ORIGINAL RESEARCH

Nurses' attitudes and perceptions towards homelessness

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ABSTRACT

Homelessness is a growing nationwide crisis with significant implications for healthcare. Nurses are frontline workers who play a large role in providing equitable and compassionate care to this vulnerable population. This research investigated the attitudes of registered nurses in Northern California toward patients experiencing homelessness. The study was conducted using a valid and reliable tool, "Attitudes Towards Homeless Inventory" (ATHI) and collecting demographic information. Participants sampled varied from several Northern California hospitals. Results found that a significant portion of respondents associated homelessness with substance abuse, resulting in homelessness as a personal versus societal causation. There seemed to be no differences in scores on the questionnaire based on age, work experience, and unit worked on when comparing attitudes towards personal vs societal causation. Total scores of the ATHI found that nurses with more experience had improved attitudes toward the homeless compared to those with less experience. Older nurses also had improved attitudes toward the homeless. The study highlights the need for interventions to address potential biases towards this population. Given the limited research on nursing attitudes toward homelessness, these findings expose a gap in investigating nursing attitudes regarding this patient population.

Key Words: Attitudes, Homelessness, Nurses, Perceptions

1. INTRODUCTION

1.1 Introduce the problem

Nursing is a healthcare profession that requires communication and interaction with patients of all sorts of backgrounds, including race, ethnicity, nationality, gender, education, social class, and socioeconomic status (SES). Providing care to a diverse community requires the ability to be culturally competent, in a way that provides care to patients with a distinct set of values, customs, and behaviors to meet the patient's tailored needs. A key role in nursing is not only to provide the necessary interventions to aid in treating the disease process, but also to take into consideration other factors that influence the health and healing of the patient. Physicians focus on treating the disease and hopefully curing the patient, while nurses focus on caring for the patient as a unique individual. A growing issue, not only nationally but globally, has been homelessness.

1.2 Importance of the problem

To discuss homelessness, it is distinctly important to first define the term. A layman's definition of homelessness is usually described as, "a person who does not have a permanent home." However, many scholars have divided the broad group of people characterized as homeless into three categories: (1) people without a place to reside, (2) people in persistent poverty, forced to move constantly, and who are homeless for eleven brief periods, and lastly (3) people who have lost their housing due to personal, social, or

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environmental circumstances.[1]

Homelessness remains a pervasive and long-standing problem. On any single night in January 2023, more than half a million people (653,104 people) were estimated to be experiencing homelessness across the United States.[2] 12.1% was the year-over-year increase in the number of people experiencing homelessness, making it the largest increase since data collection began in 2007.[2] Historically, most people experiencing homelessness are doing so for the first time, with 62% of people experiencing sheltered homelessness falling into this category in the year 2021.[2]

On a more micro level, California's homeless population continues to grow. New data shows nearly 186,000 people now live on the streets and in homeless shelters in California, proving that the crisis only continues to grow despite both local and state efforts.[3] The good news, however, is that the rate at which the homelessness crisis is growing overall compared to recent years has slowed. From 2015-2017, the rate was 16%. From 2017-2019, it was 13%. Now, from 2019-2022 it has remained steady at 13%.[3]

Homelessness is associated with poorer health outcomes and a higher prevalence of mental and substance abuse disorders when compared to housed individuals. People experiencing homelessness are at an increased risk of infectious and non-infectious diseases such as Viral Hepatitis (especially hepatitis C), Tuberculosis (TB), Human Immunodeficiency Virus (HIV), and COVID-19.[4] People experiencing homelessness also deal with mental illness and are at an increased risk of mortality by suicide.[5] The mean prevalence of any current mental disorder in the homeless population is estimated at 76.2%.[6] The most common mental health disorders include substance use disorders, antisocial personality disorders, major depression, and general mood disorders.[7] Increased risks to overall health can be ascertained from: (1) unhoused individuals staying in congregate settings like homeless shelters, increasing their risk of respiratory infections like TB and COVID-19, (2) increased stress, uncertainty, and threats to safety while experiencing homelessness leading to risk for mental illnesses such as anxiety, depression and post-traumatic stress disorder (PTSD), (3) intravenous drug use and limited access to clean needles and supplies, increasing their risk for viral hepatitis, HIV, and other bloodborne pathogens, and (4) structural and social barriers to healthcare and other social services.[4]

With the increasing homeless population in the United States and specifically in California, it is safe to presume that many homeless individuals who are at a much higher risk of developing poorer health outcomes will seek healthcare at the hospital, most notably the emergency department. Nurses, who offer essential healthcare services to vulnerable persons, are the first line of care for many of these patients, which is why it is important to assess any implicit bias or negative attitudes these healthcare professionals may have towards this population.

1.3 Literature review

Despite focused attempts to reduce health disparities, health inequalities, and higher mortality rates still exist among certain populations, including those who come from lower socioeconomic status (SES).[8] Individuals who are homeless fall into this lower SES status. There is a clear link between homelessness and lower care standards or perceptions throughout the literature. Multiple studies reported that homeless individuals perceived being treated poorly by healthcare providers.[9–12] Conducted interviews and found that participants believed they received poor quality care or were denied care for mental illness, chronic pain, and addictions when clinicians were made aware of their housing status. Homeless individuals have also reported that they feel they are treated with prejudice and receive a lower standard of care compared to housed individuals.[13] Most of the participants had experienced an unwelcoming attitude and had perceived this as an act of discrimination. The negative attitudes of healthcare staff made the homeless participants feel dehumanized and less likely to seek healthcare.[14]

In directly looking at attitudes of nurses towards the homeless population, it has been reported that negative attitudes are present, and nurses may see people who are homeless as objects and dehumanized.[15] Negative attitudes found in healthcare have been identified by the homeless as a barrier to healthcare.[16,17] Reported evidence that healthcare professionals' attitudes toward the poor contribute to the health disparities and lack of access to care by these vulnerable populations. Negative attitudes and feelings held by health providers are likely to adversely affect healthcare.[18] There is very limited research regarding nursing attitudes directly related to the homeless population, instead, much of the current evidence focuses on implicit bias. Implicit bias and attitudes are linked.

Implicit bias tends to be unintentional discrimination or attitudes. This bias can manifest itself in our explicit actions, such as providing nursing care. Implicit bias can result in health disparities and poor health outcomes for patients.[19] Implicit bias of healthcare providers (HP) has been shown to lead to negative patient assessments, inappropriate treatments, decreased time spent with patients, and discharging patients without adequate follow-up.[8] As previously mentioned, minimal research has been conducted evaluating implicit bias in nurses, rather in healthcare in general.[8] Bias

can affect HP behavior or attitudes towards patients.[20–22] A review article spanning nearly 50 years found that 73% of papers found a bias between HP SES bias and clinical decision making.[23]

1.4 Hypotheses and their correspondence to research design

Researchers' hypothesis states that the Attitudes Towards Homelessness Inventory (ATHI) will reveal negative attitudes and potential biases towards homelessness from the nursing participants.

2. METHODS

To gain a better understanding of possible biases and negative attitudes held towards the homeless population, this research aimed to investigate and collect data from current registered nurses in the Northern California Region. Data was collected using the 11-item Attitudes Towards Homelessness Inventory (ATHI), as well as a 7-item demographic questionnaire stored in the web-based software, Qualtrics. All IRB protocols were followed.

2.1 Participants

Only Registered nurses were eligible to participate. Nurses were required to have at least one year of experience to be eligible to participate. Participants were able to access the survey via the link provided in an email or using a QR code on their preferred device. All participants signed the consent form before entering the study, and participation was voluntary. Participants worked at multiple hospitals located throughout Northern California in a variety of different specialty areas. No specialty areas were excluded from participation.

2.2 Sampling procedures

Recruitment was aimed at current active registered nurses in the Northern California region. Recruitment consisted both of email and flyers. Flyers were posted in break rooms of local hospitals and given to supervisors for multiple locations. Additional recruitment included emails to nurses at Northern California hospitals. A consent form was required before authorization of participation and was required to be signed by the participant. Surveys were open for two months before they were closed for data analysis.

2.2.1 *Sample size*

Recruitment aimed to have 50 participants for the study. Researchers received a total of 22 responses, of which only 17 were fully completed. Total sample for analysis totaled 17 participants.

2.2.2 *Attitudes towards homelessness inventory (ATHI)*

The ATHI is a valid and reliable tool that has been used in numerous studies over the years.[24] The instrument chosen aimed to cover multiple dimensions of nurses' attitudes toward homelessness.

The ATHI assigns items into four subscales: (1) personal causation, (2) structural causation, (3) affiliation, and (4) solutions. Personal causation assesses the beliefs about the extent to which homelessness is caused by personal factors, such as drug abuse or experiences in childhood. Structural causation assesses beliefs about the extent to which homelessness is caused by structural factors, such as recent government cutbacks in welfare and low minimum wages. Affiliation assessed comfort in affiliating with homeless persons, such as if they would feel comfortable eating a meal with a homeless individual. The final section evaluated respondents' thoughts on solutions for homelessness. This questionnaire was stored in the web-based software, Qualtrics.

2.2.3 *Demographic questionnaire*

The demographic questionnaire assessed for age, race, ethnicity, gender, years of experience as a nurse, and current unit/specialty that participants worked on. This questionnaire contained 7 items and was stored in the web-based software, Qualtrics.

2.3 Statistical analysis

Statistical analysis was done by evaluating descriptive statistical measures. Descriptive analysis was done on both the ATHI and demographic questionnaires. The software website Datatab.net was utilized for analysis.

3. RESULTS

3.1 Demographics

The demographic questionnaire revealed participants fell into several categories for race as follows: 41.2% (7) identified as Asian, and 35.3% (6) identified as White or Caucasian. Most participants also had less than five years of experience at 58.8% (10). Lastly, 82.8% (14) of participants identified as cisgender females. For other categories, such as age and the unit that registered nurses worked on, results were more distributed among categories. 29.4% (5) were 18-25 years old, 29.4% (5) were 26-35 years old, 11.8% (2) were 36-45 years old, 23.5% (4) were 46-55 years old, and lastly 5.9% (1) were 56-65 years old. 41.2% worked on a Medical-Surgical floor, 35.3% worked in the Emergency Department, and 17.6% worked in the Intensive Care Unit. 10 Participants had less than five years of experience. Three participants had between 5-10 years of experience. One participant reported years of experience between 11-20. Three participants reported years of experience between 21-30.

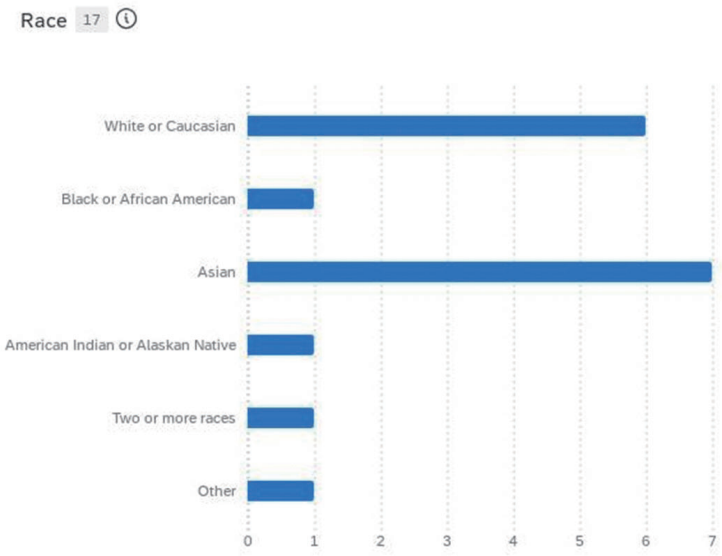

Figure 1. Participants Race Responses
Description: Results of participants' identification from demographic survey.

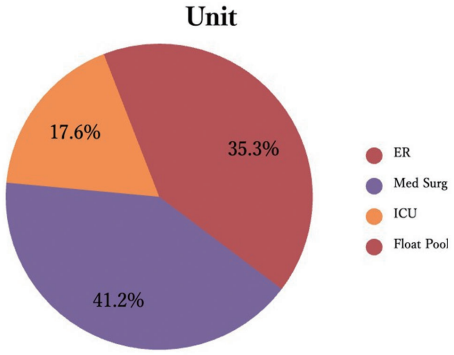

Figure 2. Participants' Specialty/Unit
Description: Results of participants' responses on which unit or specialty they work in. From the demographic survey.

3.2 ATHI questionnaire subscale

The results for each subscale of the ATHI were calculated as follows: (a) Personal Causation (PC), derived from averaging responses to items 1,7, and 8; (b) Structural Causation (SC), derived by averaging responses to items 2, 3, and 9; (c) Affiliation (AFFIL), derived by averaging responses to items 4 and 10; and Solutions (SOLNS), derived by averaging responses to items 5, 6, and 11. Responses were scored so that higher values signify higher levels of the construct that is being assessed. Items recoded were 1, 2, 3, 4, 7, 8, and 9 as follows: (6 = 1) (5 = 2) (4 = 3) (3 = 4) (2 = 5) (1 = 6). Each item had option responses of Strongly Disagree, Disagree; Unsure, but probably disagree, Unsure, but probably agree, Agree; and Strongly Agree.

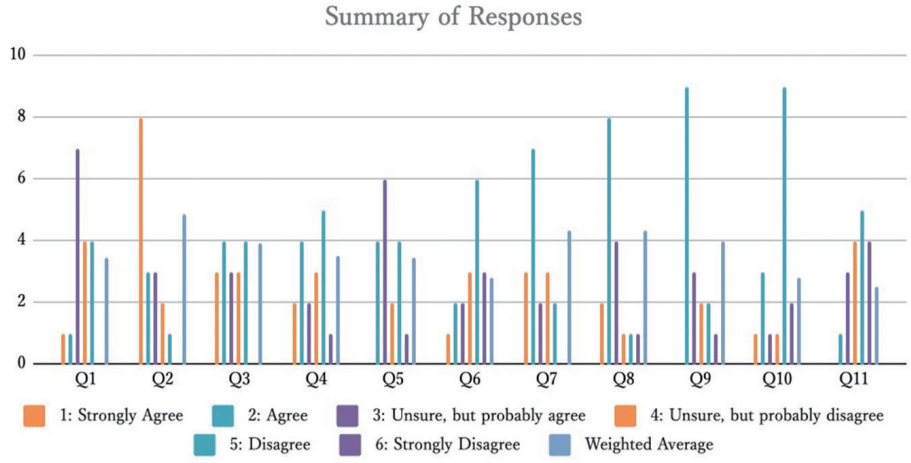

Figure 3. Summary of Responses for ATHI
Description: Summary of responses per question of the ATHI survey.

Table 1. Participant responses per ATHI questions

	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11
1: Strongly Agree-6	1	8	3	2	0	1	3	2	0	1	0
2: Agree-5	1	3	4	4	4	2	7	8	9	3	1
3: Unsure, but probably agree-4	7	3	3	2	6	2	2	4	3	1	3
4: Unsure, but probably disagree-3	4	2	3	3	2	3	3	1	2	1	4
5: Disagree-2	4	1	4	5	4	6	2	1	2	9	5
6: Strongly Disagree-1	0	0	0	1	1	3	0	1	1	2	4
Weighted Average	3.47	4.88	3.94	3.52	3.47	2.82	4.35	4.35	4	2.82	2.52
Personal Causation Average	4.05				Unsure, but probably agree						
Structural Causation Average	4.27				Unsure, but probably agree						
Affiliation Average	3.17				Unsure, but probably disagree						
Solution Average	2.93				Disagree						

Notes. Participant responses to the ATHI, along with the 4 subcategory mean scores.

For the Personal Causation category, overall, participants were unsure but probably agreed that homelessness is caused by personal factors, with a score of 4.05. For Structural Causation, overall, participants were unsure but probably agreed that homelessness is caused by structural factors, with a score of 4.27. For Affiliation, overall, participants were unsure but probably disagreed that they would feel comfortable affiliating with a homeless person, with a score of 3.17. For Solutions, overall, participants disagreed that the current solutions for homelessness are viable, with a score of 2.93.

3.3 ATHI total score results

Another aspect of the survey allows data for the total score of the ATHI, which measures attitudes towards the homeless. The total score of the inventory is 66, and the higher the score results in a more favorable attitude towards homeless individuals. Scores of participants ranged from 47 being the highest to 27 being the lowest. The total scores of males were 40.33 and females were 39.55. When looking at the total scores and comparing them with the unit in which nurses worked on yielded some very interesting results. Nurses who reported working on the medical-surgical units reported an average total score of 31, which was the lowest among the units. Those who reported working in acute care areas not listed in the survey had the highest average total score of 43.4. Nurses who worked in the ER had a total average total score of 38.2. Resulting in acute care nurses having the highest attitudes among the groups surveyed towards the homeless population.

Looking at the average total scores and years of experience of the participants led to some interesting results. Nurses with the most work experience had the highest overall total ATHI test scores, resulting in the most favorable attitudes towards the homeless population. This contrasted with the participants with less experience, who demonstrated the least favorable attitudes. Specifically, those with experience greater than 10 years of experience demonstrated an average of 46.8. Those with less than 10 years of experience 37.3.

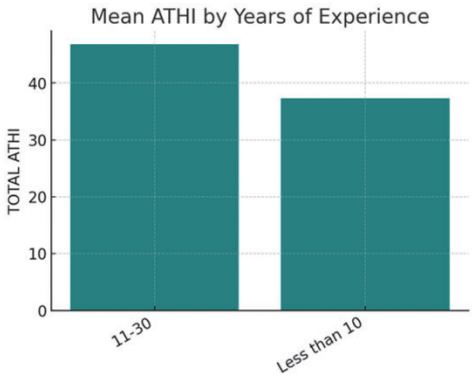

Figure 4. Mean ATHI by Years of Experience
Description: Results of participants' responses and their average score of ATHI compared to years of experience.

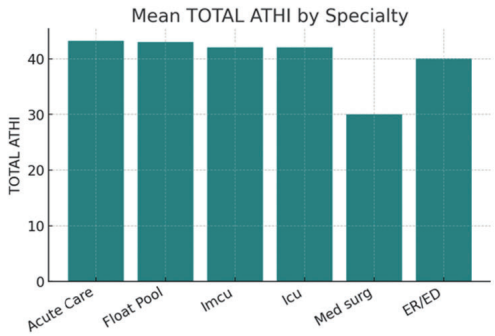

Figure 5. Mean ATHI by Specialty
Description: Results of participants' responses and their average score of ATHI compared to Specialty.

When evaluating the total score by the participant's age, the participants who reported ages between 56-65 had the highest total mean ATHI score of 43. This was followed by the age group of 46-55, which reported 42 total mean scores. The lowest total score was reported by participants in the 26-35 category. Respondents with a reported age below 35 years of age had a mean total score of 37.9. Those with a reported age greater than 35 had a mean score of 42.3, resulting in higher attitudes towards homeless individuals than their younger counterparts.

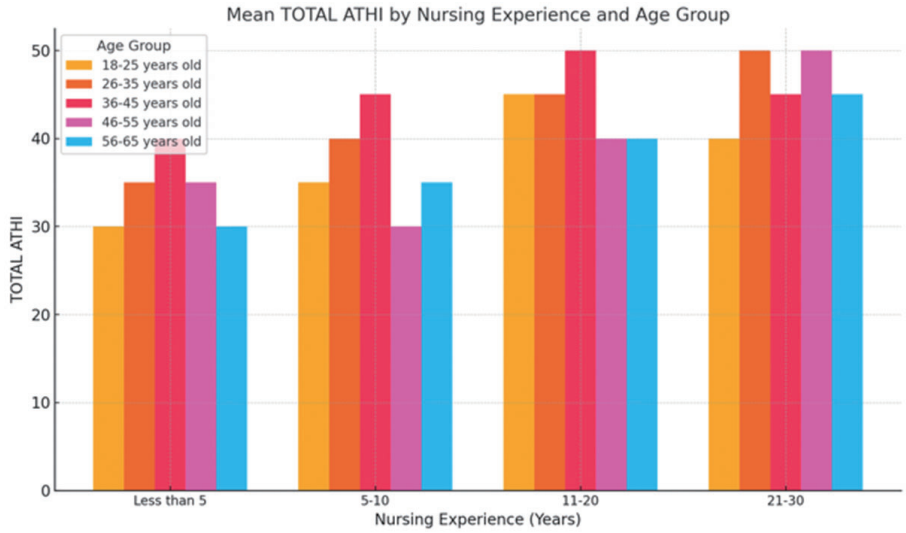

Figure 6. Mean Total ATHI score compared to Experience
Description: Results of participants' total ATHI scores with comparison to their years of experience.

4. Discussion

When looking at the ATHI total scores, several unique findings were seen. When comparing the participants by age, the oldest groups resulted in the highest scores. This represents a more favorable attitude toward the homeless population. Our attitudes and biases are in constant development and transformation throughout our lifespan and change with experiences.[20,25–27] Nurses have both positive and negative attitudes towards the homeless, but these can be transformed over time. It's unknown how long a transformation may take or what interventions can help. Time seems to be a key component when linking it to our findings. Nurses with greater than 10 years of experience had an average score of 46.8 compared to those with less than 10 years scoring an average of 37.3. Resulting in our more senior nurses having a more favorable view of the homeless population. Thus, with more experience have their views changed and been transformed?

Evaluation of the total scores and comparing them to which specialty unit participants worked on also brought to light some interesting results. Emergency nursing, float pool, intensive care, and acute care (not represented by others listed) all had a mean score of greater than 39. Nurses who reported working on medical-surgical units scored the lowest, with a mean score of 31. It's unclear why this might be, and previous research has not looked at breaking down nursing specialties regarding their attitudes. These nurses could have implicit bias, which would impact their care.[28]

The literature is clear that biases can impact care.[16,17,29,30] New research is needed to evaluate if nursing biases or negative attitudes can affect care due to current limited research specifically addressing nursing.

Overall, most participants were unsure in their responses regarding the issues of homelessness. For the PC subscale, items such as: (1) homeless people had parents who took little interest in them as children; (7) most circumstances of homelessness in adults can be traced to their emotional experiences in childhood and (8) most homeless persons are drug abusers, participants across the board either agreed, or were unsure but agreed. So, what does this mean? For the items relating to childhood and how an individual was raised, relating to emotional or physical neglect, it brings up the notion that some of the circumstances surrounding why someone may end up homeless as an adult is not entirely their fault, but that their upbringing had some involvement in their current circumstance. The item regarding drug abuse brings up an important conversation. Almost 50% of participants either strongly agreed or agreed with the statement that most homeless persons are substance abusers. Does this mean that homeless persons seeking acute care at the hospital may be seen as drug-seeking and treated differently? Or that their

reported pain levels may not be taken as seriously? It brings up an important conversation about how certain assumptions surrounding homelessness and substance abuse disorder can create negative attitudes and the potential for biases in the clinical care setting.

For the SC subscale, items such as: (2) recent government cutbacks in housing assistance for the poor may have made the homeless problem in the country worse; (3) the low minimum wage in this country virtually guarantees a homeless population, and; (9) recent government cutbacks in welfare have contributed substantially to the homeless problem in this country, overall, all responses were on some continuum of the agree side. For item two, 47% of participants strongly agreed with the statement. For item three, responses were more polarizing with almost 24% of participants each agreeing and disagreeing, while other participants were in-between unsure, but probably agreed/disagreed. Lastly, for item nine, 52% of participants agreed with the statement. In summary for this subscale, most respondents were unsure but probably agreed that structural factors contributed to the issue of homelessness, again reiterating the idea that homelessness may not always be caused by the individual's personal choices.

The AFFIL score, which contained items: (4) I would feel comfortable eating a meal with a homeless person, and (10) I feel uneasy when I meet homeless people, had very different responses for each item, which makes the overall result of, "unsure but probably disagree," that they would feel comfortable affiliating with a homeless person, skewed. For example, for item four, 52% of participants overall were on some continuum of the disagree side, demonstrating some negative attitudes. However, for item ten, results showed that 64.7% of participants were on some continuum of the disagree side regarding the statement that they would feel uneasy meeting a homeless person.

Lastly, the SOLNS score contained items: (5) rehabilitation programs for homeless people are too expensive to operate; (6) there is little to be done for people in homeless shelters except to see that they are comfortable and well-fed, and (11) a homeless person cannot be expected to adopt a normal lifestyle, overall disagreed that the current solutions for homeless are viable. 58.8% of participants either agreed or were unsure but probably agreed with item five. 70.5% of participants were on some continuum of the disagree side, with 35% generally disagreeing with the statement that there is little to be done for the homeless in shelters. Again, most disagreed with item eleven overall. This means that respondents felt that the current solutions for the homeless issue were not enough, and there should be more done to help these individuals. The argument could be made that this may translate into the idea that registered nurses within this study view homeless persons as a vulnerable population who need advocacy and assistance for their current circumstances.

Tying the results of this study with previously conducted research is done very loosely, due to the gap in research. The literature review conducted at the inception of this study demonstrated the scarcity of relevant and recent information on the topic directly relating to nursing. Retrieving relevant articles published within the last five years proved to be difficult, and so the search demanded to be broadened to fifteen years. Bias and implicit bias were also discussed, as there is a proven connection between the two, and more research has been done regarding this rather than attitudes alone.

Current research more broadly assesses perceptions and feelings of the homeless population and their experience with the healthcare system, as well as negative attitudes of nurses and how education and experience can help mitigate some of these negative attitudes that can hinder care. This study, although not representative of the population due to such a small sample size and localization to the Northern California region, is the first in recent years to look at specific demographics such as race, age, gender, and specialty that tie into bias and negative attitudes towards the homeless population. This small-scale study can be used to launch a more all-encompassing investigation that reflects the larger population, and factors that lead to negative attitudes.

4.1 Study limitations

The sample size of this research is a limitation. A larger study needs to be completed to confirm the results of this study. The current study only looked at one location in a specific geographical location in California. Findings cannot be generalized to other geographical areas without study replication with a larger sample size covering additional geographical areas.

4.2 Future implications

The sample size of this research is a limitation. A larger study needs to be completed to confirm the results of this study. This current research revealed some bias in the AFFIL subscale, which assessed comfort in affiliating with homeless persons. It also revealed that nurses who worked in acute care scored the highest, representing the most positive attitudes. Nurses who worked on medical-surgical floors had the worst overall attitudes of all groups surveyed; additional research needs to evaluate why this was found to be true. Lastly, this research revealed that the older nurse participants had the most favorable attitudes. All findings in this study need to be replicated before generalization can occur to the larger population of nurses and their attitudes and potential

for biases towards homeless individuals. Combined with further research, it is recommended that hospital organizations that deal with large homeless populations evaluate their training. Research has shown that changes in nursing attitudes toward the homeless may occur after caring for this population.[15,31] Noted after educational interventions were provided to nursing staff attitudes towards showed a small positive increase in positive attitudes of this population.

5. Conclusion

Overall, results concluded that there was some potential bias, especially in the AFFIL subscale, which assesses the level of comfort participants would feel in affiliating with a homeless person. Specific items, and not necessarily the subscale overall revealed other biases by participants, specifically with the sentiment that most homeless persons are drug abusers. Most participants were cisgender females, restricted to two hospitals in the Northern California Region, of whom the majority had less than five years of experience. Nevertheless, this research study will hopefully serve as a good starting point and continue to open the conversation about possible biases and negative attitudes held by registered nurses toward the homeless population. From there, we can continue to investigate how biases can impact care in the acute setting and how that may inadvertently affect patient outcomes.

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Conflicts of Interest Disclosure

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the research that is reported.

Informed consent

Obtained.

Ethics approval

The Publication Ethics Committee of the Association for Health Sciences and Education. The journal's policies adhere to the Core Practices established by the Committee on Publication Ethics (COPE).

Provenance and peer review

Not commissioned; externally double-blind peer reviewed.

Data availability statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

Data sharing statement

No additional data are available.

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