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# Understanding Self-Determination in People Experiencing Homelessness to Inform: Community Engaged Teaching & Learning

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**Abstract**

*The purpose of this study was to understand what health related activities of residents living in transitional housing for the homeless increases their self-determination in managing their own health, what barriers exist, and what could nursing students do to increase their self-determination in managing their health. Methods: A qualitative approach using interviews, PhotoVoice, and observations was used. Twelve semi-structured interviews utilizing Critical Incident Technique, photos submitted by eight participants, and observation notes were used to learn more about the self-care health practices of people experiencing homelessness. Results: The themes that emerged from the interviews and PhotoVoice supported the Theory of Self-Determination, which states that in order for a person to be motivated to self-care, autonomy, competence, and relatedness must occur. Conclusions: Understanding the needs of the homeless is key to improving nursing care for this vulnerable population. This study fills the gap of understanding what health related activities of residents living in transitional housing for the homeless increases their self-determination in managing their own health, what barriers exist, and what nurses can do to increase their self-determination in managing their health.*

**Keywords:** Homelessness, Community Engaged Learning, Nursing, PhotoVoice, Self-determination Theory

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Homelessness is a global public health issue associated with significantly higher morbidity and mortality rates compared to the general population, as well as poorer health outcomes overall (McWilliams et al., 2022). Despite the complex health challenges faced by people experiencing homelessness, healthcare workers, including nurses, often hold misconceptions about this population, which can lead to biased attitudes and behaviors in clinical settings. Becker and Foli (2021) noted that these biases are commonly rooted in stereotypes and a lack of understanding of the structural and social factors contributing to homelessness. As a result, homeless individuals face multiple barriers to care, including distrust in healthcare services and avoidance of seeking treatment.

One of the most effective ways to address these biases and improve health for people experiencing homelessness is through community-engaged teaching and learning for their future providers. Meaningful engagement with marginalized populations, such as through clinical placements in shelters, street medicine programs, and community outreach initiatives, fosters empathy and challenges preconceived notions about homelessness (Gardner & Emory, 2018). These experiences encourage nursing students to move beyond stereotypes and gain a deeper appreciation of the resilience and agency of people experiencing homelessness.

Nurses, as the largest group of healthcare professionals, are often the first and sometimes the only point of contact for people experiencing homelessness (McWilliams et al., 2022). This places them in a pivotal position to either perpetuate or dismantle barriers that prevent access to care. However, implicit biases among nurses can negatively impact the quality of care provided. O'Toole et al. (2019) found that nurses may unconsciously prioritize the health needs of housed patients over those of homeless individuals, assuming that the latter group is less likely to adhere to treatment plans.

To effectively care for this population, it is crucial for nurses to develop an understanding of the systemic barriers that contribute to homelessness, such as lack of stable housing, food insecurity, and limited access to preventative healthcare services (Becker & Foli, 2021). Without this awareness, nurses may unintentionally contribute to the stigma and discrimination that homeless individuals frequently experience in healthcare settings.

## Background

A research study using a qualitative design was conducted with residents living in transitional housing for people experiencing homelessness to better understand their health practices, including motivators and barriers to health. According to Housing and Urban Development, transitional housing is considered a temporary, supportive housing arrangement for people transitioning from homelessness to stable housing. Residents of transitional housing are still categorized as homeless under HUD guidelines (HUD Exchange, n.d.). The residents living at this organization are supported by an onsite case manager who helps them work towards independence and self-sufficiency. One of the performance measures used to demonstrate self-sufficiency is increasing self-determination. Self-determination goals, as set by the agency, include being able to find and keep employment, manage personal finances, and make decisions about their lives. However, self-determination related to the management of one's health has not been addressed.

The guiding framework for this study is Self-determination Theory, which states autonomy, competence, and relatedness increase motivation and well-being and for optimal motivation to occur, all three must occur (Ryan & Deci, 2000). This framework guided both the development of research questions and interpretation of participant narratives, with a focus on how interpersonal interactions, particularly with healthcare providers, can either support or hinder these basic psychological needs.

The purpose of this study was to understand what health related activities of residents living in transitional housing for the

homeless increases their self-determination in managing their own health, what barriers exist, and what could nurses do to increase their self-determination in managing their health. The research questions were: (RQ 1) For people with limited financial resources living in transitional housing for the homeless, what strategies/interventions promote healthy behaviors in their lives? (RQ2) what barriers exist to incorporating healthy behaviors in their lives? and (RQ3) what can nurses do to help them with their health needs?

This study builds upon a prior study which examined student perceptions of clinical learning when working with the residents in the transitional housing facility (DeBrew, 2024). During the previous semester, nursing students, while in their mental health nursing course, began working with the residents to establish a new clinical site which would offer basic health screenings, such as blood pressure and blood sugar checks, screenings for depression, and health education. Students completed a needs assessment with the residents, who reported they would like to know more about how to stay healthy. Data were collected from student reflections to understand what learning experiences they found meaningful when learning about various populations, including people experiencing homelessness, in hopes of designing nursing curricula aimed at teaching nursing students about caring for patients with limited financial resources. Learning that the students found the clinical site a meaningful learning opportunity allowed the focus to then move to the residents. What would the residents want the students to know about how they stay healthy and what barriers impact their ability to stay healthy? If the residents had the chance to inform nursing education, what would they want nurses to know about working with people in poverty?

## Methods

Approval for the study was given by the university's institutional review board, as well as the community organization in which the study took place. Data collection consisted of two parts: qualitative interviews and PhotoVoice (Wang & Burris, 1997). Residents were asked to participate in the study through several measures: the organization's monthly newsletter, fliers in the community center, emails from the director, and through personal invitation when they visited for a health screening. Participants were asked to consent to a 30-to-45-minute audio recorded interview with the PI who used critical incident technique (Flanagan, 1954) to create the following questionnaire:

- Tell me about a good experience you've had in healthcare, such as one that motivated you to have healthy habits like diet, exercise, medications.
- Tell me about a bad experience you've had in healthcare, such as one that did not motivate you to be healthier.
- What do you want future nurses to know about caring for people with limited financial resources?

The audio recordings were downloaded to the PI's password protected university owned computer. Participants who completed the interview received a $25 gift card to a local store. The incentive suggestion was made by the agency director who gave input into the type of incentives that were viewed favorably by the residents.

*Data Analysis*. For the interviews, audio recordings were transcribed, reviewed by the PI and shared with each participant. Participants were asked to read and give their feedback on whether they agreed with the transcribed interview. All agreed that the interviews were transcribed correctly. Researchers conducted a preliminary exploratory analysis separate of one another and then and coded the data separately, using a thematic analysis approach. This method allowed us to identify, analyze, and report patterns (themes) within the data. In vivo coding, or the actual words of the participants were used to create the codes. The codes were

then grouped into the themes that emerged (Creswell, 2013). The researchers then met to discuss their individual analysis, compared codes, and reached agreement on the coding scheme and the themes that emerged. Themes were developed collaboratively through an iterative process, with regular discussion to ensure consistency and rigor in interpretation.

*PhotoVoice.* In addition to the interviews, participants were invited to share their stories through PhotoVoice, a method that allowed them to visually communicate what they wanted future nurses to understand. Participants were asked to upload 3 to 5 photos to the PhotoVoice platform that they felt best represented their message for nurses. They were then instructed to provide captions for each photo in their own words. During observations in the community center, it was noted that most residents have smart phones with photo taking capabilities. Therefore, when participants were asked to complete part two of the study, they were asked to use their own phone. If they chose not to use their phone, or they did not have a phone, a disposable camera was given to them. The pictures taken by the residents were then uploaded with assistance of the researcher but titled and captioned by the resident. A display of the photos, along with their captions, was planned to showcase the photos. Stakeholders, including staff from the organization and nursing students, would be invited to view the exhibit and read the participants' captions. Participants were informed about this second part of the study during their interview. At that time, their email addresses were collected to give access to the PhotoVoice platform. Once participants uploaded and captioned their photos, they received a $25 gift card to a local store as a token of appreciation.

*Data analysis.* Data analysis for the PhotoVoice portion of the data collection was similar to that of the interview portion. The pictures and the captions given to them by the participants were analyzed separately by the researchers and then shared. After the coding scheme and themes were identified and discussed, the researchers compared the themes from PhotoVoice to the themes from the interviews.

*Ensuring rigor.* Rigor was ensured in this project through two methods: multiple data sources and member checking. First, multiple sources were used to obtain data, including interviews, PhotoVoice and observation. Observations took place while the PI was onsite at the organization for the health screenings and other events. During these observations, the PI made observations that demonstrated evidence of health and dysfunction among the residents. A second way that rigor was maintained was through member checking. After each interview was transcribed and photos were uploaded, participants were asked to review and state agreement, if applicable. Additionally, the results of the interviews and the PhotoVoice were complied into a power point and presented at the organization's four mandatory resident meetings for the month of . Through this member checking strategy, the resident feedback was positive. They felt that the research participants adequately verbalized and demonstrated their healthy behaviors and barriers, and stated praise and gratitude that their voices were heard.

## Results

Twelve interviews were completed. The demographics of the 12 participants were as follows: 9 African American and 3 white; 7 were female and 5 male; and, ages ranged from 33-to-68 years old. Most participants had lived at the agency less than a year, but three participants had lived there greater than two years.

Research question one asked about strategies the participants used to promote healthy behaviors in their lives. Themes related to this question are included in Table 1 and described in the following paragraphs.

*Table 1*

| RQ 1 | Theme |
|---|---|
| | *Providers who listen and demonstrate care* |
| | *Seeing results with self-care* |
| | *Family and friends* |
| | *Faith* |

*Providers who listen and demonstrate care*. Some participants identified "going to the doctor" as a healthy practice. Those that did, told stories of feeling heard and cared for by their providers. One participant said, when he was asked about why he said his health care provider was a healthy strategy:

> *"…I think it's his kindness and he's really smart. He hadn't told me anything wrong so far. He told me what he expects me to do everyday like take my medicine… Dr. [ ] can look at me and say 'Mr. [ ] you doing something right.' You know he sees that in me."*

Seeing results with self-care. Participants had a variety of self-care practices, which primarily included a healthy diet, taking their medications, and exercise. When they saw the results of these efforts, they were motivated to continue. One participant stated:

> *"So I'm going to the doctor and I'm getting on a scale, and he's telling me that I lost five pounds from the last time I came."*

*Family and friends*. Participants identified having family and friends as a part of a healthy lifestyle. Children and grandchildren, in particular, were motivators to being healthy. One participant stated:

> *"That and then if you do have children, they're watching and we want to put them on a road to stay healthy from a young age on up. As long as you get them into the bad habit of eating out, then they're going to want to do it when they're teenagers, because they're going to be used to doing it. So you want to get them on the right track now, so when they do get twenties and thirties, they think, y'all eat out every day? They can look at it. They're not used to it so they won't do it as much."*

*Faith*. Having an active spiritual life with faith practices, such as reading the Bible, was identified by some participants as being part of a healthy lifestyle. One participant stated:

"Cause I operate just hope and faith. It's amazing."

Research question two asked about barriers that prevented the participants from healthy behaviors. Themes related to this question are described as (Table 2):

*Table 2*

| RQ 2 | Theme |
|---|---|
| | *Providers who don't listen or say "you can't"* |
| | *Transportation* |
| | *Time* |
| | *Limited finances* |
| | *Not seeing results* |
| | *Feelings of isolation* |
| | *Substance abuse* |
| | *Knowledge deficit* |

Providers who don't listen or say "you can't". Most participants had a story about a provider visit where they felt ignored, disrespected, or not heard. Others had negative experiences such as having to wait too long at appointments, or feeling like their situation was not addressed holistically. One participant stated:

> *"in so many words she said, 'You can try, but you're never going to lose weight. You're going to have to have a knee replacement because you're so heavy.'*

*Transportation*. The participants who do not own a car cited lack of transportation as a barrier to their health. Most of these participants relied on the city's public bus system, the county transportation available to people using Medicaid, and friends for their transportation needs. One participant stated:

> *"Of course. When you don't have the money for transportation and, and stuff like that. I've missed doctor's appointments before because I didn't have money for car fare, you know, So, and then, uh, the transportation that the county offer, a lot of times they don't even show up. I missed appointments with them because, simply because they didn't show up."*

*Time*. Time constraints were an issue for many, especially the younger participants with children in the home. One participant said:

> *"And it's crazy because it's like I'm on top of my kids, but it's like for myself, I just don't have that. It's like at school. I have the doctor write them a strict diet. The teachers, we communicate about what they eat at home, they exercise every night. I'm watching what they're eating, what they're drinking. But it's like when it comes to me, it's like I just can't get it together for myself. My schedule is a barrier"*

*Limited finances*. Having limited finances, though not always explicitly stated, was viewed as a barrier to health, particularly as it related to healthy food choices and access to reliable transportation. In the case of this participant, healthy food choices are not only more expensive, but also more time consuming to prepare than cheaper, less healthy food:

> *"Consistency. Eating healthy is more expensive as well. Very much so. Sometimes it's quicker to grab those unhealthy snacks or prepackaged meals than it is to make it home sometimes. If you're having a full schedule, like hey, prepackage is already ready."*

*Not seeing results*. Implementing healthy lifestyle choices, but then not seeing results was cited as a barrier in managing one's health. One participant stated:

> *"I just get depressed and you know, I guess I'm not seeing results fast enough and you kinda like give up."*

*Feelings of isolation*. Despite living in a large apartment complex with multiple units that house families and single adults, participants reported feeling lonely, isolated and bored. These feelings seemed to worsen on the weekends when staff were not present. One participant said:

> *"On weekends we don't have nothing to do here. I know everybody go to their families, which is good cause you gotta do with your family. We be bored on the weekend. I know. I do. I guess everybody. I know I be bored."*

*Substance abuse*. A few participants admitted to a history of substance use or current substance use and acknowledged that it impacted their health. One participant stated:

> *"Cause it's, when you're a drug addict, you don't eat right. When you do drugs, you don't eat right. You don't, you don't take care of your body. Right. You don't do things that you, you know, your blood pressure high you everything you drinking, you drinking all the time. Most of the time you drinking and drug more than you eat. So you putting stuff in your body before, you know, that's really make your body kind of, it ain't, it ain't no fun. You know, so it really, you*

*unhealthy, you really unhealthy when you on drugs and alcohol."*

*Knowledge deficit*. Participants indicated that there were times when they did not understand something a provider said or were confused by the conflicting messages received by the media, especially about diet and exercise. One participant described a situation in which she misunderstood the instructions for a colonoscopy, and that resulted in having to pay a fee:

*"So I had to pay $200 cause I failed to know the proper procedures and cancellation in a procedures and exams like that. You have to give a five day notice. You have to have someone drive you and stay with you and I didn't have anyone."*

Research question three asked what nurses can do to help with the health needs of people experiencing homelessness. Themes related to this question are described as: (See Table 3)

*Table 3*

| RQ 3 | Theme |
|---|---|
| | *Show empathy* |
| | *Education* |
| | *Help with feelings of boredom and isolation* |

*Show empathy*. Participants overwhelmingly asked for empathy, understanding, and encouragement. They said things like "get to know us" and "be aware that health may take a backseat". One participant stated:

*"…we're not any different. You know, we're not what we did. We're not what we do and it's not always by choice."*

*Education*. Participants seemed genuinely interested in learning about their health and learning from the nursing students about healthy food, goal setting, and resources. One participant stated:

*"Well first of all know that they may not have the resources or the knowledge that they may have and take that into consideration. If they could give them any resources or information on what to and what not to do, give them information on free clinics. So they know that can help if they are having any problems, just to get their blood pressure and everything checked, or just to make sure that they're in good health with the free clinics. Start there."*

Help with feelings of boredom and isolation. Participants, especially those who live in the adult single unit apartments, expressed a desire to be in community with others living in the apartment complex. One participant stated:

"But I wish it was some like we had a day where they could come out. We can just have bingo night or pizza night."

**PhotoVoice**

The findings from the second part of the study, pictures using PhotoVoice, supported the findings from the interviews. There were eight participants who completed the PhotoVoice part of the study, with 38 pictures and captions included in the analysis.

When asked about evidence of healthy behaviors, the themes that emerged were:

*Eating healthy*. There were many pictures of healthy foods and meals cooked using healthy foods. Most of these pictures were taken at the weekly fresh produce distribution at the center.

Exercising and being outdoors. Some residents had their picture made walking for exercise, and one even had a picture lifting weights.

*Community center*. The community center, which is part of the housing complex, was viewed by many as a place that promoted their health. Some had pictures of the blood pressure screenings that take place, as well as the computer room that they have access too. Several included pictures of themselves serving as volunteers during the weekly food distribution.

*Self-care practices*. Pictures of daily medications, a Bible, and pets demonstrated personal practices that some residents used to improve their health.

When asked about barriers to their health, the themes that emerged were:

*Walk to the bus stop*. Many residents cited the long distance to the bus stop, the uneven pavement, the lack of sidewalks, and the uphill climb as a barrier to their health.

*No green space*. Those with children identified the lack of green space and play areas as a barrier to their health.

*Physical changes*. Some identified physical changes, such as swelling in their feet, as barriers to healthy behaviors that prevented them from getting exercise.

*Personal safety concerns*. Personal safety concerns included things like cars speeding in the parking lot, roaming animals and people jumping a fence to cut through their neighborhood.

Table 4 includes the PhotoVoice themes.

*Table 4*

| PhotoVoice | **Healthy Behaviors** |
|---|---|
| | *Eating healthy* |
| | *Exercising and being outdoors* |
| | *Community Center* |
| | **Barriers to Health** |
| | *Walk to the bus stop* |
| | *No green space* |
| | *Physical changes* |
| | *Personal safety concerns* |

## Discussion

The results of this study support the Theory of Self-Determination and provide direction for guiding nursing practice, especially in the consideration of communication and education of people experiencing homelessness. Self-determination Theory states that autonomy, competence, and relatedness increase motivation and well-being and for optimal motivation to occur, all three must occur (Ryan & Deci, 2000). However, if one of these attributes is not met, motivation for self-care decreases. Participants lacked at least one of these attributes when it came to managing their health and that resulted in a lack of motivation. For example, participants reported having the autonomy to obtain food, but lacked the competence to know what foods to choose for a healthy diet. Or participants had the autonomy and competence to manage appointments with their healthcare providers, but their interactions with them left them feeling unsupported and lacked the relatedness they needed to build their intrinsic motivation.

The use of PhotoVoice as a methodology proved to be powerful, yet not without difficulty. First, pictures were difficult to obtain from the participants that agreed to take them. Despite participants having a device to take the photos, only a few did so without prompting from the researcher. It seemed that the participants did not fully understand the task and seemed to be hesitant to take pictures that demonstrated anything negative about the center or themselves. They also seemed to not understand how to use their cameras. It was not until one of the researchers walked around with the participants and helped them use their cameras, or either took them herself when instructed by the participants, that the pictures were obtained. In hindsight, printing pictures after each

participant took them may have helped to realize the issue of poor quality prints before the study had gone too far.

Another problem occurred when the photos were printed so that the participants could review their photos and choose which ones they wanted to display in the photo exhibit. The printed photos taken by the participants were blurry and unable to be used to create the exhibit. Therefore, the power point presentation was created and shown to the residents at their monthly mandatory meeting, as described earlier.

Even though there were issues, the photos were beneficial and prompted needed changes in the community. The photos, particularly those taken of the walk to the bus stop, were shown to the agency's director, which then prompted contact with the city's transportation department and eventually a visit from a member of city council to hear the residents' concerns regarding the bus stop and the conditions of the path to the bus stop. It was later shared that there are plans to move the bus stop closer to the organization, install streetlights, and add a sidewalk leading to the stop.

## Limitations

This study has several limitations. First, it reflects the experiences and perspectives of a small group of individuals in a single community, which may limit the generalizability of findings to other populations or settings. Second, participants may have been hesitant to share anything negative, either about themselves or about the organization. Finally, because participants were already engaged in a supportive program, their perspectives may not represent those who are more isolated or disconnected from services.

## Implications for Community Engaged Teaching and Learning

The process of completing this study provides direction for faculty from any discipline who want to utilize community engaged teaching and learning with their students. First, relationships are crucial. The primary investigator had built a relationship with the director and the residents prior to conducting this research, and the relationship did not end when the study ended. Second, involving the community members in designing learning opportunities for the students is important. The residents in this organization are constantly reminded, as they were when conducting this study, that they are helping to educate new nurses and when they allow a student to "practice" on them, they are contributing to healthcare in our state. Finally, a presence in the organization is necessary to maintain trust. The PI visits the organization through volunteering at their food distribution, and hosting special events, like an ice cream party, to keep a presence and meet new residents as they arrive.

Students in all disciplines need structured opportunities to engage meaningfully with people who are experiencing homelessness, where genuine connections can be fostered. Such interactions help to break down biases and enhance understanding. Gardner and Emory (2018) found that senior nursing students who worked with the homeless not only improved their advocacy skills but also significantly increased their empathy towards this vulnerable population. These experiences are critical in reshaping negative perceptions. However, for interactions to be truly meaningful, nurses must be educated about the unique needs and challenges faced by people experiencing homelessness.

The findings from this project have meaningfully shaped our teaching practices. One of the most significant changes was the integration of detailed content on homelessness, with a focus on how it affects individuals in our local community. This was accomplished by inviting guest speakers from local organizations that serve people experiencing homelessness, allowing students to learn directly from community experts. Additionally, trauma-informed care principles have been incorporated into the course through a structured online

module, helping students better understand and respond to the impact of trauma on health. Perhaps most importantly, we placed greater emphasis on patient interviews as a key tool for building therapeutic relationships, fostering trust, and gathering essential health information from individuals who may be reluctant seto share their stories.

By providing nursing students with practical strategies to build rapport, understand the lived experiences of their clients, and reflect on their communication and teaching styles, healthcare providers can begin to dismantle the barriers that often hinder people experiencing homelessness from engaging in their own care. Doing so can improve not only the quality of care these people receive but also their overall health outcomes by addressing the critical psychosocial components of health that are often overlooked.

This study fills a gap in understanding how to motivate patients towards self-care, which can lead to improved health outcomes for people experiencing homelessness. The findings demonstrate the need for people experiencing homelessness to feel connected, supported and heard, to find motivation needed to manage their own health. While more needs to be understood about the interaction of nurses and the homeless seeking health care, these findings of this study reinforce the need for students to have "real life" opportunities to develop their skills. Community engaged learning is one way to provide those learning opportunities. This reinforces existing research on the importance of therapeutic relationships, while contributing new insights into how those relationships can be cultivated through educational experiences.

Future research should further explore the dynamics of nurse-patient relationships in this context, aiming to develop targeted interventions that enhance communication and support systems for homeless patients. Ultimately, improving these interactions can lead to more effective health management and better health outcomes for people experiencing homelessness. Research is also needed to assess how community-engaged learning experiences affect nursing students' long-term attitudes and behaviors toward underserved populations.

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