treatment, and prognoses. White coats, uniforms, stethoscopes, and name badges signify knowledge and positions that healthcare professionals hold, while acknowledgment of military rank, such as sergeant, or corporal, are appreciated and may be interpreted automatically, while still influencing and impacting interactive process.

From this interaction, meanings that form our sense of who we are as individuals emerge. These may include such things as dialogues and thought processes. It is important to the individual to be part of a social interaction and be seen as playing a part, or having a role, such as might arise from military experience. Examples include being a pilot, attaining the rank of officer, returning home as a hero, or fulfilling a leadership role in a combat squadron or platoon during the war. These self-perceptions motivate behavior.

After being in the military, and possibly in a leadership position, being homeless and possibly ill may cause HVVs to feel vulnerable and powerless. Personal connections and interpretations become indicators for mutual interaction and influence decision-making process. Language also affects interactions are meaning is assigned to symbols, which can affect behavior.

Meanings are modified by interpretation and interaction of shared symbols. As HVVs age and become more vulnerable, they have greater healthcare needs. Social structure of military life shapes interactions with others, while incorporating a particular language and associated symbols. There is a hierarchy in the military that is carried forward and respected, long after veterans return to the U.S. and leave active military service. To further compound the issue of vulnerability, there is the possibility that HVV with health care issues may be identified by conditions rather than as distinct individuals. It is important for HVV to be seen as people who were initially shaped by society through their military service but then grew to make further contributions to the development of society. Acknowledgments of the veteran’s military rank, such as sergeant or corporal, are appreciated and would be interpreted automatically, influencing and impacting an interactive process.

METHODS

Using Grounded Theory Methodology (GTM) and guided by the philosophical framework of SI, a preliminary, substantive theory to the research question was developed: "What is the process utilized by HVV to make the decision to access or to not access health care services?" The specific aims were to develop a preliminary theory grounded in data to recognize and improve understanding about experiences and challenges of HVV seeking health care services.

DATA COLLECTION

Institutional Review Board (IRB) approval was received and anonymity of participants was safeguarded to protect confidentiality. Semi-structured interviews took place at a community homeless shelter using snowball sampling. Psychosocial and relational elements that reflected perceptions, descriptions, and evaluation of the HVVs decision-making process were sought. In the Straussian, or substantive GTM tradition, work began with in-depth interviews of HVVs to collect, analyze, and categorize data. For the purposes of this study, HVVs were defined as adults who served in the military stateside and in foreign countries during the Vietnam War (1959-1975). Homelessness was

defined as not having a permanent nighttime residence, other than a homeless shelter or camp. Available health care was defined as any care provided by VHA or community-funded facilities. Interviews were audio recorded, transcribed word for word, and checked to ensure exactness. Field notes during and immediately after each interview were noted in the transcripts, adding pertinent information, such as appearance, gestures, body language, and non-verbal behavior. Rigor was verified by attending to credibility (i.e., accuracy of data collected) and confirmability (i.e., checking results for researcher bias).

DEMOGRAPHIC DATA

Even though the inclusion criteria indicated men and women, no women were identified as possible participants for the study. Eleven men participated (n=11) and all reported being Vietnam-era veterans who qualified as homeless and received services at a homeless shelter. The ages ranged from 55 to 66 years of age (M= 61.36 years). The majority were Caucasian (n=9), with one African-American, and one Hispanic. Most of the participants were divorced (n=8), two were widowed, and one was separated from his wife. All participants had volunteered for military services rather than being drafted, enlisting during a twelve-year period from 1965 to 1977. All but one participant was a teenager when they enlisted. Four enlisted at 17 years of age, four were 18 years old, two were 19 years old, and one enlisted at 27 years of age (M=18.64 years). The parents of the four who enlisted at 17 years of age signed waivers for their under-age sons to join the military.

Eight participants were assigned to Basic Training immediately upon graduating from high school. Of those eight, five were deployed to Vietnam and engaged in active combat with tours of duty that ranged from 8 to 18 months (M= 13.6 months). The other participants did not serve in Vietnam (n=5). The participants left the military between the years of 1970 and 1992. All of the participants were honorably discharged. One participant with a history of gastric ulcers reported that his discharge was for medical reasons. One participant reported that he was honorably discharged the first time he enlisted, but dishonorably discharged after he re-enlisted. Three of the participants slept at the shelter at night. Most veterans (n=8) slept outside or found other temporary accommodations, such as one participant who slept in a self-storage facility.

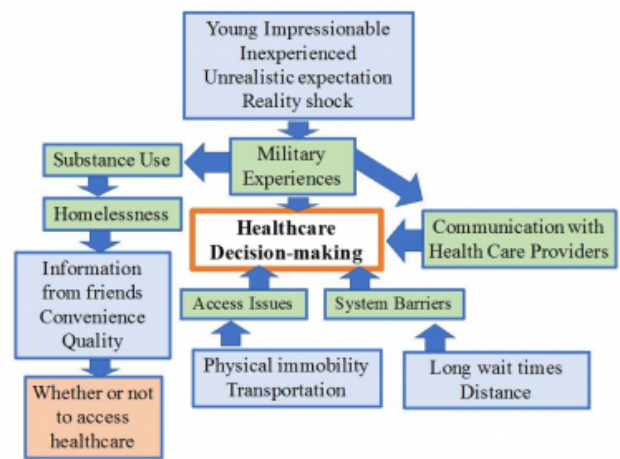
DATA ANALYSIS

During open coding, the researchers examined the text for

salient categories, applying codes and labeling phenomena. The transcripts were reviewed line-by-line, sentence-by-sentence. Word phrases or sentences were analyzed by selecting one word that seemed significant, listing all of the possible meanings, and then validating the findings against the text. Concepts that related to the same phenomena were then grouped and coded into categories. As data began to explain people, places, events, conditions, or settings, the sample was expanded to add more cases and gain additional information. The categories were named using ideas from literature or by using participant’s terms, such as family dynamics, substance use, arrest history, employment, medical issues, meeting basic needs, health care, military history, and benefits.

Axial coding explored the relationship of categories, while making connections. Constant comparison was used to achieve saturation by comparing the data, looking for instances that represented the categories. Systematic comparisons were made, asking “what if” and exploring additional dimensions, while simultaneously looking for differences. A concept map was created to visually display the inter-relationship of the categories (see Figure 1).

Figure 1
HVV Healthcare Decision Making Concept Map



After data saturation was achieved, the categories were re-examined and adjusted; some were condensed and renamed, including communication, substance use, system barriers, access issues, homelessness, and military experiences. Through selective coding, a single category emerged as the central phenomenon, which formed the basis for the construction of the conceptualization of the core category: health care decision-making. Final categories were then refined.

FINDINGS

Using GTM, a preliminary theory was inductively derived from relationships and interactions of HVVs with each other and health care providers. The main categories that contribute to and influence HVVs in their decision-making regarding accessing health care were identified. The six categories of 1) military experiences, 2) substance use, 3) homelessness, 4) camaraderie (informal communication, “grapevine”), 5) access issues (long wait times, inconvenient location, lost records, system inefficiencies), were associated with the core concept 6) health care decision making. HVVs’ stories are exemplified in Table 1 by concept and veteran characteristic.

Table 1
Concepts with Veterans’ Characteristics

CONCEPT	PROPERTIES	ILLUSTRATING QUOTE
Military experiences (non-modifiable)	Young, naive	<i>I was young- didn't know no better. Started to drink most of the time.</i>
	Decisions made for them	<i>I was at the airport in Saigon- I was an MP. That wasn't my job originally- they decided to put me as an MP. I had no choice.</i>
Substance Abuse	Personal sacrifices	<i>31,000 men we lost in Vietnam. They come home after the war was over and they were spit on like dogs. How can you treat a man this way when he wore his colors and defended your right to be free- calling them "baby killers" and "rapists"?</i>
	Began in Vietnam	<i>I started out like anybody- smoking weed, first and then started doing acid when I was 18-19- while I was in Vietnam. Then I started doing cocaine and heroin- it was the only way to get through that time. You'd talk something to make it all go away and then come down and have to start the cycle all over again.</i>
Communication	Continued after war	<i>I liked it- I did it well! I was 35.</i>
	Health care providers (attends, negative expectations, not questioning treatment)	<i>When I first went to the VA, the doctor was an Indian- a woman doctor. She treated me funny- I ain't know- like she was looking at me funny and talking down to me. It was hard to understand her- I ain't the chief. Why can't they speak English?</i>
Access Issues	Informal grapevine	<i>VA's not getting any better from what I've seen personally and talking to these guys down here and all they want to do is push the pills and push pills help to a certain extent but it's no cure. You know, you can push the pain pills onto people and you're not trying to cure you're just trying to get them to calm down.</i>
	System inefficiencies	<i>I was really, really sick and they dumped me into the ice. I knew the clinic was coming. In best comp. I got pneumonia and they dumped me in the ice then, too.</i>
Comaraderie	Continuance	<i>I've talked to a lot of guys and they gave me the down low on what's happening at the VA in Temple and it's real nice.</i>
	Access Issues	<i>One time I had an 8 AM appointment so I got there at 6:30- I sat there and sat there and went up and asked and was told they were running late. I was there until 3:30 in the afternoon.</i>
Comaraderie	Limited mobility	<i>On the day I have an appointment, I go two hours early to one place for lab work and then go about 13 miles to the clinic where the doctor is. Transportation is tough.</i>
	Continuance	<i>I had my knee replaced. I had a lot of arthritis. I can't walk without this (points to his walkers).</i>

Military experiences appeared with all of the participants, as being a HVV was a condition for inclusion in this study. Properties of military experiences included personal sacrifices, as all HVVs in this study volunteered for military duty, most of them immediately after completing high school when they were young, impressionable, and inexperienced. The participants reported having expectations of changing the world, making a difference, and being successful. They also said that decisions were made for them, as they trusted their government leaders and military officials. Instead, they experienced reality shock upon landing in Vietnam and turned to drugs and/or alcohol to help them cope with the harsh realities of war. Additionally, upon returning home, many HVVs reported disillusionment as they were labeled “baby-killers” and “spit on”.

All of the participants spoke about substance use, which began soon after entering the military and/or being in Vietnam. Most participants indicated this was a coping

mechanism for the unforeseen experiences and tough realities of being in the military and/or combat in Vietnam. Substance use continued after returning home, leading to health issues, or the dissolution of the family, and homelessness. Lifestyle behavior has a significant role in continued substance use, which impacts health and decision-making.

Trying to make ends meet was discussed by each of the participants. Properties of homelessness were socioeconomic adversity, stressful experiences, camaraderie and using informal avenues of communication, such as the informal grapevine. Ten of the participants entered the military soon after graduating from high school, having a 12th grade education. Ten participants were unemployed and attributed their inability to work on advanced age and physical disability. Participants discussed the shortage of affordable housing, saying that their retirement or disability income was insufficient to pay for a house or apartment.

Stressful experiences, such as dissolution of the family, either from divorce or the death of a spouse, led or contributed to HVVs struggling to make ends meet and, subsequently, becoming homeless. Legal issues added to the stress. One participant explained that homeless people who are on waiting lists for transitional housing cannot have been arrested within 6 months of placement. If they are arrested, usually for loitering or public intoxication, the 6-month waiting period begins again. As was the case of 2 participants in this study, court-ordered rehabilitation led to homelessness as they had houses, cars, and jobs before entering court-ordered rehabilitation but, by the time the program ended, those assets were gone and they were left without resources.

Camaraderie and the importance of community to HVVs appeared many times in conversations about relationships, camps, and shelters. Relationships were reported as important, with closeness and respect demonstrated within communities. Participants spoke about being members of a community, where they watched out for and took care of each other. They were observed sitting together and demonstrated closeness by talking in undertones when strangers came near. When a member of the community is absent, other members share what they have heard about the missing colleague’s whereabouts. Communication occurs via the grapevine, with one person reporting or recommending a health care professional or facility, not necessarily based on actual experiences, but on hearsay. Participants ultimately chose health care more for

convenience rather than quality.

Ten participants reported health care access issues. The properties of access issues are limited mobility and system inefficiencies. Most of the HVVs had physical limitations, such as joint pain associated with arthritis or they walked with a limp from accidents. Some of the participants ambulated with an assistive device, such as a cane or walker. Standing or walking for long periods of time or climbing stairs was difficult for many participants.

System inefficiencies were described by all of the participants, including long wait times to be seen by a health care provider, inconvenient locations of clinics, delayed appointments, and quality of healthcare. The distance to health care clinics is a problem when transportation means taking the bus, walking, or asking friends for rides. Many participants reported that it takes a long time to get to VHA clinics when using public transportation even though the commitment to improve access to and quality of health care services for veterans is shown by VHA's quality initiatives and increasing number of Community Based Outpatient Clinics (CBOC) being developed. (11) Six of the participants reported being happy with the quality of health care they received with VHA facilities and reported being treated with respect. Even so, participants reported a lengthy delay between making appointments and seeing health care professionals, sometimes as long as three weeks.

The major finding of this research is that health care decision-making was the central phenomenon for HVVs. As decision-making is important for anyone who needs to access health care services, the theme of health care decision-making highlights the causal conditions of HVVs: military experiences, substance use, homelessness, camaraderie, and access issues. The prevalent attitudes are that quality is not as important as convenience of health care. Information was obtained from friends regarding where to go, rather than being referred to the most appropriate health care provider.

RELATION OF FINDINGS TO PHILOSOPHICAL FRAMEWORK

HVVs interpreted their realities based on their youthful, inexperienced, and naive awareness of reality, as they continued the process of creating meaning. For HVVs, meaning came from an interaction between trusting the government, having decisions made for them, and being sent to the war in Vietnam. Since meaning is not inherently deduced from symbols, but rather comes from an interaction

between person and symbol, people interpret their realities based on an individual awareness of reality, which are three truths to every situation: my interpretation of what happened, your interpretation of what happened, and what really happened. If we take the example of the three truths that can be applied to every situation, it becomes the HVV's interpretation of what happened, society's interpretation of what happened, and what really happened during the Vietnam War and upon returning home. To further explain this concept, inter-relatedness between a person and a symbol allows for multiple social interpretations to emerge. As Vietnam veterans continued to serve, military leaders and the disciplined military life influenced them and their families. The three truths were evaluated to determine proper behavior as it applied to understanding reality, which then allowed for growth. As the process continued to evolve, actions became more consistent. In the case of Vietnam veterans, many turned to substances when faced with war and being in a strange country. To share meanings, symbolic communication was used, creating an awareness of experiences and interpreting meanings. For Vietnam veterans, because of the mistreatment and disillusionment upon returning home, many HVVs reported they continued to use substances and did not speak of the events related to the Vietnam War, so sharing and interpretation did not occur, thus no meaning was given to these events.

Using inductive inquiry and basing this research on SI allowed for better understanding of the health care decision-making process utilized by HVVs in determining whether or not to access health care. For HVVs who have few possessions, relationships and friends are very significant and become symbolic. The words, advice, and opinions offered by trusted friends are important.

For those who served in the military, status and rank have meaning. This was particularly noted at the individual level when HVVs interacted with health care professionals. The actions/interactions of healthcare professionals influenced and impacted the process of the HVVs receiving health care services. The social hierarchy of the military continues even after veterans return home and leave military service. It is important for HVVs who were shaped by military service to be treated with deference. HVVs commented on showing and being treated with respect, using direct eye contact, and the ability to understand when communicating.

Through the application of SI, understanding was gained that HVVs defer to people bearing symbols of military hierarchy and of health care professions, as status and rank have

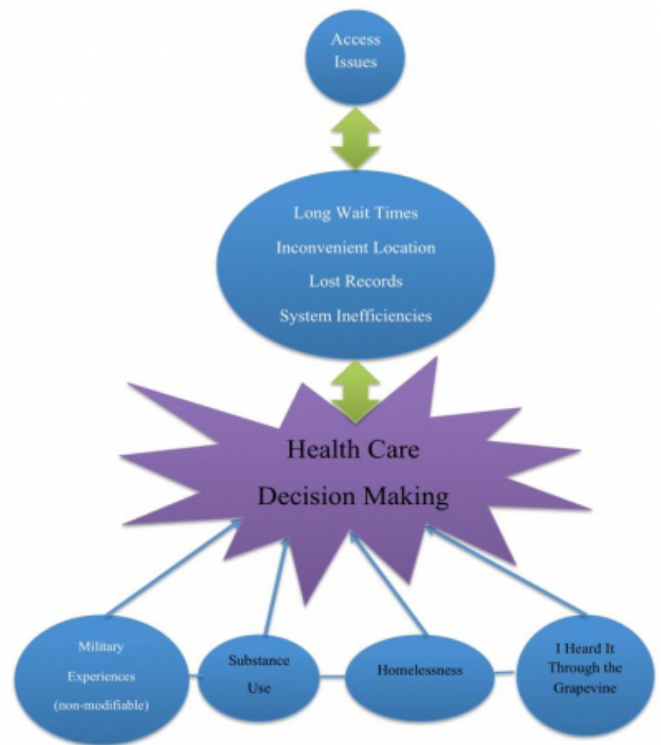
meaning. This was mainly noted when HVVs interacted with health care professionals. Many of the participants in this study said they felt health care providers were insensitive and rude. The actions of health care professionals influenced the healthcare decision-making of HVVs as five of the participants said they would never seek treatment at VHA facilities again, regardless of quality of care. HVVs went so far as to recommend that health care professionals should demonstrate respect, using direct eye contact, and speaking clearly, ascertaining HVVs understand what they are told. Thus, a preliminary theory emerged founded on the philosophical underpinnings of SI.

PRELIMINARY HOMELESS VIETNAM VETERANS HEALTH CARE UTILIZATION THEORY

The major categories, which appeared in the responses by the majority of the participants, surfaced from the data analysis. The minor categories, reported by some but not all of the participants, include family dynamics, arrest history, employment, and benefits. The phenomenon of interest remains health care decision-making with the recognition that convenience over quality determines how healthcare decisions are made. The causal factors for HVVs in their decision-making processes remain military experiences, substance use, homelessness, and access issues. Rather than focusing solely on healthcare, the refined version of the preliminary theory of healthcare decision-making used by HVVs represents a shift. Based on HVVs Health Care Utilization Patterns, it is recognized that health care professionals need to help HVVs make decisions based on quality rather than the current method of convenience.

While none of these concepts alone appear to be the primary trigger for health care decision-making in HVVs, health care decision-making certainly occurs within the context of the collective of these concepts. HVVs have an alternate view of wellness and health. Rather than health being the absence of disease, it is surviving in the presence of disease. The environment of homelessness enhances diminished or compromised wellness, especially when HVVs enter the health care environment, and experience more burden than benefit because of access issues. Further, camaraderie is important in the homeless environment, where information sharing occurs via informal networks, as through the grapevine (see Figure 2).

Figure 2
Preliminary Homeless Vietnam Veterans Health Care Utilization Theory Model



CONCLUSIONS

The situations or contexts that contribute to health care decision-making in HVVs include scarcity of resources, high incidence of family dissolution, legal issues, importance of belonging to a community and having friendships, communicating via the grapevine, limited mobility, distance to health care clinics, long wait time to be seen by a health care professional, negative experiences and poor impressions. Intervening conditions are that HVVs were young, impressionable, and inexperienced when they volunteered for military service, having expectations of military life that, in reality, turned out to be much different. They suffered reality shock and turned to coping mechanisms, such as denial of the true situation, acceptance of substance use, and avoidance of reality

Conclusions may be derived from this research, which cross many interdisciplinary fields. Most important among them is that HVVs continue to survive in the face of adversity, forced to develop informal support systems and skills to survive. However, HVVs require assistance, which can come in informal or institutional forms. As discussed, a context of health care decision-making is dominant in HVVs. Support can come from health care professionals as HVVs currently make access decisions based on

convenience more than quality. Assistance would allow HVVs to improve their health and overall well-being by gaining timely treatment for illnesses or injuries.

From listening to the stories of the HVVs in this study, there was a clear theme of disillusionment—with the government, military leaders, and themselves. Many indicated they had hopes and aspirations to be successful and change the world. Instead, they reported they were lied to and promises, that would later be broken, were made by people they trusted and looked to for well-being. An image of antisocial behavior, substance use as an escape, and combat stress was assigned to HVVs. In this study, HVVs shared their disillusionment in the way they were treated upon returning home, burdened by the knowledge they had no choice but to follow orders and shoulder the blame for the events that occurred in Vietnam.

This study sought to understand what it is like to be a HVV determining the need for healthcare, capturing stories and gaining new perspectives. For a population of veterans who are known to be reluctant in sharing their Vietnam experiences, this study gave voice to the memories, thoughts, and actions of HVVs and established the importance of healthcare decision-making by creating a preliminary theory, explaining the factors that influence HVVs. Even though past military experiences of HVVs cannot be changed, they are a contributing factor in the decision making of HVVs. Since the war in Vietnam ended, there have been additional wars, and a new generation of homeless veterans. Ultimately, Americans—especially healthcare professionals—have a shared responsibility to ensure that men and women who served in the military are not forgotten and that they have access to the quality, timely healthcare they deserve. APNs can take the lead by identifying, correcting, and limiting barriers that fragment healthcare delivery for servicemen and women, their opportunities to access to healthcare may increase and their health status may improve (see Table 2).

Table 2

Clinical Resources for Homeless Veterans

Homeless Veteran’s Clinical Resources and Websites
Department of Veterans Affairs Blueprint for excellence (13): http://www.va.gov/HEALTH/docs/VHA_Blueprint_for_Excellence.pdf
The 2015 Annual Homeless Assessment Report to Congress: Point in Time Estimates of Homelessness: https://www.hudexchange.info/resources/documents/2015-AHAR-Part-1.pdf
Enhancing Veterans health care—programs, resources and clinical assessment tools (14): https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4671760/

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Author Information

Susan Lee, PhD, RN, CNE

Texas Board of Nursing, Nursing Consultant for Education
Austin, Texas

Pamela Willson, PhD, RN, FNP-BC, CNE, FAANP

Texas State University - Graduate Studies, Director of Leadership and Administration in Nursing Program, Clinical Professor
Round Rock, Texas