Barriers to Well Child Care for Homeless Children under Age 13
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Abstract
Barriers perceived by homeless families to preventive health care for their children under age 13 have been underdocumented. This descriptive study was designed to identify perceived barriers to care and to determine if there was a relationship between perceived barriers and duration of the family's 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 was surveyed via questionnaire.

Four barriers were cited most frequently by the respondents as greatly affecting their children's care. These barriers involved provider-selection difficulties, waiting for well child appointments, waiting during well child appointments, and the high cost of transportation and/or parking. No relationship was found between duration of homelessness and perceived barriers.

These findings confirm the reality of potential barriers to care suggested by earlier studies. Innovative forms of health care delivery that may reduce or eliminate these barriers include the use of shelter-site clinics, mobile units, and the use of a nurse liaison between family shelters and hospital-based clinics.

INTRODUCTION
The faces of America's homeless are changing. Once considered the domain of older, uneducated male alcoholics, the streets of America are increasingly the home of the "new" homeless: They are younger (average age 35 to 40 years), and increasing numbers are women (approximately 25%), minorities (at least 50% nonwhite), and children (Bowdler & Barrell, 1987). Families are the fastest-growing subgroup of the homeless (Bassuk & Rosenberg, 1988; Berne, Dato, Mason, & Rafferty, 1990; Damrosch, Sullivan, Scholler, & Gaines, 1988; Wood, Valdez, Hayashi, & Shen, 1990a). Estimates of the size of the homeless family population range from 25% to 40% of the total homeless population of 3 million (Alperstein & Amstein, 1988; Bassuk & Rosenberg, 1988; Berne, et al., 1990; Children's Defense Fund, 1989; Hodnicki, 1990; U.S. Conference of Mayors, 1986).

Mirroring national trends, local surveys in two southern California counties (Riverside County Dept. of Community Action, 1993: San Bernardino County Homeless Coalition, 1993) revealed that the homeless populations in both counties were becoming younger and included increasing numbers of women, minorities, and children. The average age of the homeless individual in one county was 23.3 years. Children made up 36%–43% of the total homeless populations of both counties. Both county surveys revealed a disproportionate number of minorities, particularly African Americans and Hispanics, in the homeless population, as compared with the general population in each county.

Sebastian (1985) reported that the unique features of the "biopsychosocial" environment of the homeless cause or exacerbate a number of health problems. These problems include difficulties in the maintenance of body temperature,
exacerbation of chronic illnesses, exposure to pollutants, incomplete or delayed resolution of acute health problems, constant mobility, and infectious diseases/unhygienic living conditions. The homeless are also vulnerable to a variety of mental health and social problems—for example, they lack eligibility for government assistance programs such as Medicaid due to lack of an address. Health promotion is extremely difficult for homeless individuals and families because their highest-priority needs are physical and psychosocial survival. (Sebastian, 1985).

The unique features of the homeless environment place families, and particularly children, at risk for serious and long-lasting physical and psychological problems (Alperstein & Arnstein, 1988; Bassuk & Rubin, 1987; Berne et al., 1990; Bowdler, 1989; Brickner et al., 1986; Hunter, Crosby, Ventura, & Warkentin, 1991; Kinzel, 1991; Wood, Valdez, Hayashi, & Shen, 1990b). Previous studies of sheltered homeless family populations revealed that homeless children displayed significant behavior and developmental problems and nutritional and growth disorders, as well as higher rates of chronic and acute disorders, such as asthma, anemia, upper respiratory infections, skin ailments, and ear and eye infections, than non-homeless children (Hu, Covell, Morgan, & Arcia, 1989; Miller & Lin, 1988; Wood et al., 1990b).

The few studies done in the area of homeless children and health care have shown significantly lower levels of preventive health care for this high-risk population than for the general population of children (Hu et al., 1989; Miller & Lin, 1988; Roth & Fox, 1990). Low levels of immunization, untreated acute or chronic problems, and lack of a regular health provider or health insurance are among the many health problems found in homeless children. Because they are less likely than housed low-income families to have Medicaid or any type of insurance, access to care is severely reduced (Alperstein & Arnstein, 1988; Damrosch et al., 1988; Hu et al., 1989; Hunter, Getty, Kemsley, & Skelly, 1991; Miller & Lin, 1988; Roth & Fox, 1990; Wood, 1989). However, even when preventive health care services are free and easily available (good access to care), families may not always take recommended health actions due to perceived barriers, such as fear or pain.

Despite the growing numbers of children in the homeless population, no local studies have been done to examine well child care for homeless children or to determine what barriers might be perceived by homeless families in obtaining well child care. However, a number of factors have been identified as potential barriers to preventive health care for the homeless. They include priority of time-consuming searches for food and shelter (Alperstein & Arnstein, 1988; Wood, 1989); lack of health coverage or a regular health provider (Berne et al., 1990; Hu et al., 1989; Hunter, Getty et al., 1991; Miller & Lin, 1988; Roth & Fox, 1990; Sergi, Murray, & Cotanch, 1989); lack of money (Alperstein & Arnstein, 1988; Hodnicki, 1990; Hunter, Getty et al., 1991); lack of transportation (Alperstein & Arnstein, 1988; Bowdler, 1989; Hodnicki, 1990); fear of labeling and rejection by health personnel (Berne et al., 1990; Bowdler, 1989; Hodnicki, 1990; Hunter, Getty et al., 1991); difficulty in navigating the large, complicated bureaucracy of health institutions (Bowdler, 1989; Bowdler & Barrall, 1987; Skelly et al., 1990); long waits at medical offices or for appointments (Berne et al., 1990); language difficulties for non-English speakers (Hu et al., 1989); and unfamiliarity with neighborhood shelter locations (Alperstein & Arnstein, 1988; Berne et al., 1990).

Interpretation of these results, however, has been limited by two factors. First, homelessness varies by geographical and seasonal influence (Sergi et al., 1989). Second, none of these studies used consistent categories and operational definitions of barriers to comprehensively examine the barriers perceived by the homeless family to obtaining well child care.

In planning health services, it is particularly important to be aware of the barriers perceived by families since it is these barriers that prevent the homeless child from receiving preventive health care. It is also important to know whether and how these perceptions of barriers change over time. The study reported here, therefore, was designed to identify the barriers perceived by homeless families to well child care for their children under age 13, and to determine if there was a relationship between perceived barriers and duration of homelessness.

THEORETICAL FRAMEWORK

The study was based on the concept of barriers found in the Health Belief Model (HBM) (Rosenstock, 1974a; 1974b). Though the HBM had not been used previously to guide studies of the homeless, it was considered an appropriate framework since the study focused on the sheltered homeless. Sebastian (1985) suggested that it is not appropriate to discuss issues of health promotion with people whose basic survival needs are not being met. However, as Kinzel (1991) pointed out, the basic survival needs of the homeless can be met by existing shelters. Additionally, Hunter et al. (1991) suggested that with a few exceptions, basic health needs are essentially the same for the homeless as for the general population. It would follow that if the homeless have most of their basic needs met, it is appropriate to explore mechanisms aimed at promoting health behaviors and, consequently, overall health. The HBM was specifically created to help understand and promote health behaviors.

The HBM posits that whether or not an individual undertakes a recommended health action is dependent upon four
elements: perceived personal susceptibility to disease; perceived seriousness or severity of the disease; an evaluation of whether the benefits of taking the action outweigh the costs or barriers to the action (such as expense, pain, or inconvenience); and whether or not the individual has received a cue or cues to take the action (such as reminder postcards).

The theoretical definition of barriers in the HBM is consistent with the unified concept agreed upon by the authors of 14 of the major models of health behaviors. Barriers are defined as the “individual’s belief concerning the costs associated with taking a health action” (Cummings, Becker & Maile, 1980: 140). According to the HBM, or elimination of barriers increases the likelihood that a recommended health action (such as the seeking of well child care) will occur.

SAMPLE AND SETTING

The study used a descriptive design with a questionnaire format. A convenience sample of homeless families with at least one child under age 13 was drawn from the population of residents at three transitional homeless shelters in two neighboring southern California counties. All were church-affiliated shelters with 35–40 beds available, and they allowed families to remain up to 60 days while receiving food, shelter, and social services.

Access to health care was similar for all shelters at the outset of the study. Large county medical centers and health department clinics were available in both counties. During the study, however, a mobile van program was initiated that offered well child checkups once a month at Shelter 1; this increased available well child care services for that shelter.

A pilot study of four families at one shelter was conducted to refine data-collection techniques. Following the pilot study, additional clarifying instructions were written and provided orally to all subjects.

Data were collected from January to July. The investigator went to the shelter sites during regularly scheduled evening meetings, where families were given a description of the study and given the opportunity to volunteer. All families who chose to participate were assured confidentiality and told that participation would not affect their shelter status. All participants signed an informed consent form. A total of 53 families met the study criteria and consented to participate. The questionnaire was administered to them by the investigator in the shelters during evening hours.

MEASUREMENTS

Demographics

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 also 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

An investigator-modified version of the Barriers Scale developed by Melnyk was used (Melnyk, 1990). The Barriers Scale was designed to assist health care professionals in improving the provision of preventive health services by identifying barriers perceived by consumers to receiving care. The scale consists of 27 statements in five subscales: Provider/Consumer Relationship, Site-Related Factors, Cost, Fear, and Inconvenience. Each statement describes possible barriers to preventive health care. The respondent is asked to identify the degree to which each barrier affects receiving care (greatly, moderately, slightly, none).

The Barriers Scale is scored on a 4-point Likert scale from 3 to 0, with “greatly” equal to 3, “moderately” equal to 2, “slightly” equal to 1, and “none” equal to 0. Values are summed to produce scores on individual subscales and on the entire scale.

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. However, focus and content of the statements were not changed. Respondents were also asked to identify 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?”

Content validity was established for the original Barriers Scale through the use of a Delphi procedure to generate barriers items. Reliability analyses of the five subscales produced an alpha for each subscale as follows: Provider/Consumer Relationship—0.91; Cost—0.85; Site-Related Factors—0.77; Inconvenience—0.63; and Fear—0.76 (Melnyk, 1990). Reliability analyses of the investigator-modified version of the Barriers Scale produced an alpha for each subscale as follows: Provider/Consumer Relationship—0.85; Cost—0.70, Site-Related Factors—0.70; Inconvenience—0.73; and Fear—0.72.

FINDINGS

Characteristics of the Sample

The sample included 53 families with 120 children. The typical study respondent was a mother with two children ($m = 2.3$), primarily school-age. The duration of the current episode of homelessness ranged from 1 to 365 days ($m = 34.1$ days). A history of previous homelessness was reported by 23.4% of the respondents. The duration of previous homelessness ranged from 0 to 910 days ($m = 36.1$ days) (see Table 1).
Shelters differed only in ethnicity. Shelter 1 respondents \( (n = 5) \) were all self-identified as "other" white. The 28 Shelter 2 respondents \( (n = 29) \) identified themselves as African American (54%) and other white (46%). One subject did not respond. Shelter 3 respondents \( (n = 19) \) were self-identified as representing five ethnic groups (African American—24%, Hispanic/Latino and other white—33% each, Asian and other—5% each).

The ethnicity differences may be explained in part by the small sample size for Shelter 1. The ethnic makeup was not the usual distribution for this shelter—the investigator observed a wide variety of ethnic backgrounds during site visits made both before and after the study period. The county in which Shelter 2 is located has a higher proportion of African Americans in its population than the county where Shelters 1 and 3 are located (14.9% and 6.9%, respectively) (Horner, 1987), and it was thus expected that there would also be a higher proportion of African Americans in its shelter.

**Identification of Perceived Barriers**

Scores on the 27 barrier items varied widely, ranging from 0.0 (none) to 3.0 (greatly). Reasons for the wide range of scores are unknown, but interviews with many of the respondents indicated that reasons may have been related to antecedent conditions not measured in the study, such as parental educational level. Respondents who described prior access to private health insurance or becoming homeless due to financial reasons rather than disturbed family relationships (such as drug use or domestic violence) seemed less likely to regard the barriers as having a major impact on obtaining well child care.

**Provider-Consumer Relationship Subscale**

The 10 barriers in the Provider-Consumer Relationship subscale address characteristics of the relationship between the family and the health care provider (doctor or nurse). 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 were between 1.0 and 2.0 on 9 of the 10 items. The mean score for the item “There’s no way to find out how to pick a good doctor or nurse” was 1.8. Twenty-three respondents chose the response “greatly” (3), indicating that this greatly affected their ability to obtain well child care. Three was the modal score for this barrier.

**Site-Related Factors Subscale**

The four barrier items in the Site-Related Factors subscale address factors such as the availability of transportation/parking, waiting time at the appointment, and the distance to the office or clinic location.

The mean score on the Site-Related Factors subscale was 1.5; mean scores were between 1.0 and 2.0 on all four barrier items. The mean score for the item “The wait is too long at the time of the appointment” was 1.8. Nineteen respondents chose the response “greatly” (3), indicating that this barrier greatly affected their receiving well child care. Three was the modal score for this barrier.

**Cost Subscale**

The four items in the Cost subscale address cost of care and availability of insurance to cover well child care. The mean score for the Cost subscale was 0.9; mean scores were less than 1.0 on three of the four items.

**Fear Subscale**

The five barriers 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. The mean score on the Fear subscale was 0.9; mean scores were less than 1.0 on four of the five items.

**Inconvenience Subscale**

The four barriers 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 the inconvenience of parking.

The mean score for the Inconvenience subscale was 1.2; mean scores were between 1.0 and 2.0 on three of the four items. The mean score for the item “Appointments for a well child visit have to be scheduled too far ahead” was 1.5. Nineteen respondents indicated that this greatly affected their receiving well child care. Three was also the modal score for this barrier.

Analysis of variance was done to determine if there were significant differences between residents of different shelters on the subscale scores; the only significant difference was found on the Site-Related Factors subscale. Scheffe’s post-hoc analysis revealed a significant difference between the scores of families at Shelter 1 and those at Shelter 2 on this subscale ($F(2.50) = 4.8, p < .01$). The difference may be in part explained by the recent inauguration of a mobile van program offering well child checkups once a month at Shelter 1. The availability of on-site services may have reduced respondents’ perceptions of site-related factors as barriers to well child care. No significant association was found between perceptions of the barriers to well child care and length of time the family had been homeless.

**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?” Content analysis of the responses revealed a number of themes. Seven respondents identified lower quality of care associated with Medi-Cal providers as an important barrier to care. Other concerns included the need for baby-sitting for siblings, transportation, cost, lack of continuity of care, and inconvenient office hours for working parents.

**DISCUSSION**

This study identified barriers to well child care for homeless children under age 13 using an investigator-modified version of Melnyk’s Barriers Scale. Four barriers were selected most frequently by the respondents as greatly affecting their children’s receiving care. These barriers concerned provider selection difficulties, waiting for well child appointments, waiting during well child appointments, and the high cost of transportation and/or parking. These barriers were also mentioned by respondents in their answers to an open-ended question asking for additional barriers.

These findings confirm the findings of Berne, Dato, Mason, and Rafferty, who identified unfamiliarity with local providers, waiting for appointments, and transportation problems as potential barriers to health care for homeless families (Berne et al., 1990). While these barriers are a problem for caretakers in obtaining well child care, they may seem even more formidable to homeless families who are sheltered out of their usual neighborhood and must spend so much time planning how they will meet future survival needs.

Assessment of perceived barriers to health care is a first step in planning better health services for homeless children. Since this study had a small ($n = 53$) convenience sample, more research on perceived barriers to health care for homeless children is needed to confirm these findings. Information on parental age, educational level, marital status, income, health insurance, and reason for homelessness was not obtained in this study but should be included in future studies to ascertain the role of these variables.

The HBM posits that or elimination of perceived barriers will increase the likelihood that a recommended health care behavior or action (such as seeking well child care) will occur. Thus, measures aimed at reducing or eliminating the barriers identified by this study may result in improved well child care for homeless children.

Innovative forms of health care delivery may successfully reduce or eliminate these barriers. Innovations might include the use of nurse-managed shelter-site clinics or mobile units (Berne et al., 1990; Hunter, Crosby et al., 1991; Malloy, 1990; Skelly et al., 1990), either of which would eliminate the need for transportation and parking costs, and eliminate or at least reduce waiting for or during well-child appointments. They might also reduce or eliminate difficulties in selecting a health care provider.

A nurse who acts as liaison between a family shelter and hospital-based clinics, as suggested by Bass, Brennan, Mehta and Kodzis (1990), may also reduce or eliminate barriers to care. The shelter nurse liaison could assist with health care provider selection as well as transportation and parking costs. A major goal of formal affiliations should be reduction of shelter families’ waiting time for and during appointments.

All public health nurses should ask the homeless families they encounter about perceived barriers to obtaining well child care, including those identified by this study. Measures to reduce or eliminate perceived barriers should then be implemented within the local environment. These measures must include immediate assistance for individual families as well as long-term advocacy for improved health care delivery systems for homeless families in their communities.

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