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Identified Barriers to well Child Care for Homeless Children Under Age Thirteen

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ABSTRACT

IDENTIFIED BARRIERS TO WELL CHILD CARE FOR HOMELESS CHILDREN UNDER AGE THIRTEEN

by

Judith G. Riemer

The purpose of this study was to identify barriers perceived by homeless families to well child care for their children under age thirteen and to determine if there is a relationship between perceived barriers and duration of homelessness. Using an investigator-modified version of Melnyk's Barriers Scale and a demographic measure, a convenience sample of homeless families ($N = 53$) from three transitional shelters in two southern California counties were surveyed via questionnaire. Barriers to well child care for homeless children were identified. No relationship was determined to exist between duration of homelessness and perceived barriers using a measurement of correlation.

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IDENTIFIED BARRIERS TO WELL CHILD CARE FOR
HOMELESS CHILDREN UNDER AGE THIRTEEN

by

x Judith G. Riemer

A Thesis in Partial Fulfillment
of the Requirements for the Degree Master of Science
In Nursing

June 1992

Each person whose signature appears below certifies that this thesis in his/her opinion is adequate, in scope and quality, as a thesis for the degree Master of Science.

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ACKNOWLEDGEMENTS

The author wishes to acknowledge the assistance and support of Lois Van Cleve, Ph.D., R.N., Clarice Woodward, M.S., R.N., and Michael Galbraith, Ph.D., R.N. in the preparation of this paper. The statistical assistance of Floyd Petersen is also appreciated. This study was funded by a research grant from Sigma Theta Tau International, Gamma Alpha Chapter.

CHAPTER ONE

INTRODUCTION

Need for Study

The faces of America's homeless are changing. Once considered the domain of older uneducated male alcoholics, the streets of America are increasingly becoming the home of families, particularly families of women with young children. These children's health care needs are overwhelming and unique. A paucity of research on preventive health care for the homeless child exists despite the recognition of regular preventive health care as a cost-effective and life-enhancing necessity (Kovar, 1982; Kirscht, 1983).

The provision of health care for children is widely recognized as a parental task; however, parental ability to care for children can be adversely affected by stress or lack of support (Belsky, 1984). Homelessness is recognized throughout the literature as a crisis event causing severe stress for the family, which may result in lower levels of preventive health care provision for children. This has been evidenced by the limited number of studies which have been done in the area of homeless children and health care. They have shown significantly decreased levels of preventive health care in this high-risk population (Miller & Lin, 1988; Hu, Covell, Morgan & Arcla, 1989; Roth & Fox, 1990). The interpretation of these

results, however, is limited by two factors. First, homelessness varies by geographical and seasonal influence (Maurin, Russell & Mermott, 1989; Sergl, Murray & Cotanch, 1989). Secondly, none of these studies have comprehensively examined the barriers perceived by the homeless child's family to obtaining well child care utilizing consistent categories and operational definitions of barriers.

The purpose of this study was to identify barriers perceived by homeless families to well child care for their children under age thirteen and to determine if there is a relationship between perceived barriers and duration of homelessness.

The concept of barriers has only recently been operationalized by Melnyk (1990) in recognition of the conflicting results in barriers research due to lack of uniform categories and operational definitions of the concept. There is an important need for such research to provide a "new vehicle for examining the dynamics between the consumer and the health care system" (p. 108). Recognition of perceived barriers must be considered in health services planning as it is these barriers to care from the family's point of view that prevent the homeless child from receiving necessary levels of preventive health care. Additionally, it is useful to examine if there is a temporal relationship between perceived barriers and duration of homelessness. Knowing what barriers homeless

children's families perceive in obtaining well child care and how these perceptions may change over time assists the public health nurse in formulating effective nursing interventions aimed at increasing the level of health care in this high-risk population.

This study provides information about barriers to well child care for homeless children through the use of a tool with recently developed categories and operational definitions of barriers. This study appears to be the first research study on the homeless family population in Riverside and San Bernardino Counties. Recognition of the need for this study is evidenced by letters of support which were received from the Department of Community Action in Riverside County, the Riverside County Health Department the San Bernardino County Health Department, and three local shelters (see Appendix 1).

Research Questions

The following questions were addressed in this study:

1. What barriers are perceived by homeless families to well child care for their children?
2. What is the relationship between perceived barriers and duration of homelessness in the sampled families?

Theoretical Framework

The theoretical framework for this study is based on the concept of barriers found in the Health Belief Model of preventive health behavior originally developed

by Rosenstock (1974a, 1974b). Rosenstock used Kasl and Cobb's classic definition of health behavior which is "any activity undertaken by a person believing himself to be healthy, for the purpose of preventing disease or detecting it in an asymptomatic state" (Kasl & Cobb, 1966, p. 246). The Health Belief Model of health behaviors grew out of efforts by the U.S. Public Health Service to explain the failure of individuals to demonstrate preventive health behavior. Lewin's theory of goal setting in the level-of-aspiration situation formed the basis for its development. Lewin hypothesized that behavior depends mainly on two variables: (a) the value placed by an individual on an outcome and (b) the individual's estimate of the chances that the given action will result in that outcome (Malman & Becker, 1974). As interpreted by Rosenstock (1974a), the Health Belief Model maintains that whether or not an individual undertakes a recommended health action is dependent upon four elements: (a) perceived personal susceptibility to the disease; (b) perceived seriousness or severity of the disease; (c) an evaluation of whether the benefits of taking the action outweigh the costs or barriers of the action (such as expense, pain or inconvenience); and (d) whether or not the individual has received a cue or cues to take the action (such as interpersonal interactions, media communication, or reminder postcards).

The Health Belief Model also proposes that modifying factors exist which serve to condition the individual's perceptions and the perceived benefits of preventive actions (Rosenstock, 1974a; Rosenstock, 1974b). These factors include demographic variables, such as age, sex, race, and ethnicity; sociopsychological variables, such as social class, peer and reference group pressure; and structural variables, such as knowledge or prior contact with the disease. It appears that homelessness has not yet been examined utilizing the Health Belief Model, nor has duration of homelessness been explored as a modifying factor to individual perceptions of barriers.

Definitions of Terms

For the purpose of this study, the following theoretical definitions of terms were used:

Family. A family is a primary group of people living in a household in consistent proximity and intimate relationships (Helvie, 1981).

Homeless. A homeless individual lacks shelter or a permanent residence.

Homeless shelter. A homeless shelter is a transitional facility offering social services and shelter for up to 60 days for families.

Preventive health care. Preventive health care is any medically recommended action, voluntarily undertaken by a person who believes himself to be healthy, that

tends to prevent disease or disability and/or detect disease in an asymptomatic stage (Langille, 1977).

Barriers. Barriers are the perceived costs associated with taking a health action (Cummings, Becker & Malle, 1980).

CHAPTER TWO

REVIEW OF LITERATURE

Introduction

A review of current literature on homelessness clearly indicates the need for research on barriers to well child care for homeless children. Relevant research on the homeless family is a relatively recent phenomenon. Research on preventive health care in homeless children is limited with few reports on barriers to such care. This literature review will address the following:

1. Overview of Homelessness.
2. Homelessness in Riverside and San Bernardino Counties.
3. Causes of Homelessness in Families.
4. Demographic Changes in the Homeless Population.
5. Health Care Needs of the Homeless Family.
6. Preventive Health Care for Homeless Children.
7. The Health Belief Model and Barriers Research.
8. Barriers to Health Care for Homeless Children.

Overview of Homelessness

The population of homeless individuals in the United States is large and growing. Estimates of the number of homeless individuals in this country range from 0.5 to over 3 million (Brickner, Scanlan, Conanan, Elvy, McAdam, Scharer, & Vicic, 1986; Bassuk & Rosenberg 1988; Sergi, et al., 1989; Bass, Brennan, Mehta, & Kodzis, 1990).

Difficulties in estimation of size is due partly to lack of standardization in the definition of homelessness and the logistics involved in counting individuals who are found at night in a variety of places, including doorways, abandoned buildings, cars, bus stations, etc..

Homelessness in Riverside and San Bernardino Counties

The homeless population in Riverside County is estimated to be in excess of 3,000 individuals; approximately 500 individuals are estimated to be homeless in the city of Riverside with 36% of that number being children (Department of Community Action, 1989). Estimated population for the city of Riverside is 226,505; for the county of Riverside, 1,170,413 (Salditch, 1991).

The homeless population in San Bernardino County is unknown; approximately 2,000 individuals are estimated to be homeless in the city of San Bernardino ("Funds OK'd for homeless shelters", 1990). Estimated population for the city of San Bernardino is 164,164; for the county of San Bernardino, 1,491,000 (Salditch, 1991).

Causes of Homelessness in Families

Multiple factors are associated with or contribute to the causes of family homelessness. They include the following:

1. The shortage of affordable housing is cited throughout the literature as a primary cause of family homelessness (Francis, 1987; Alperstein & Arnstein, 1988,

Hodnicki, 1990). The Children's Defense Fund (1989) reported that in 1985 over one-half of all poor renter households spent more than 70% of their income solely on housing. These individuals are felt to be just one crisis away from joining the ranks of the homeless.

2. Numerous researchers point to the declining economy, decreased government aid to families and increasing poverty as contributing to family homelessness (Abdellah, Chamberlain & Levine, 1986; Alperstein & Arnstein, 1988; Damrosch, Sullivan, Scholler & Gaines, 1988). Women are felt to be particularly prone to effects from changes in the economy which has given rise to increasing numbers of women and families on the street (Slavinsky & Cousins, 1982).

3. Disturbed family relationships due to violence, drugs, and separations are also potent contributors to homelessness and are again felt to impact more strongly on women and children (Francis, 1987; Alperstein & Arnstein, 1988; Damrosch, et al., 1988; Hodnicki, 1990; Wood, Valdez, Hayashi & Shen, 1990a).

Demographic Changes in the Homeless Population

Although the public stereotypes of homeless individuals as alcoholics or addicts who choose, prefer or deserve their lifestyles are persistent, they are inaccurate (Sebastian, 1985; Damrosch, et al., 1988). The "new" homeless are younger and contain increasing numbers of women, children and minorities (U.S. Department

of Housing & Urban Development, 1989; Hodnicki, 1990; Stephens, Dennis, Toomer & Holloway, 1991). Sebastian (1985) reported that until the late 70's only 25% of the homeless were women--that number now approaches 50%. Homeless women are extremely vulnerable to violence on the streets--many report instances of assault and rape (Bargmann, 1985; Hilfiker, 1989).

Families are the fastest growing subgroup of the homeless population (Damrosch, et al., 1988; Wood, 1989; Berne, Dato, Mason & Rafferty, 1990). National estimates of the size of the homeless family population range from 25% to 40% of the total homeless population of three million individuals (U. S. Conference of Mayors, 1986; Bassuk & Rubin, 1987; Alperstein & Arnstein, 1988; Children's Defense Fund, 1989; Berne, et al., 1990). Percentages of homeless families in major urban centers are estimated to be even higher (Philadelphia - 50%, New York - 76%) (U. S. Conference of Mayors, 1986). Counting the homeless family population has proven difficult as parents hesitate to identify themselves as homeless out of fear of being charged with neglect and the possibility of losing custody of their children (Children's Defense Fund, 1989). Although past research on the homeless has centered mainly on the mentally ill or the single adult homeless individual, work describing the characteristics of homeless families is now appearing in the literature.

The homeless family is particularly prone to the problems and effects of chronic hunger. Twenty million people are chronically undernourished in the United States; 60% of them are children (Alperstein & Arnstein, 1988). In California, 5.35 million individuals are at 150% of the poverty level and at risk for hunger. This includes over 2.6 million children, 1 million families and 400,000 women head of households (Selling, 1988). Because residential stability is a requirement for many government assistance programs such as AFDC or WIC, many homeless families do not get the help they need (Sergi, et al., 1989).

Health Care Needs of the Homeless Family

The homeless population is "emerging as a medically underserved population with significant health problems and unique health needs" (Bowdler, 1989, p. 51). In 1985, annual costs to hospitals for treating the homeless ran as high as \$7 million (McDonald, 1986). Although some government programs exist to assist the homeless, such as the Stewart B. McKinney Homeless Assistance Act (PL 100-77), the amount of aid available falls far short of what is needed (Selling, 1988; Children's Defense Fund, 1990).

Brickner et al. (1986) reported that most of what has been known about the health care needs of the homeless has been generated from the past study of urban male alcoholics who now make up a much smaller percentage of the

homeless than before. The primary medical disorders seen in today's homeless population are mental problems, trauma, respiratory disease, pulmonary tuberculosis, infestations of scabies and lice, peripheral vascular disease and chronic diseases.

The three most common diagnoses made at the primary care nursing clinics for the homeless run by the UCLA School of Nursing were acute nasopharyngitis, need for TB screening and open wounds/lacerations (Lindsey, 1989). Sebastian's (1985) study of the special health needs and conditions of the homeless also added to the understanding of the unique needs of homeless families. He reported that health promotion is extremely difficult for homeless individuals because their highest priority needs are physical and psychosocial survival. The unique features of the "biopsychosocial" environment of the homeless were felt to cause or exacerbate a number of health problems. These problems included a) difficulties in the maintenance of body temperature, b) exacerbation of chronic illnesses, c) exposure to pollutants, d) incomplete or delayed resolution of acute health problems, e) constant mobility, and f) unhygienic living conditions.

Preventive Health Care for Homeless Children

In a population-based cross-sectional survey of a sample of 82 families with 158 children living in emergency homeless shelters in King Co., Washington,

Miller and Lin (1988) used a Family Shelter Inventory and height and weight measurements in an attempt to describe health characteristics of homeless families. Homelessness was a recurrent problem for over 50% of the families. Many of these children were not up-to-date on immunizations, had untreated acute or chronic problems and had no regular health care provider or health insurance. Compared to the general U.S. pediatrics population, the proportion of those in "fair" or "poor" health was four times higher (13% vs. 3.2%).

Wood (1989) has reported similar findings from a descriptive study using interviews of 200 homeless families in ten greater Los Angeles shelters. He found that a majority of families were headed by single women. Those women who had relationships with men were typically (over 50%) involved with men with serious problems such as alcoholism, physical abusiveness, poor work history and mental illness. He concluded that the day to day struggle for survival results in the neglect of children's essential needs such as emotional support, discipline and health care. These children are seldom current in preventive health services which is a serious problem because homeless children are at high risk for inadequate nutritional intake, failure to thrive, delayed growth and obesity. He advised the use of an outreach nurse for follow-up in order to address homeless children's health needs.

Wood, Valdez, Hayashi and Shen (1989, 1990a, 1990b) conducted the Los Angeles Homeless Families Study, comparing a group of 196 homeless families from ten shelters to a group of 194 stably housed AFDC families during 1987 and 1988. Combining a 45 minute, questionnaire-guided interview with the mother with other measures, information was recorded regarding housing, economics, family problems, child health status, and access to health care. Findings revealed high rates of acute health problems in both the homeless and AFDC children populations. Children from the homeless families had more behavioral problems, dietary problems, developmental delays and reduced access to health care than children from the AFDC families.

Hu, et al. (1989) interviewed thirty families regarding the health care status and needs of their children. They reported that while 88% of the U. S. general population have a regular source of health care with 88.6% having health care coverage, only 56.7% of the sample parents reported a regular source of health care. A total of 46.6% had no form of health care insurance and of that number, 85% had no regular source of health care ($p < .01$). Increased duration of homelessness correlated with poorer reported health of the children ($r = .21$, $p < .05$) but it was not significantly related to prenatal care, immunization status or number of check-ups in the previous year.

Roth & Fox (1990) collected data on health status and

health care utilization from 70 homeless families and compared it to data for low-income families. They also concluded that primary and preventive health care use is lower for homeless children than low-income children.

Many of these studies demonstrated the need for preventive health services for homeless children. The costs of medical care make prevention "an attractive, if not a necessary, alternative to traditional medical solutions, particularly the curative model" (Kirscht, 1983, p. 277), yet preventive health care has not been valued at the federal funding level (Hodnicki, 1990).

Kirscht (1983) defines primary prevention as that action which is aimed at preventing the occurrence of a condition; secondary prevention is concerned with detection and early treatment while tertiary prevention is aimed at alleviating the effects of a condition after its occurrence. As noted earlier, homeless children are less likely to be up-to-date on immunizations, an observation also shared by Lindsey (1989) and Stephens, et al. (1991), or to have routine health care or examinations. The lack of TB skin tests as part of preventive care for children is also particularly serious. The active TB rate of 13 per hundred thousand in the United States as a whole may be as high as 1700 per hundred thousand in the homeless population (Bowdler, 1989). A knowledge deficit regarding childhood communicable diseases observed in minority low-income mothers (Dawkins,

Ervin, Weissfeld & Yan, 1988) may partially explain the high incidence of communicable disease observed in a 15 state survey of homeless shelters conducted by Gross and Rosenberg (1987).

Further research is needed to understand the barriers to preventive health services for homeless children. The need for nurses to conduct this type of research is emphasized by the United States Public Health Service (Abdellah, et al., 1986).

The Health Belief Model and Barriers Research

The Health Belief Model is recognized throughout the literature as an important means of understanding health behaviors. Additional theoretical models have been developed to explain preventive health behavior, such as Andersen's model of health services utilization. In recognition of strong similarities among the general classes of factors included in the Health Belief Model and other models, the authors of fourteen of the major models collaborated to identify and define unified concepts in their models (Cummings, et al., 1980). They collectively defined perceived barriers/costs as the "individual's belief concerning the costs associated with taking a health action" (p. 140). This is consistent with the theoretical definition in the Health Belief Model (Rosenstock, 1974a).

The Health Belief Model has shown significant predictive ability in use (Champion, 1984) and has been

used in a variety of settings, including settings requiring modification of the original model to explain illness behavior and sick role behavior. It has been used as the model for studies relating to TB, polio vaccination, smoking behaviors, genetic screening, swine flu immunization, dental visits, etc. (Rosenstock, 1974b; Kirscht, 1983). Recent additions to the original concepts of the Health Belief Model include health motivation (the incentive to behave based on the perceived value of reduction of perceived threats) and self-efficacy (the belief of one's personal abilities in specific settings) (Rosenstock, Strecher & Becker, 1988).

The Health Belief Model has been used as a theoretical framework by nurse researchers. Champion (1984) developed an instrument with Health Belief Model constructs which was used on a sample of 301 women to describe behaviors related to breast self-examinations and breast cancer. Dawkins and Ervin (1987) used the Health Belief Model as the theoretical framework for a nursing study investigating use of well-baby clinics among minority clients.

In a comprehensive review of the literature, Melnyk (1988) demonstrated that confusion exists from study to study regarding categories and operational definitions of barriers. In response to these findings, Melnyk (1990) developed the Barriers Scale to measure the concept of barriers. Five factors were found to encompass categories

of indicators of barriers to a well population seeking secondary preventive health care: (a) Provider-Consumer Relationship, (b) Cost, (c) Site-Related, (d) Inconvenience, and (e) Fear.

Barriers to Health Care for Homeless Children

The literature identified a number of areas which may be barriers to preventive health care for the homeless. These possible barriers include: (a) priority of time-consuming searches for food and shelter (Bargmann, 1985; Alperstein & Arnstein, 1988; Wood, 1989), (b) lack of health coverage or regular health provider (Bargmann, 1985; Miller & Lin, 1988; Selling, 1988; Hu et al., 1989; Sergl, et al., 1989; Bass, et al., 1990; Berne, et al., 1990; Roth & Fox, 1990), (c) lack of money (Alperstein & Arnstein, 1988), (d) lack of transportation (Alperstein & Arnstein, 1988; Bowdler, 1989; Hodnicki, 1990), (e) fear of labelling and rejection by health personnel (Selling, 1988; Bowdler, 1989; Children's Defense Fund, 1989; Berne, et al., 1990; Hodnicki, 1990), (f) need to navigate large complicated bureaucracy of health institutions (Bowdler & Barrell, 1987; Bowdler, 1989), (g) too long of a wait at the medical office or for an appointment (Wood, et al., 1989; Berne, et al., 1990), (h) language difficulties for non-English speakers (Hu, et al., 1989), and (i) unfamiliarity with neighborhood shelter is located in (Berne et al., 1990).

Summary

Research has revealed the pressing need for improving health care for the growing numbers of homeless families in this country. Potential barriers to obtaining well child care for homeless children have been understudied. A tool for examining barriers based on the Health Belief Model was developed by Melnyk (1990) and was used with modifications in this study.

CHAPTER THREE

METHODOLOGY

Purpose

The purpose of this study was to identify barriers perceived by homeless families to well child care for their children under age thirteen and to determine if there is a relationship between perceived barriers and duration of homelessness.

Study Design

A descriptive design was used, utilizing a questionnaire format.

Sample and Setting

Sample. A convenience sample of homeless families ($N = 53$) was drawn from the population of residents at three transitional homeless shelters. The investigator described the study during regularly scheduled evening meetings and families were given the opportunity to volunteer at that time. Families met the following inclusion criteria:

1. The family of adult(s) and child(ren) was self-identified as a family.
2. The adult family member participating in the study signed an informed consent form indicating willingness to participate (see Appendix 2).
3. The adult family member participating in the study was a parent or other primary caretaker.
4. The family had children under age thirteen

living with them.

Setting. Three transitional homeless shelters for families comprised the setting for this study. All were church-affiliated shelters and allowed families to remain up to 60 days while receiving food, shelter and social services. Shelter 1 had 35 beds available for families and single women in a renovated motel complex. Shelter 2 had 40 beds in a dormitory arrangement for women and children and 16 beds in 4 rooms for men. Shelter 3 had 40 beds available for families and single women in individual family rooms. All were located in urban areas.

Human Rights

All families who chose to participate were assured confidentiality and that participation would not affect their shelter status. All participants read and signed a "Consent for Participation in a Nursing Investigation" (see Appendix 2). Data were kept in a locked cabinet at the investigator's residence.

Data Collection

Method. A pilot study of four families at one shelter was conducted to refine techniques. Following the pilot study, additional clarifying instructions were written and discussed orally with all later subjects.

Data were collected from January 27 to July 5, 1991. A total of 53 families met the study criteria and were willing to participate. Five families participated from Shelter 1,

nineteen families participated from Shelter 2, and twenty-nine families participated from Shelter 3. The questionnaire (see Appendix 3) was administered by the investigator in shelter dining rooms during evening hours. Spanish-speaking interpreters were available at all locations.

Use of compensation. As an expression of gratitude for participating in the study, each family received a health product or products. [Families in two of the shelters received children's acetaminophen and over-the-counter cough syrup samples. Locked areas were available for medicine storage. The third shelter did not allow dispensing of over-the-counter medication; families at this shelter received toothpaste instead.] These items were donated for study use by a local pediatrician, a local dentist, and a pharmaceutical representative.

Measurements

Demographics measure. Respondents were asked for the ages and number of children living with them and the length of time the family had been homeless in number of days. They were asked the relationship of the respondent to the child(ren) (e.g., parent) and to identify themselves as members of a specific ethnic group.

The Barriers Scale. A investigator-modified version of the barriers indicator tool developed by Melnyk (1990) was used (see Appendix 3). This tool was designed to guide

health care professionals in developing strategies to improve the provision of preventive health services by identifying consumers' perceived barriers to seeking different types of preventive health care. It consisted of twenty-seven statements in 5 subscales: a) Provider/Consumer Relationship, (b) Site-related Factors, (c) Cost, (d) Fear and (e) Inconvenience. Each statement described possible barriers to preventive health care. The respondent was asked to identify the degree to which each barrier affects receiving care (greatly, moderately, slightly, none). The tool was altered by the investigator from first person statements to statements appropriate for a child's parent or adult caretaker to respond to regarding well-child visits.

Permission was granted for the use of the copyrighted tool by the author. It was used in its entirety. Respondents were also asked to identify any other barriers not included in the Barriers Scale through the use of an open-ended question "What other kinds of things that have not already been mentioned do you feel stop you from getting well-child visits for your children?"

Scoring. The Barriers Scale is scored with a four-point Likert scale from three to zero, with "greatly" equal to 3, "moderately" equal to 2, "slightly" equal to 1 and "none" equal to 0. Values were summed to produce scores for individual subscales and the entire scale.

Reliability and validity of tool. Content validity was

established for the original Barriers Scale (Melnyk, 1990) through the use of a Delphi procedure to generate barriers items from a panel of 12 individuals selected for their knowledge of the health care system, including nurses and consumers. Barrier items were classified by distributing questionnaires of barrier items to 800 employees of a large private university.

Exploratory factor analysis was conducted, resulting in 33 of the 54 original barrier items loading on five factors (subscales), with loadings of .40 or greater. Reliability analyses performed by Melnyk of the five subscales produced a standardized alpha and an inter-item correlation for each subscale as follows: Provider/Consumer Relationship, 0.91 and 0.51; Cost, 0.85 and 0.58; Site-Related Factors, 0.77 and 0.46; Inconvenience, 0.63 and 0.30; and Fear, 0.76 and 0.39 (Melnyk, 1990).

Although the investigator-modified tool was altered so that statements reflected respondents' perceptions of barriers to care for another (their child) rather than themselves, the main focus of each statement was not changed.

Operational Definitions of Terms

The following operational definitions of terms were used in this study.

Family. A family is composed of adult(s) and child(ren) under age thirteen self-identified as a family

upon entrance to a homeless shelter. The family will be represented by a parent or, if applicable, an adult family member who is identified by the family as functioning in a parental (primary caretaking) role for the children in the family.

Homeless shelter. A homeless shelter is one of three study shelters. Shelters 1 and 3 are located in Riverside County. Shelter 2 is located in San Bernardino County. All of these shelters are known as transitional shelters, which offer shelter, food and social services for up to 60 days to families.

Preventive health care. Preventive health care is a well-child visit with services, such as receiving immunizations or having a physical examination.

Barriers. Barriers are the indicator items on Melnyk's (1990) Barriers Scale.

CHAPTER FOUR

FINDINGS

Demographic Characteristics of Sample

The total sample size was 53 families. The general study respondent was a mother with two children, primarily school-aged. Duration of the current episode of homelessness in the sampled families ($n = 52$) ranged from 1 to 365 days ($M = 34.1$ days). A history of previous homelessness was reported by 23.4% of sample respondents ($n = 47$). Days of previous homelessness ranged from 0 to 910 days ($M = 36.1$ days).

Number of children in sampled families. A total of 120 children were living with the adult respondents participating in the study (see Table 1). The number of children per family ranged from one to seven ($M = 2.3$).

Ages of children in sampled families. Ages of children in the sampled families were identified and ranged from one month to 20 years (see Table 2). Forty-eight percent of the children were between the ages of 6 to 12 years.

Relationship of adult family member to children. Fifty-two (98.1%) of the adult family members participating in the study identified themselves as the mother of the children living with them; one adult family member participating in the study identified himself as the father of the children living with him (1.9%).

Ethnicity of sampled families. Respondents identified

Table 1

Frequency Distribution of Number of Children per Family
in Sampled Homeless Families

No. of Children per Family ($n = 53$)	Frequency	%
1	19	35.8
2	18	34.0
3	6	11.3
4	5	9.4
5	4	7.5
7	1	1.9
TOTAL	53	100.0

Table 2

Frequency Distribution of Ages of Children in Homeless
Families ($n = 52$)

Age	Frequency	%
0-11 months	5	4.3
1-5 years	46	39.3
6-12 years	56	47.9
13 years and older	10	8.5
TOTAL	117	100.0

themselves as members of specific ethnic groups (see Table 3). Thirty-six and a half percent of the sampled families identified themselves as black and 46.2% as other white (non-Hispanic/Latino).

Due to small cell size, a chi-squared analysis was not done; however, a visual examination of the data revealed differences among shelters by ethnicity. Shelter 1 respondents were all self-identified as other white. Shelter 2 respondents were self-identified as black (54%) and other white (46%). Shelter 3 respondents were self-identified as representing five separate ethnic groups.

Table 3

Frequency Distribution of Ethnicity of Homeless Families by Shelter

Ethnic Group	Shelter (n = 52)			Total
	<u>1</u>	<u>2</u>	<u>3</u>	
Black		14	5	19
Hispanic/Latino			7	7
Other White	5	12	7	24
Asian			1	1
Other			1	1
Total	5	26	21	52

Identification of Perceived Barriers

The first research question was "What barriers are perceived by homeless families to well child care for their children?" Scores on the twenty-seven barrier items varied widely, ranging from 0.0 (none) to 3.0 (greatly) for each.

Provider-Consumer Relationship Subscale. The ten barrier items in the Provider-Consumer Relationship Subscale address characteristics of the relationship between the family and the health care provider (doctor or nurse). Their scores indicate the degree to which those characteristics affect the child receiving well child care. These characteristics include factors such as perceptions of impatience, criticism or lack of explanations by the provider and lack of continuity of care (seeing the same provider on each visit).

The mean score for the Provider-Consumer Relationship subscale was 1.3; mean scores between 1.0 and 2.0 were obtained for nine of the ten barrier items (see Table 4). The mean score for Barrier #10 (there's no way to find out how to pick a good doctor or nurse) was 1.8. Twenty-three respondents indicated this barrier greatly affected receiving well child care by choosing the response of 3.0 (greatly), the modal score for this barrier.

Site-Related Factors Subscale. The four barrier items in the Site-Related Factors Subscale address factors such as availability of transportation/parking, waiting time at the

Table 4

Mean Values for Provider/Consumer Relationship Subscale

Barrier Item	M
#1- Child's problems seen as unimportant	1.4
#2- Language problems	0.9
#3- Provider is impatient/critical	1.2
#4- Provider is not good	1.1
#5- Shows no interest in parent's worries	1.1
#6- Lack of answers or explanations	1.2
#7- Shows no interest unless child is sick	1.5
#8- No continuity of care	1.1
#9- Can't be reached by telephone	1.4
#10- Provider selection difficulties	1.8

appointment and the distance of the office or clinic location. Their scores indicate the degree to which these factors affect the child receiving well child care.

The mean score for the Site-Related Factors Subscale was 1.5; mean scores between 1.0 and 2.0 were obtained for all four barrier items (see Table 5). The mean score for Barrier #11 (the wait is too long at the time of the appointment) was 1.8. Nineteen respondents indicated this

barrier greatly affected receiving well child care by choosing the response of 3.0 (greatly), the modal score for this barrier.

The mean score for Barrier #12 (the cost of transportation and/or parking is too high) was 1.5. Nineteen respondents indicated this barrier greatly affected receiving well child care by choosing the response of 3.0 (greatly), the modal score for this barrier.

Table 5

Mean Values for Site-Related Factors Subscale

Barrier Item	M
#11- Long wait at appt.	1.8
#12- High travel costs	1.5
#14- Distance	1.4
#17- No transportation	1.4

Cost Subscale. The four barrier items in the Cost subscale address issues of cost of care and availability of insurance to cover well-child care. Their scores indicate the degree to which these issues affect the child receiving well child care. The mean score for the Cost Subscale was 0.9; mean scores of less than 1.0 were obtained for three of the four barrier items (see Table 6).

Table 6

Mean Values for Cost Subscale

<u>Barrier Item</u>	<u>M</u>
#13- Lack of insurance	1.0
#15- Visit cost too high	1.2
#16- Complicated insurance	0.5
#18- Reimbursement delays	0.9

Fear Subscale. The five barrier items in the Fear Subscale address factors such as fear of doctors or nurses, fear of discovering serious conditions and preference for previous health care providers. Their scores indicate the degree to which these issues affect the child receiving well child care. The mean score for the Fear Subscale was 0.9; mean scores of less than 1.0 were obtained for four of the five barrier items (see Table 7).

Inconvenience Subscale. The four barrier items in the Inconvenience Subscale address factors such as length of travel time to the office or clinic, the amount of time an appointment has to be made ahead and convenience of parking. Their scores indicate the degree to which these factors affect receiving well child care.

The mean score for the Inconvenience Subscale was 1.2; mean scores between 1.0 and 2.0 were obtained for three out of the four barrier items (see Table 8). The mean score for

Table 7

Mean Values for Fear Subscale

<u>Barrier Item</u>	<u>M</u>
#19- Past provider better	1.2
#20- Child dislikes exams	0.9
#23- Child fears providers	0.9
#25- Fear of potential diagnoses	0.7
#26- Child dislikes providers	0.8

Barrier #21 (appointments for a well-child visit have to be scheduled too far ahead) was 1.5. Nineteen respondents indicated this barrier greatly affected receiving well child care by choosing the response of 3.0 (greatly), the modal score for this barrier.

Table 8

Mean Values for Inconvenience Subscale

<u>Barrier Item</u>	<u>M</u>
#21- Long wait for appt.	1.5
#22- Inconvenient parking	0.8
#24- Expensive tx.	1.2
#27- Long travel time	1.3

Analysis of variance among shelters for subscale scores. ANOVA was done to determine significant differences among shelters for all subscale scores; the only significant difference was found for the Site-Related Factors Subscale. Scheffe's post-hoc analysis revealed a significant difference between Shelter 1 and Shelter 2 for Site-Related Subscale scores ($F(2,50) = 4.8, p = .01$).

Responses to Open-ended Question

Thirteen of the 53 respondents answered the question "What other kinds of things that have not already been mentioned do you feel stop you from getting well-child visits for your children?" Seven respondents identified a lower quality of care associated with Medi-Cal providers as being a significant barrier to care. The remaining responses represented a variety of concerns, including: (a) need for baby-sitting for siblings, (b) transportation, (c) cost, (d) lack of continuity of care and (e) inconvenient office hours for working parents.

Determination of Relationship between Duration of Homelessness and Perceived Barriers

The second research question was "Is there a relationship between perceived barriers and duration of homelessness in the sample population?" No significant relationship was found (see Table 9).

Table 9

Correlations Between Duration of Homelessness and
Subscale/Total Barriers Scale Scores

<u>Subscale/Scale</u>	<u>r</u>
Provider/Consumer Subscale	-.09
Site-Related Factors Subscale	.08
Cost Subscale	.20
Fear Subscale	-.10
Inconvenience Subscale	.13
Total Barriers Scale	.02

Note: none are significant at $p < .05$

CHAPTER FIVE

DISCUSSION

Summary and Discussion

This study identified barriers to well child care for homeless children under age thirteen using the Health Belief Model as a theoretical framework. An investigator-modified version of Melnyk's Barriers Scale was used.

Four barriers contained in the Provider-Consumer Relationship Subscale, the Site-Related Factors Subscale and the Inconvenience Factors Subscale were found to represent items of importance to respondents as indicated by mean and modal scores. These barriers concerned (a) provider selection difficulties, (b) waiting for well child appointments, (c) waiting during well child appointments, and (d) the high cost of transportation and/or parking. Identification of these barriers was also supported by anecdotal remarks made by respondents to an open-ended question asking for additional barriers. Barriers contained in the Cost and Fear Subscales were not found to represent items of importance to respondents.

This study supported the work of Berne, et al. (1990) who identified unfamiliarity with local providers, waiting for appointments, and transportation problems as potential barriers to health care in a nursing model proposed to address the health needs of homeless families.

Assessment of perceived barriers to health care is a first step in the planning of better health services for homeless children. The Health Belief Model posits that the reduction or elimination of perceived barriers increases the likelihood that a recommended health care behavior or action (such as the seeking of well child care) will occur. Measures aimed at reducing or eliminating the barriers identified by this study may result in improved levels of well child health care for homeless children.

New and innovative means of health care delivery designed to reduce or eliminate these barriers may be explored. These might include the use of nurse-managed shelter-site clinics (Malloy, 1990) which would eliminate the barrier of transportation and parking costs and reduce or eliminate waiting for or during well-child appointments. This option might also reduce or eliminate the barrier of difficulties in selecting a health care provider.

An affiliation between a family shelter and hospital-based clinics (Bass, et al., 1990) made possible through the use of a shelter nurse liaison may also reduce or eliminate identified barriers. The shelter nurse liaison may assist with health care provider selection and transportation and parking costs. A goal of a formal affiliation between a family shelter and hospital-based clinic should be the reduction of waiting time for and during appointments for shelter families.

No relationship was found between perceived barriers and duration of homelessness. Similarly, Hu, et al. (1989) found that increased duration of homelessness was not associated with immunization status or number of check-ups in the previous year. Duration of homelessness may not affect sheltered homeless families' perceptions of barriers to preventive health care.

The difference by ethnicity between Shelter 1 (Riverside) and Shelter 2 (San Bernardino) may partially be explained by the small sample size for Shelter 1 ($n = 5$). This ethnic makeup was not felt to be usual for this shelter--the investigator observed a wide variety of ethnic backgrounds during site visits made both prior and subsequent to the study period. San Bernardino also has a higher proportion of blacks in its population than Riverside (14.9% and 6.9%, respectively) (Horner, 1987) and it may be expected that it would also have a higher proportion of blacks in its shelters.

The significant difference for Site-Related Factors Subscale scores between Shelter 1 (Riverside) and Shelter 2 (San Bernardino) may partially be explained by the recent inauguration of a mobile van program offering well child check-ups once a month at Shelter 1. The availability of on-site services may have reduced respondents' perceptions of site-related factors as being barriers to well child care.

Limitations

Small sample size ($N = 53$) limits application of these results outside of the study population. Another potential limitation of this study was the use of three settings for data collection; however, few statistical differences among shelters were obtained.

Implications and Recommendations

More research on perceived barriers to health care for homeless children is needed as findings from this study should be applied only to this specific study population. A number of suggestions for future studies may be made: (a) confirmation of the results of this study should be made with a larger sample; (b) information on marital status, income, health insurance and reason for homelessness was not obtained in this study and should be covered in future studies to ascertain the role of these demographic variables on perceived barriers; and (c) measurements of correlation between duration of homelessness and perceived barriers in non-sheltered homeless families should be made to clarify the role of housing on perceptions of barriers.

APPENDIX 1
LETTERS OF SUPPORT



County of Riverside
DEPARTMENT OF COMMUNITY ACTION
3600 Lime Street, Suite 714
RIVERSIDE, CA 92501-2996 • (714) 787-2262



January 30, 1990

RE: Judith Riemer, RN

To whom it may concern:

Judith Riemer is a graduate student working on an advanced degree at Loma Linda University. She will be doing a survey within the homeless community to evaluate medical problems and needs in family situations. The Department of Community Action (DCA) feels that her data will provide valuable insights, not only for her research purposes but also to the community of homeless services providers as well.

Please give her your full cooperation. If you have any questions, please feel free to contact me or the staff of DCA.

Sincerely,

Lois J. Carson
LOIS J. CARSON
Executive Director

jd/ncw

DIGNITY AND SELF-SUFFICIENCY FOR THE POOR

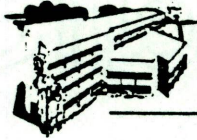
Lois J. Carson
Executive Director

Administration
(714) 787-2262

Energy Programs
(714) 787-6888
6687

Weatherization Programs
(714) 369-0828
0829

General Community
Programs
(714) 787-2262



COUNTY OF RIVERSIDE DEPARTMENT OF HEALTH

4065 COUNTY CIRCLE DR. RIVERSIDE, CA. 92503 (Mailing Address - P.O. Box 7600 92513-7600)

July 2, 1990

TO WHOM IT MAY CONCERN:

I have interest and concern regarding the medical and social needs of homeless women and children. I am aware of national statistics which reflect a high percentage of women and children in the homeless population. Judy Reimer has discussed with me her project which will study this population. She expects to assess the health status and unmet needs of women and their children under the age of five. Judy has been in close contact with me from the beginning of her graduate studies. She has expressed ongoing concern for improving the health status of women and children. I will be very interested in reviewing the data collected in Judy's study and expect that it may be valuable in documenting service needs as new programs are developed for women and children in Riverside and San Bernardino Counties. I will be happy to consult with Judy and assist her as the need arises.

Sincerely,

Shirley Pollinger
Shirley Pollinger
Director of Nursing

SP:dlh

CINDA HOWELL, B.S.N., M.B.A. DEPUTY DIRECTOR OF HEALTH PERSONAL HEALTH SERVICES
JIM FARMING, M.S., M.P.A. DEPUTY DIRECTOR OF HEALTH ENVIRONMENTAL HEALTH SERVICES
E. SALASHER, M.S., M.P.A., M.A. DIRECTOR OF HEALTH
M.C. MOLE, D.V.M., M.P.A. DEPUTY DIRECTOR OF HEALTH SPECIAL SERVICES
E.R. COYNE, M.S. DEPUTY DIRECTOR OF HEALTH ADMIN. & SUPPORT SERVICES

HEALTH CENTERS

BRIDGE 3025 RAMSEY STREET - Corona, CA 92720 ● S. 11th 263 NORTH BROADWAY - Blythe, CA 92225 ● CASA BLANCA 7240 MARGUERITA - Riverside, CA 92504 ●
CORONA 302 SOUTH BUENA VISTA - Corona, CA 9 720 ● HEMET 882 NORTH STATE STREET - Hemet, CA 92342 ● INDIO 46-229 OASIS STREET - Indio, CA 92201 ●
LAKE ELSMIRE 30 99 FRASER DR. - Lake Elsmore, CA 92530 ● PALM SPRING 3225 "ANGEL" TR. MCALLISTER - Palm Springs, CA 92262 ● PERRIS 237 NORTH 10th ST. - Perris, CA 92377 ● RIVERSIDE 520 WILSON ST. - Riverside, CA 92507 ● RUBIDOU 1888 W 65th St. - Riverside, CA 92529

DEPARTMENT OF PUBLIC HEALTH

351 North Mt. View Avenue • San Bernardino, CA 92415-0010 • (714) 387-6280

**COUNTY OF SAN BERNARDINO**GEORGE R. PETERSEN, M.D., M.P.H.
Director of Public Health

June 26, 1990

To Whom It May Concern,

This letter is to confirm that Judy Riemer has met and spoken with me about her project regarding homeless families. The Public Health Nursing Field Services program in our Department is currently providing health assessments and interventions in selected homeless family shelters in San Bernardino County. We are looking forward to involvement in Judy's project and in her findings.

Sincerely,

Kay Hemphill, RN, SPHN
Community Health Services Division

KH:kjc



Lutheran Social Services of Southern California

Genesis Shelter Services

... rehabilitation services for homeless families and single women...

11 December 1990

Judy Reimer, R.N.
5920 Shaker Drive
Riverside, CA 92506

Dear Judy:

I write to confirm our telephone conversation of 10 December. I am looking forward to you doing your study at the shelter on health care on children under the age of five years. It will give us valuable information on available care and needs of our residents.

Any donations of toys, children's clothing, personal hygiene items..are always welcome at the shelter. I think that you will probably find people willing to participate.

Again, I look forward to working with you.

Sincerely,


Caroline Arter,
Director of Shelter Services



November 16, 1990

Mrs. Judith Riemer
5920 Shaker Drive
Riverside, CA 92506

Dear Judy,

As per our discussion and your confirming letter, we would be most happy to cooperate fully with you in regard to your research program on health care for homeless families at the Hospitality House.

Please let me know in advance how many families you want to interview and what the time frame will be.

Best regards,

Mary Schmid
Homeless Shelter Supervisor

I CARE Shelter Home

P.O. Box 749 · Riverside · California · 92502

Rev. Sherry Sweetman, Executive Director

(714)354-2273

Judy Reimer
5920 Shady Dr.
Riverside, Ca. 92506

January 3, 1991

Dear Mrs. Reimer,
you have the permission of
the I Care Shelter Home to
conduct research with the homeless
families that are here in residence.
Any way we can aid in the
health concerns of the homeless
will be honored.
Thank you, Mrs. Reimer, for
caring.

Sincerely,
Bethel Mayhew
Asst. Director

APPENDIX 2
INFORMED CONSENT FORM

Loma Linda University



School of Nursing
Loma Linda, California 92350
714-824-4360

Consent for Participation in a Nursing Investigation

Title: A Study of Barriers to Preventive Health Care for Homeless Children Under Age Thirteen

Investigator: Judith Riemer, R.N., B.S.

This form is a request for you to participate in a nursing research study. The purpose of the study is to identify what barriers homeless families see as preventing them from getting well-child visits (such as for immunizations or having physical examinations) for their children. Although there may be no immediate personal benefits to you or your family for participating in this study, this research will increase nurses' understanding and knowledge on how to better help you and other homeless families obtain health care for your children in the future.

As a homeless family, you are being asked to participate. One parent or adult who cares for the children in each family will be asked to complete a questionnaire. Your participation in this study will involve no more than 15 minutes of your time. Your effort in taking this time will make the study possible.

The study is completely voluntary and should you decide not to participate, your shelter status will not be affected in any way. Your name and all information in this study are confidential. Upon completion of the questionnaire, you will receive a health care product.

You will receive a copy of this consent form. Your signature will indicate your willingness to participate. If you have any questions or concerns, please call me at 714-692-0477. If you wish to contact an impartial third party not associated with this study regarding any complaint you may have about the study, you may contact Jerry Doyle, Homeless Services Manager, County of Riverside Department of Community Action, 3600 Lime Street, Suite 714, Riverside, Ca., 92501, phone 275-8900. Thank you very much.

Judith G. Riemer, R. N., B. S.
Investigator

Date: _____

Subject's Signature

Date: _____

Witness' Signature

APPENDIX 3
STUDY QUESTIONNAIRE

Study Questionnaire
A Study of Barriers to Preventive Health Care for
Homeless Children Under Age Thirteen

Thank you for agreeing to participate in this study. Please complete all items.

BARRIERS SCALE

The relationships people have with their children's doctor or nurse can affect whether or not their children get the preventive care they need, such as well-child visits (immunizations, physical exams when your child is not sick). Please indicate how much you think each of the following characteristics of your relationship with your child's doctor or nurse affects getting well-child visits and try not to skip any item. Circle the word you select as your answer.

1. The doctor or nurse may not think my child's problems are real or important

GREATLY MODERATELY SLIGHTLY NONE

2. The doctor or nurse doesn't speak my language very well

GREATLY MODERATELY SLIGHTLY NONE

3. The doctor or nurse is/are sometimes impatient and critical and act like s/he/they know everything

GREATLY MODERATELY SLIGHTLY NONE

4. I don't think my child has a good doctor or nurse

GREATLY MODERATELY SLIGHTLY NONE

5. The doctor or nurse isn't/aren't interested in my worries about my child's health

GREATLY MODERATELY SLIGHTLY NONE

6. The doctor or nurse doesn't take enough time to explain what s/he's doing or why, or to answer my questions

GREATLY MODERATELY SLIGHTLY NONE

7. The doctor or nurse isn't interested in my child unless my child is sick or injured

GREATLY MODERATELY SLIGHTLY NONE

8. I almost never see the same doctor or nurse twice in a row when I make a visit

GREATLY MODERATELY SLIGHTLY NONE

9. The doctor or nurse can't be reached by telephone because the receptionist won't interrupt him/her for anything

GREATLY MODERATELY SLIGHTLY NONE

10. There's no way to find out how to pick a good doctor or nurse

GREATLY MODERATELY SLIGHTLY NONE

Certain characteristics of the health care system can affect whether or not people get their children the preventive care they need, such as well-child visits (immunizations, physical exams when your child is not sick). Please indicate how much you think each of the following characteristics of the health care system affects getting well-child visits and try not to skip any item. Circle the word you select as your answer.

11. The wait is too long at the time of the appointment.

GREATLY MODERATELY SLIGHTLY NONE

12. The cost of transportation and/or parking is too high

GREATLY MODERATELY SLIGHTLY NONE

13. My child does not have insurance which covers a well-child visit

GREATLY MODERATELY SLIGHTLY NONE

14. The office or clinic is too far away

GREATLY MODERATELY SLIGHTLY NONE

15. The cost of having a well-child visit is too high

GREATLY MODERATELY SLIGHTLY NONE

16. My insurance is too complicated to figure out

GREATLY MODERATELY SLIGHTLY NONE

17. There's no transportation to the office or clinic

GREATLY MODERATELY SLIGHTLY NONE

18. There are long delays before insurance repays my expenses

GREATLY MODERATELY SLIGHTLY NONE

People's past experiences or personal preferences and needs can affect whether or not they get their children the preventive care they need, such as well-child visits (immunizations, physical exams when your child is not sick). Please indicate how much you think each of the following circumstances affects getting well-child visits and try not to skip any item. Circle the word you select as your answer.

19. No one can take care of my child like the doctor or nurse s/he used to have

GREATLY MODERATELY SLIGHTLY NONE

20. My child doesn't like to be examined or asked a lot of questions

GREATLY MODERATELY SLIGHTLY NONE

21. Appointments for a well-child visit have to be scheduled too far ahead

GREATLY MODERATELY SLIGHTLY NONE

22. Parking is inconvenient

GREATLY MODERATELY SLIGHTLY NONE

23. For some reason, my child is afraid of doctors or nurses

GREATLY MODERATELY SLIGHTLY NONE

24. The doctor or nurse doesn't think about inexpensive treatments

GREATLY MODERATELY SLIGHTLY NONE

25. I'm afraid to find out if my child has serious health problems

GREATLY MODERATELY SLIGHTLY NONE

26. My child doesn't like doctors or nurses

GREATLY MODERATELY SLIGHTLY NONE

27. It takes too long to travel to the office or clinic.

GREATLY MODERATELY SLIGHTLY NONE

What other kinds of things that have not already been mentioned do you feel stop you from getting well-child visits for your children?

1. How many children are living with you? _____

2. What are their ages (in years for children over one year of age; in months for children less than one year of age)?

_____ years/months (circle one) _____ years/months (circle one)

_____ years/months (circle one) _____ years/months (circle one)

_____ years/months (circle one) _____ years/months (circle one)

3. What is your relationship to the children living with you (circle all that apply)?

1. mother 2. father 3. legal guardian 4. grandmother

5. grandfather 6. aunt 7. uncle 8. other _____

4. What ethnic group do you identify yourself with (please check one)?

_____ Black _____ Hispanic/Latino _____ Other White

_____ Asian _____ Other _____

5. How long has your family been homeless this time?

_____ days

6. Have you been homeless before this?

_____ No _____ Yes, for _____ days

THANK YOU AGAIN FOR YOUR HELP!

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