

Using Photovoice Methodology to Give Voice to the Health Care Needs of Homeless Families

Joyce A. Bredeesen, DNP, RN

Assistant Professor

School of Nursing

Metropolitan State University

700 East Seventh St. St. Paul, Minnesota 55106, USA.

Marcia S. Stevens, DNSc, RN

Professor

School of Nursing

Minnesota State University, Mankato

360 Wissink Hall Mankato, MN 56001, USA.

Abstract

Photovoice is a participatory action research strategy that enables community members to document and discuss their life conditions as they see them. This photographic technique can give “voice” to vulnerable populations who seldom have access to policymakers in positions to make change on their behalf. Thirteen homeless individuals living in St. Paul, Minnesota were provided cameras and asked to document the everyday reality of their personal or family’s health. They were directed to photograph any image they believed either positively or negatively influenced their personal or family’s health. The primary investigator met with each participant to conduct a semi-structured interview using the participant’s photographs to guide the interview. Content analysis procedures were used to analyze the recorded interviews. This report is a description of the initial phase of a project that culminated with a public forum designed to develop recommendations for a community action plan.

Keywords: healthcare, homeless, photovoice, health

1. Introduction

At last report, in the seven-county metropolitan areas of Minneapolis and St. Paul, Minnesota, there were between 9,200 and 9,300 homeless people on any given night (Amherst Wilder Foundation, 2007). Families with children make up about one third of this population and over half of this number has children under the age of 5 (Amherst Wilder Foundation, 2007). Just 20 percent of homeless adults reported they were employed. Forty percent of homeless adults reported a job loss or reduced hours as a reason for losing housing. African American adults make up 41 percent of the homeless population (compared to 4% of Minnesota’s population) and American Indians 11 percent of the homeless population (compared to 1% of overall population in Minnesota) (Amherst Wilder Foundation, 2007).

The dramatic effect of homelessness on the health and well-being of people of all ages has been well documented (Bauman, 1993; Grant, Shapiro, Joseph, Goldsmith, Rigual-Lynch & Redlener, 2007; Hwang, Tolomiczenko, Kouyoumdjian & Garner, 2005). Multiple investigators have used ethnographic and phenomenological study designs to describe the challenges of homelessness for adults (La Fuente & Lan, 1995; Williams & Stickely, 2011) and youth (Bassauk, 2010; DeForge, Zehnder, Minick, & Carmon, 2001; Ensign, 2004). Others have used qualitative research methods to gain in-depth understanding about the experiences of homeless families with use of the healthcare system and their perception of the quality of healthcare they receive (Bagge, O’Connell, Singer, & Rigotti, 2010; Bralock, Farr, Kay, Lee, Smythe-Padgham, Scherlin, et al., 2011; Daiski, 2007; Martins, 2008; Nickasch, & Marnocha, 2009; Wen & Hudak & Hwang, 2007). Photovoice, an innovative participation action research method, has been used in health research to empower marginalized groups of people (Catalani, & Minker, 2009).

Photovoice has been used with Latino-American adolescent immigrants (Streng, Rhodes, Ayala, Eng, Arceo, & Phipps, 2004); African American breast cancer survivors (Lopez, Eng, Randall-David, & Robinson, 2005), people living with HIV/Aids (Hergenrather, Rhodes, & Clark, 2006) among others. To date, photovoice, has had limited use with the homeless population (Bukowski, & Buelow, 2011; Radley, Hodgetts, & Cullen, 2005; Wang, Cash, & Powers, 2000).

Photovoice is a process that has three goals: (1) to enable people to record and reflect their community's strengths and concerns; (2) to promote critical dialogue and knowledge about important issues through small and large group discussion of photographs and the stories attached to them and (3) to bring about change that will improve conditions and enhance lives by reaching and influencing policymakers (Wang, 2006; Wang, & Burris, 1997). This approach was developed by Caroline Wang and Mary Ann Burris in 1992. It is based on the theoretical perspectives of "critical consciousness" (understanding the way that society, politics and power relationships affect one's own world situation), feminist theory (emphasizing the importance of "voice") and documentary photography (commonly used to bring about social change)(Wang, 2006; Wang, & Burris, 1997). The assumptions of this methodology are that images teach, pictures can influence policy, and community members along with policy makers can co-create policy and make changes in the community (Wang, 2006; Wang, & Burris, 1997). Therefore, the purpose of this study was to use photovoice methodology to learn about the health and health care experiences of homeless families living in St. Paul, Minnesota. The goal of gaining this information was to complete a needs assessment for presentation at a public forum with invited policy makers and community members in order for them to create an action plan based on discussion of community strengths and changes in conditions needing improvement for this vulnerable population.

2. Method

2.1 Participants

Thirteen of the 15 participants completed the study. The two who did not complete the study did not return for the third meeting, nor were they located after that time. Each participant was compensated \$50.00 cash for participation in the study.

2.2 Demographic Characteristics. Nine females and four males between the ages of 21 and 42 participated in the study. Eleven were African American, one was Latino, and one was Caucasian. All of the individuals interviewed had at least one child between the ages of one and 16 years. Seven of the adult participants had preexisting or current health issues such as Facet syndrome, diabetes, asthma, and/or mental health issues. All participants were residing in homeless shelters or transitional housing units at the time of the study. A total of 24 children were dependent family members of the participants. Four had significant health issues. Two children had asthma, one child had anemia, and one 6-year old girl was dealing with treatment for leukemia. Five of the participants stated that they had taken their children to the emergency room for care during the past 6 months. Six of the participants stated that they, or their children, were taking medications. These medications included inhalers, insulin, cancer medications, narcotics, antidepressants, and various other medications for mental health conditions.

2.3 Design and Procedure

In early July 2011, a purposive sample of 15 homeless adult family members who frequent a community based volunteer wellness clinic at a local church in a St. Paul, Minnesota neighborhood were invited to participate in this qualitative study. A police liaison for the homeless, (a social worker who is hired by the police to work on the streets with homeless adults to keep them out of prison) who is well known to the homeless community assisted in recruiting participants by identifying individuals who met inclusion criteria: spoke English, at least 18 years of age, oriented, currently homeless and were interested in participating in the study. The study was approved by the Institutional Review Board of Minnesota State University, Mankato and a letter of support provided by the director of the wellness clinic in St. Paul prior to data collection.

Each subject met with the primary investigator on three separate occasions during the ten month long study. The meetings were conducted in a private room within the wellness clinic. All of the meetings were conducted by the primary investigator, a community health nurse with several years of experience providing care for homeless people seeking services from the wellness clinic.

During the initial meeting, the investigator reviewed the project with the participant, obtained informed consent, and supplied a disposable camera and a fanny pack for ease and safety in carrying the camera. Directions on the basic use of the camera, and instructions on ethical and safe documentary practices were provided at this time. Topics such as safety when carrying the camera, safety when taking pictures, making sure not to take pictures of people or if the environmental situation is unsafe, storage of the camera, and other topics were addressed at this initial meeting (Wang, 2006). Participants were instructed to take pictures of things, items or places that they perceived to be related to their personal or family's health and either positively or negatively influencing their health. A follow-up meeting time was arranged for purposes of returning the camera in order to develop the film.

At the second meeting, the film was returned to the investigator for developing and a final meeting date and time was arranged. During the final meeting, participants were presented with the developed photos and encouraged to discuss each of them using a modification of the SHOWeD technique (Hergenrather, Rhodes, Cowan, Bardhoshi, & Pula, 2009). This mnemonic technique has been used in other photovoice studies and is helpful for contextualizing photographs by asking individuals to describe the personal meaning or story behind the images they have chosen to photograph. Each individual was asked the following questions:

1. Tell me why you took this picture and tell me what it means to you. What do you See here? What is really Happening here?
2. How does it relate to your health or you family's health? How does this relate to Our lives? Why does this problem exist?
3. What can we Do about it? How can the community improve services or resources that would be helpful for you and/or your family's health?

Finally, all participants were asked to describe how they felt while taking the photographs and what it meant to them to share their stories through their description of the images.

These audiotaped discussions lasted between 30 and 60 minutes.

2.4 Data Analysis

Audiotaped responses to the open-ended questions and discussion about the photographs were transcribed verbatim. These transcriptions were then coded in an effort to categorize the data. Content analysis was used to create a series of conceptual categories. These categories or themes, supported through clusters of words and phrases, were used to analyze the issues mentioned most frequently by the participants. Each transcript was reviewed multiple times and content analysis continued until no new themes emerged (Neuendorf, 2002).

3. Results

3.1 Food and nutrition

All 13 participants stated they had access to at least two meals through the shelters on a daily basis. Although four of the participant families were provided three meals a day at the shelter, they stated that their children were hungry between meals and they were not able to provide healthy snacks for them. Nine of the participants talked about the lack of food choices, and seven of this group stated that the lack of nutritional food was a concern.

"We were told that while we were at the church, that you can't request stuff (snacks for children and more nutritional food), like, that's what we started to do, like we requested certain foods and what-not, but then they had a meeting with us telling us that what they put out there is what we're gonna get. So that's really stressful to deal with."

3.2 Shelter/Housing

The families in this study had been homeless anywhere from one month to ten years. Of the total participants, only one family had spent a night sleeping on the street. When housing was unavailable for the families of the participants, seven resorted to leaving their child (ren) with a relative or friend while parent(s) slept on the street. Issues that emerged related to the theme of shelter and housing were: lack of permanency, communal living, lack of privacy, and hygiene concerns.

“This is a picture of my bags and this is the closet I put them in (at the shelter). I took this picture because it reminds me of being homeless and not having my home...carrying my bags around. Everything I own fits in these bags right now.”

“There weren’t any rooms. This is a picture of where they put us, in a large room with basically boxes to divide off each family, which of course means, you’re close to other families. Which I don’t think is enough privacy at all when you’re changing clothes or just talking to your kids you’re always gonna hear the next person. Or if it (the cardboard wall) falls, you’re gonna see the next person.”

“That’s what I was trying to get through with the picture, just how we sleep. That’s another way that we’re stressed. Just by the fact that we have to live like that. It’s just the fact that we’re actually living in a cardboard box if you think about it...”

“There’s two bathrooms upstairs (in the shelter). You know, people have got to use the bathroom while other people are in there. My daughter has peed on herself because she couldn’t get to the bathroom....there’s like 40 people trying to use two bathrooms because of all of the families in the shelter.”

3.3 Safety

Of the 13 participants, five stated they generally felt safe. Two participants specifically discussed their concerns over their personal safety.

“You have to worry about who you’re around. There are a lot of preys out there. It’s hard to be prey. Pretty much I think I’m a good judge of character. Thieves come in all sizes and shapes. I really don’t trust too much so I pay attention to everything. More so because I have my two little ones with me so I have to look out for them, too.”

“I just took this picture, like, you don’t know who you are really around – who’s next to you. You know nothing about too many people you meet on the streets, because, everybody is going through their own thing. You could trust them and they could be the wrong person to trust. You have to be, pretty much like I said, aware of your surroundings.”

“You don’t want to misplace her medicine. You have to be very careful. With this in the wrong hands of somebody, they could sell it. She does get like Oxycodone and a couple of narcotics for her pain, if she’s in pain, so them getting into the wrong hands, I have to be aware. And give it to her only when she needs it so she doesn’t become a junky at the age of six. If we were moving place to place I would keep it on my person. I kept it pretty much on my body at the (shelter) because the lockers there don’t lock.”

Seven of the participants took photographs of their belongings and talked about their concerns regarding theft, storage, and safety of their belongings.

“A couple people while we were there had a couple items come up missing. You only have so much, like the clothes on your back and a couple different items.”

“This is my locker. Where I keep my stuff at. It’s just like, this is how I have to live right now. Sometimes I just want to call somebody and just cry. You know, because, sometimes, some people can go in your locker and take your stuff out of here. You gotta pay attention to your locker and make a point of everything that’s in there. Some people really will take your stuff if you don’t pay attention to it. This is how we gotta live.”

3.4 Support and resources

Twelve of the 13 participants stated that they had the initial support of family and friends but over time they ‘used up’ that support system. They described initially staying with family and friends as long as possible before seeking other shelter or resorting to sleeping on the street.

Eleven of the participants took photographs of transportation and talked about how they relied on others to get around.

“When I was homeless (in transitional housing at present time) I wasn’t always able to get access to health care all the time because of course, transportation was an issue-trying to get there to get it, and then it would be so many follow-ups..just to get the meds.”

Four participants discussed how helpful it was to have their insurance provide transportation for medical appointments.

“This is my transportation to my doctor’s appointments. When I went to go see about my hernia, this is the ride that comes to get me to take me there. They’re always late and they’re rude but it’s a good thing that they give me transportation because it’s all the way in Woodbury, cause that’s the best clinic.”

“We have state funded – I think our son has Medica and we have U-Care. I hear a lot of people complain about it but we generally get the stuff we need and the Dr. ’s are nice and help us with other resources that we can’t necessarily afford. On several occasions when we did ask – things we couldn’t afford the Doctor helped us out. He said, “If you go to this place they will give you samples here.” So that was nice. That’s a plus. It’s really helpful.”

Eleven of the participants talked about how hard it was to get jobs. Each of the 11 participants discussed the frustrations of job hunting with limited resources available.

“Oh, dishwasher, warehouse work, um, through temporary services and that type of thing. Most of them have a 90-day thing, so you can get hired after 90 but most of the jobs only last about 30-40 days.”

“All the traffic and all of that but you have all the capital there, right there, you know where everything goes on, you just wonder, do they really care about people that are homeless? I think that there could be a little more time put into it as far as me, and my situation, wanting to work and all of that. I feel there’s a bill that should be passed that gives fellas a second chance, you know, I mean, to right their wrongs. We pay our debts to society. I think that should be it. I’m not saying give me a top job, but I mean, give me a chance to show that I could be productive. I think it hurts the system more by not allowing these jobs because all that leads to is crime. You end up in a revolving door going back to jail for some other different offenses because you have nothing to lose. I think that could be probably worked on.”

These participants all stated a desire to find work and to support their families.

“I just want a job. I’ve got custody of my son and I wanted to get him away from the old neighborhood to give him a fair chance. By me being his father, can’t no other man do it but me so I had to drop every I was doing and head this way with him. I didn’t want to, but I had to.”

“What I need right now, is housing, and I need a job. I been looking and I done filled out applications, I done been to job fairs, I done been everywhere, filling out all...nobody call me back, nobody got in touch with me or nothing so...”

Financial concerns were discussed by 11 of the 13 participants. Ten of those participants shared concerns about the ‘spend down’ required by the county. Each family had been given financial assistance by the county; the amounts varied depending on family size, program, and situation. Besides stating frustrations with this system, there was also a sense of despair related to being able to get back into the shelter after the spend down period.

“Now we get some money from the county, but they have this spend down rule, so basically what you get is taken away in order to stay at the shelters, it’s really kind of crazy.”

“They give us a \$150 dollars per month. The rest has to go into escrow. After 30 days you have to spend it down at a hotel. After you spend it down at a hotel you can go back to the [shelter] if they have an opening. If they don’t have any openings....That’s things that I think about, and I know a lot of people think that it’s crazy that we would stay in a hotel. Why can’t we take that money and go toward an apartment or something like that?”

“That’s a picture of this place. This is where I live. This is where I live. I have 30 days here. Hopefully I get a place within that 30 days. That’s my goal. Most people end up having to do the spend down, going back to the [shelter] and then getting sent back here. I don’t want to go through that transition. I can’t do it. The ‘spend down’ is where the money that you earn or the money that you get from the state, you give to the shelter, and then you have to spend it at a hotel or something, which really doesn’t make sense to me. Why would you have me go to a hotel when you could keep that money and put it towards me getting a place, and furniture and stuff that I needed. It’s hard to understand. But I understand that they can’t afford everything. I guess it’s a boost to help you want to get your own place, but it still doesn’t make sense.”

3.5 Healthcare access, barriers and services

Of the 13 participants, 11 had health insurance. One of the male participants did not have insurance but stated that “his children were covered.” One participant’s health insurance had lapsed due to the lack of a consistent mailing address. Only four of the participants stated they had a primary care clinic and physician. Four discussed concerns of the expense of co-pays and their inability to pay for medicine and services.

“He have asthma. But right now we can’t even get the medicine because they cut us off medical but now I took care of it but he couldn’t get his medicine at first because they had cut us off. Blue Plus. Cause they wasn’t, the Family Place wasn’t giving me my mail and they was sending it back instead of holding it, cause I’ll be back so why send it back so I didn’t get any of my mail that I was supposed to get. So they cut us off of it so now...basically, yeah.”

“It’s just bad when you get money at the beginning of the month and by the end of the month you don’t have any money and you need to go to the emergency room or you’ve need to go to the doctor or pay for birth control or, you know, things like that.”

Seven of the participants had health issues relating to hernias, chronic migraines, anemia, foot and hand problems, diabetes and neuropathy, and asthma. One participant stated she was “told she needed surgery for her hernia but she was concerned about having surgery because she would lose her spot at the shelter and would not be guaranteed a place to sleep for herself and her children when she left the hospital”. Five of the participants self-reported mental health issues which included: depression, anxiety, post-traumatic stress disorder, and undisclosed mental health issues. Two of the participants reported having a mental health counselor.

3.6 Control versus Lack of Control

Feelings of powerlessness, lack of control over one’s own life, and feelings of isolation were described by the study participants. Individuals shared photographs and stories related to the lack of control they perceived having over aspects of their lives.

“Just knowing that we don’t have a place to stay and to be here we don’t have a choice. It (the shelters) should be as comfortable as possible.”

“The reason I took picture number two is because, it’s like, we had to come in here (sign in sheet at the shelter), if we don’t sign up, we’re absent here at the place. We have to sign up, put our name, how many family,, my daughter’s name. It’s for our attendance to be here (at the shelter). A lot of rules that are here. If you are absent (from the list) then you have to leave. If the people in the office don’t see your name on this clipboard, if you forget to put your name on the thing you’re in trouble. That’s really important.”

“There was a tear on his face (18 month old son). That always affected our outlook on things because he gets sad and he’s overwhelmed a lot of times because he’s in a new situation every day for sleeping. It’s a hard transition for our son. That was rough to see. There isn’t really any place to put him down. He sleeps in his stroller mostly.”

“It’s really stressful (living in the shelter) and it affects me and it affects my daughter because I notice a whole different attitude in her. She never used to talk back to me, she never used to hit other kids but when she sees other kids hitting, she starts to do the same thing. She sees other kids talking back to their parents, she’s gonna do the same thing. So it affects both of us, not just me.”

3.7 Stigma of homelessness

All but two of the participants made frequent references to the disrespect they experienced in being “labeled as homeless”. For example, as one participant described his photo of the lobby of a shelter *“The most frustrating part with (the shelters) is, in the beginning, they label everyone as the same. What I mean is, you’re homeless or you did something wrong and now you’re homeless.”* While viewing images of set up cardboard boxes participants reported:

“That is our wonderful bedroom, the cardboard boxes in the gymnasium at a church or at a school that we were staying in. Everyone was in the same room, just separated by cardboard boxes, which was, um, I’ve never seen anything like that in my life, so . . . they really need to have an actual shelter where they can have rooms, even in the process that they go through. There are people with kids that are small crying, yelling, and have really no sense of self, you know. We’re homeless, we are not degenerate. It does really separate, it strips you down from the person that you were believed to be.”

“We’re homeless, we are not degenerate. It does really separate, it strips you down from the person that you were believed to be. They treat the people like animals. We’re just treated like animals.”

Eleven of the participants made statements expressing a desire for a sense of normalcy. One participant commented on a picture of a slice of pizza and salad in a restaurant saying:

“We had fun that day. We had a lot of fun. This was the first day I got the camera. People from here (family shelter) went—they had a little drawing. Me and my daughter won the drawing. It was really fun, we got to be like normal people and eat pizza.”

Another participant stated:

“The most difficult piece of being homeless has been that I’m really big on family and I like to spend time with family. And that’s not so hard to do but, you know, if you want to relax and hang out with your family and you can’t do the things you normally do. Me and my wife cook together a lot when we have a home and we miss out on all these little small family activities. That’s the hardest thing.”

“The most frustrating part with (the shelters) is, in the beginning, they label everyone as the same. What I mean is, you’re homeless or you did something wrong and now you’re homeless.”

3.8 Reframing experience

The participants universally shared images and stories that represented their efforts to reframe their challenges by personal efforts to make change when change was possible, maintain hope for the future through their faith and beliefs in a higher power and express appreciation for the efforts of the community on their behalf.

Acknowledgement to the Red Cross (house had burned down). *“So I definitely want to give acknowledgement because they were so many people that just freely, voluntarily helped, you know, and they got nothing in return.”*

“It’s also really hard to give our son what he needs, such as snacks and stuff. We really don’t have a choice on what foods we get or what we can give him. Sometimes they aren’t too healthy and we don’t feel like eating, but we still are thankful we have food.”

“I mean, but it wasn’t so bad, it’s just hard that, that’s where we were at for a couple of weeks at a time, but, I mean, it could be on the streets so I’m grateful that I did have somewhere to sleep at. That’s why I took that picture there.”

For example, one woman stated while referring to an image of a tattoo on her arm of her child’s name:

“There was a lot of time when I felt like giving up and just letting go or giving temporary custody to my ex....but, it’s like, if I give up, I’m back at square one, so I made it my duty to keep going through it, you know, keep pushing forward, think of the positives, even though it’s stressful.”

Another participant referred to an image of a single flower blooming under a post.

“It’s a picture of flower that had grown up underneath the streetlight post. Against all odds the thing came and survived, because they spray for plants and flowers. I saw the guy spraying. And I saw that flower and it gave us some hope that against odds that aren’t so good, things will get better. That goes to the mental health.”

Seven of the participants discussed how their faith was important to their survival and was a comforting and supportive measure while being homeless.

“Fourteen is a picture of the church that we go to. That’s like the stronghold in seeing our way through this day by day. We’re very religious and we pray a lot and we lift things up to God and just hand him each little thing at a time so it’s not too overwhelming. I think that’s why we have better help that a lot of people here, because I found that when your mental health goes downhill and you are negative about things your immune system goes to garbage and you get all these other sicknesses.”

3.9 Suggestions by participants

Each participant was asked to give suggestions to improve health care services and resources. The participants were deliberative and thoughtful in their responses. A selection of them follows.

“Have resources in one place. They are out there, just need to have the information all in one place.”

“More donations and more centers would be helpful. Getting more people involved and volunteers to play with the kids at the centers to give parents a break would help. There’s nothing that only one person can do. Everyone’s got to join together to do it.”

“Train workers who work in the shelters. Have liaisons at apartment complexes and leasing agents that are willing to rent to homeless families. Don’t recycle the homeless, 30 days at a facility is not a long enough time to find housing and a job. The ‘spend down’ needs to be addressed, it causes a cycle. You can’t save for a place or spend the money on clothing or furniture; things that you need.”

“You gotta take care of the women and children, no matter what! There is no way a momma and a child should be homeless.”

“Someone that’s able to always be there and talk to you right then and there when you need it and not turn you away, encourage you, tell you that it’s gonna be better sometime.”

“It would be helpful to have someone that’s able to always be there and talk to you right then and there when you need it and not turn you away, encourage you, tell you that it’s gonna be better sometime.”

4. Discussion

Homeless participants in this study used Photovoice to provide insight into perceptions of their individual and family’s health and the positive or negative things impacting their health. Using this method enabled the investigator and subsequently community members to gain insight into the issues of concerns and community assets from the perspective of the individuals living the experience.

The findings from this study are consistent with that of other investigators who reported that for homeless adults meeting the basic needs of food, shelter and safety is closely tied to perceptions of one’s health status (Daiki, 2007). Homeless individuals frequently have inadequate access to shelter, healthy food, a place to bathe or clean clothes to wear. And, while taking care of one’s health is an important basic need, these others take priority (Bagge, O’Connell, Singer & Rigotti, 2010). The health issues described, particularly for children, are consistent with other investigators who reported the multiple asthma triggers present in shelter life, the high rate of iron-deficiency anemia due to non-nutritious food being served in shelters and the increased incidence of mental health and developmental problems (Grant, Shapiro, Joseph, Goldsmith, Rigual-Lynch, & Redlener, 2007).

Unfortunately, as with other research findings, the individuals in this study reported that the social support they initially received ended up with conflict as a result, causing them to experience family dysfunction (Marra, McCarthy, Lin, Ford, Rodis, & Frisman, 2009). Unlike other studies reporting that lack of health insurance is a barrier to accessing health care, almost all of the participants in this study had health insurance (Bonin, Brehove, Carlson, Downing, Hoeft, Kalinowski, Solomon-Bame, et al., 2010; Martins, 2008). However, only a small percentage of the participants had a primary care clinic and doctor whom they regularly visited. It would seem that as other investigators have reported, copayments for medications and clinic visits, transportation, and accessibility issues continue to prompt homeless families to use emergency department services more frequently (Bassauk, 2010; Nickasch, & Marnocha, 2009). This means that emergency department physicians and nurses who may not know much about this population, or the recently published "Adapting Your Practice: General Recommendations for the Care of Homeless Patients" (Bonin, Brehove, Carlson, Downing, Hoeft, Kalinowski, Solomon-Bame, et al., 2010), are most likely to be the episodic care providers (Radley, Hodgetts, & Cullen, 2005; Strehlow, Kline, Zerger, Zlotnick & Proffitt, 2005). As other investigators have reported, it is these care providers that must improve their ability to be respectful and sensitive to this population so that they do not continue to avoid health care services (Montauk, 2006; Strehlow, Kline, Zerger, Zlotnick & Proffitt, 2005).

Unique to this study sample is universal frustration with what is termed "spend down." Ten participants shared concerns about the 'spend down' required by the county. Each family was given financial assistance by the county or state; the amounts varied depending on family size, program and situation. The participants' understanding of the spend down is that they are allowed to keep a certain amount of the allotted monthly money given to them by the state or county, and the rest of the money needs to go into an escrow account (if they are staying within the shelter system). The shelter system allows individuals or families a 30 day limit of consecutive nights within the shelter. The money that is in the escrow account at the end of the month needs to be 'spent down' in order for them to be able to remain in the shelter. The participants are given their escrow monies and then directed to spend it only on housing. Because the money is not enough to rent an apartment, all the participants described how they needed to go and stay at a hotel to spend the money down and then needed to show proof of spending the money on housing, even if it was a hotel, in order to be able to be eligible for access to the shelters. Besides stating frustrations with this system, there was also a sense of despair related to being able to get back into the shelter after the spend down. There are no guarantees that an opening will be available to them when they are done spending their money on housing (hotels in most instances), and will then be put at the bottom of the waiting list to get back into the shelters. Comments regarding the spend down included:

"Now we get some money from the county, but they have this spend down rule, so basically what you get is taken away in order to stay at the shelters, it's really kind of crazy."

"They give us a \$150 dollars per month. The rest has to go into escrow. After 30 days you have to spend it down at a hotel. After you spend it down at a hotel you can go back to the [shelter] if they have an opening. It they don't have any openings....That's things that I think about, and I know a lot of people think that it's crazy that we would stay in a hotel. Why can't we take that money and go toward an apartment or something like that?"

"They take your money. They give you your \$150 to live off for the month. They take the rest of it and make you freeze it up. You know freeze it up where you can't spend it. And then once your time is up at this place they make you go spend it at a hotel for a week. Some people don't make it a week. Some people that's all it is, is enough for a week. Then when you come out of the hotel you still don't have housing but you're broke. So you're trying to find a new place broke. With no money, waiting on housing, waiting on them to get another paycheck from you and run your money through the system."

"I gotta go off on the spend down and spend my money and it's still not a guaranteed spot that we would get back in here (the shelter) so that's the robbery of it, that's the big thing. And it's cold, it's fitting to get cold."

“That’s a picture of this place. This is where I live. This is where I live. I have 30 days here. Hopefully I get place within that 30 days. That’s my goal. Most people end up having to do the spend down, going back to the [shelter] and then getting sent back here. I don’t want to go through that transition. I can’t do it. The ‘spend down’ is where the money that you earn or the money that you get from the state, you give to the shelter, and then you have to spend it at a hotel or something, which really doesn’t make sense to me. Why would you have me go to a hotel when you could keep that money and put it towards me getting a place, and furniture and stuff that I needed. It’s hard to understand. But I understand that they can’t afford everything. I guess it’s a boost to help you want to get your own place, but it still doesn’t make sense.”

This county program has been in place for several years. It requires that homeless families able to enter a transitional shelter put aside, into escrow, a sum of money that would become available to them were they to find more permanent housing. Unfortunately, most families are unable to find permanent housing with the amount of funds provided and at the end of the month are forced to “use it or lose it” prompting families to move out of transitional shelters after the 30 day stay limit requirement into motels or hotels where they are able to “spend” the money and qualify for another month’s funding—this cycle and the rules connected to it for allowable spending were overwhelmingly reported by families as disruptive and from their perspective a waste of County funds.

The participants in this study reported being labeled and stigmatized describing feelings of being categorized with others in disrespectful ways. They longed for what they consider “normal”. Many reported that they were interested in finding employment but the complexity of disconnected services made it nearly impossible to achieve this goal.

Given all the challenges of being homeless almost all the participants reframed the experience in such a way that allowed them to maintain hope for an improvement in their conditions and expressed appreciation to those who provided the services they have been able to use for their own and their family’s health. Brush, Kirk & Gutekin, et al. (Brush, Kirk, Gultekin, Baiardi, 2011) describe this concept as “overcoming”. They were also able to arrive at several thoughtful suggestions for how community services could be improved in an effort to improve their individual and family health experience. The eight homeless adults interviewed for Williams and Stickley’s (2011) study of how homelessness affected their mental health and personal identity also found that although the participants had experienced exclusion and dehumanizing responses from others, they were able to form strong opinions about recommendations for policy and service provision.

The limitations of this study are the small sample size and the inability to generalize the results to other groups. Although one might argue that participants are limited in the issues they can present because they are not easily captured on film, this group of participants made great effort to capture pictures that would illustrate their experiences. All of them commented on the empowerment they felt by being asked to share their perspectives and stories. Several were in attendance at the public forum that followed completion of this phase of the study. Together, with the presentation of their photographs, sharing of their stories and dialogue with community members and policy makers attending the public forum several community based initiatives were developed.

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Table 1. Identification of Issues

Themes	Identification of Issues
Food/ Nutrition	Access to food (at least 2 meals/day) Lack of food choices/nutritional food Statements about "continuing to be hungry"
Shelter/Housing	Shelter/Housing (nights on street) Lack of permanency Communal living concerns/lack of privacy Hygiene concerns
Safety/Security	Concern about personal belongings Generally "feel unsafe in shelter" Concern about personal safety
Support/Resources	Initial family/friend support – then over time "lost support" Lack of job resources/concerns Transportation issues Financial concerns 'Spend Down' concerns
Healthcare Access and Challenges	Health insurance Health issues/illness Medications Emergency room visits (over last 6 months) Self-reported mental health issues Lack of primary physician Co-pays
Control vs Lack of Control	Parenting issues/ concerns Rules to be followed
Stigma of homelessness	Desire for sense of normalcy Dehumanizing feelings/ frustrations Negative perceptions of others toward self
Reframing experience	Resilience/ hope/ determination Faith and belief in higher power Thankfulness/ appreciation