ASSESSMENT OF HOMELESS CHILDREN AND THEIR FAMILIES IN A NON-METROPOLITAN AREA

by

Mary Beth Burton

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APPROVED:

[redacted]

Donna B. Jensen, R.N., Ph.D., Associate Professor, Thesis Advisor

[redacted]

Caroline M. White, R.N., DrPH, Professor, First Reader

[redacted]

Margaret M. Crowley, R.N., M.P.H., Second Reader

[redacted]

Carol A. Lindeman, R.N., Ph.D., F.A.A.N., Dean, School of Nursing

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CHAPTER I

INTRODUCTION

The incidence of individuals having tenuous or no claim to conventional housing in the United States has been steadily increasing since the early 1980s. The federal Department of Housing and Urban Development (HUD) has estimated that 250,000 to 350,000 are without a home nationwide (Ropers and Boyer, 1987) while the Robert Wood Johnson Foundation reports that an estimated 2.5 million persons in the U.S. are homeless at any given time (Nichols, 1986). Of even greater significance is the increasing number of families with young children who are joining the ranks of the homeless.

Much research has been generated in recent years focusing on the homeless. More is being ascertained about why homelessness is on the rise. Deinstitutionalization of the mentally ill (Roth and Bean, 1986) (Bassuk, 1984), the decrease of available low-income housing (Wright and Lam, 1987), decreases in social welfare programs (Ropers and Boyer, 1987), and substance abuse and domestic violence (Hagan, 1987) have all been implicated.

It is evident that the demographics of homelessness are different now than in the late 1960s. The average age of men who are homeless has decreased from 44 to 36.5 years of age, the average education level has increased from 9 to 11 years and the fraction of the homeless population that is white has dropped from 49% to 15% (Wright and Lam, 1987).

In the past few years family homelessness has been increasing. In early 1986, it was estimated that family members comprised more than 20% percent of the overall homeless population (Basler, 1986). The U.S. Conference of Mayors (1987) places the proportion even higher at 30% overall with a range in surveyed cities from 95% in Norfolk, Virginia to 7% in Minneapolis. In Portland, Oregon, one half of the homeless individuals in 1986 were in family units (Stone, 1987). Bassuk and Rubin (1987) note that the vast majority of families who are homeless are headed by single women with two to three children, two-thirds of whom are five years and younger. In New York City, three-fourths of homeless individuals living in shelter hotels are children (Acker, Fierman and Dreyer, 1987). In Los Angeles, it is estimated that there are 10,000 children who are homeless (McGee, 1988). Little is known about how these figures compare with less urban parts of the country.

While much is yet to be learned about the health status of children who are homeless, a variety of acute and chronic health and psychiatric problems have been recognized in homeless adults, including trauma, TB, infestations, and peripheral vascular disease (Brickner, et al, 1986). In predominantly urban settings in Massachusetts, Bassuk, Rubin and Lauriat (1984) interviewed men, women and children in homeless shelters. Ninety-one percent were found to have primary psychiatric diagnoses of psychoses, personality disorder or chronic alcoholism. One-third had been hospitalized for psychiatric care. Children in another Bassuk,

Rubin and Lauriat study (1986) were found to have developmental delays, anxiety, depression and learning difficulties and about one-half required further psychiatric evaluation.

Literature on the effects of homelessness on children is sparse. Moreover, studies that have been done focus on homeless populations in densely populated areas which may not accurately reflect the problems of those who are homeless in less populated parts of the country. The purpose of this study was to gather demographic information about selected families of preschool children who are homeless in a less densely populated part of the country and to evaluate these children for developmental delays focusing on four areas: fine motor adaptive, gross motor, language, and personal/social. In addition, the study describes as case studies, five selected homeless families who were interviewed during the process of the study.

Review of the Literature

The review of the literature focuses on four main areas: a general overview of homelessness, its assumed causes and resulting problems; literature specific to women as their issues are inextricably woven to those of their children; problems unique to children with a special emphasis on studies describing the characteristics of sheltered homeless families in predominantly urban Massachusetts; and, finally, information specific to the setting of this study.

Overview of Homelessness

The deinstitutionalization of the mentally ill, a movement

that began in the mid-sixties after the introduction of psychotropic drugs, offered the hope of rehabilitating the mentally ill in a community setting. This movement has been cited by many as contributing to the rising numbers of homeless in the U.S. (Roth and Bean, 1986) (Lamb and Talbott, 1986) (Bassuk, 1984) (Bachrach, 1987) (Fisher, Shipiro, Breakey, Anthony, & Kramer, 1986). It is noted by both Bachrach (1987) and Bassuk (1984) that a certain number of chronic mentally ill who have been released from state mental institutions are a part of the homeless today. Diversion policies related to the deinstitutionalization process have left many mentally ill individuals to fend for themselves who might have been institutionalized in earlier times. The authors note that deinstitutionalization has not been accompanied by the needed increase in local mental health facilities, half-way houses or group homes to help integrate the mentally ill into the community. This shortcoming has contributed to the increasing numbers of homeless with mental health problems. Lamb and Talbott (1986) add to this picture by noting that a good number of unsupervised mentally ill individuals stop taking medication, lose touch with social agencies and become too disorganized to manage their lives, thus falling into homelessness.

Bassuk, Rubin and Lauriat (1986) found that 90% of the women they interviewed in shelters for the homeless in Massachusetts were assigned either DSM III Axis I or Axis II diagnoses of major psychiatric syndromes or personality disorders. Their interviews were conducted by mental health professionals but were limited

because of privacy factors. It is also not clear from this report how homelessness itself along with shelter living contributed to the diagnosis of "personality disorder."

Exacerbation of chronic health problems by fragmented health care is cited as another major problem in this population. Brickner, et al (1986) in a review of health care needs for the homeless lists trauma, pulmonary TB, infestations and peripheral vascular disease as common problems of the homeless. This information was gathered from data across the country and is not described in relationship to age or sex.

Wright and Lam (1987) argue that the homeless problem of the late 1980s is directly attributable to the "virtual decimation of the low income housing supply in most large American cities." They note that the total number of housing units renting for $80 or less per month has dropped from 5.5 million in 1970 to 1.1 million in 1980 to 650,000 in 1983. Portland, Oregon, recognizing this need, has made housing one of its top priorities in dealing with the homeless (Stone, 1987).

Unemployment, increased poverty, cut backs in the social security roles and other decreases in social welfare programs have also been mentioned by authors as contributing factors in rising homelessness (Ropers and Boyer, 1987) (Wright and Lamb, 1987) (Bassuk, 1984).

Women Who Are Homeless

Stoner (1983) notes that many times women who are homeless and their children are the victims of the "feminization of

poverty", resulting from family breakdown through divorce, desertion, and abuse. Poverty alone puts women and children at high risk of homelessness (Hagan, 1987). Especially vulnerable are those households relying on public assistance benefits which are not keeping pace with the cost of housing. She adds that family violence, both wife battering and sexual abuse, place women and girls at risk. Based on data from 227 individuals who requested services from an agency designed to coordinate care for the homeless in a moderate sized community, Hagan found that women had a greater incidence of eviction and domestic violence as factors contributing to homelessness. These cases of domestic violence also represented eight children under 16 years. Women in the Hagan study were noted more often than men to have a source of income, usually from employment (18.9% vs. 8.4%), and were having fewer problems with alcohol abuse (one-third vs. two-thirds).

An overview of the literature on homeless women by Slavinsky and Cousins (1982) notes that there is an increase (up to 50%) of homeless who are women and that few of these women have alcohol problems. Many women who are homeless do have contact with health care facilities although many are not utilizing prescribed treatments correctly. Many of the women in the Slavinsky/Cousins study have ongoing mental health needs.

Chavkin, Kristal, Seabron, & Guigli (1987) focus on the reproductive experiences of women living in hotels for the homeless in New York City. These women were found to have overall fewer prenatal visits, and a higher incidence of low birth weight

infants and infant mortality than a matched group of low income housed women.

A review of the literature on homeless women by Stoner (1983) finds that women who are homeless are both vulnerable to different problems and have different coping strategies than men who are homeless. Women are vulnerable to rape and crime along with other hazards of the street. Many are forced to panhandle, steal drugs, shoplift, become prostitutes or trade sexual favors for food, shelter and other necessities. Some characteristics of older homeless women such as foul odor were seen to be conscious defense mechanisms.

Problems Unique to Children and Their Families

An in-depth study by Bassuk, Rubin and Lauriat (1986) addresses mental health concerns of those who are homeless in mostly urban Massachusetts. Eighty mothers and 151 children living in homeless shelters in Massachusetts were interviewed by mental health professionals. Out of the 14 shelters used in this study, 11 were located in urban areas with a population of over 50,000. Slightly more than 62% percent of the individuals interviewed were from Boston. One-fourth of the mothers were assigned DSM-III Axis I diagnoses indicating the presence of major psychiatric clinical syndromes. Twenty-one percent were given Axis II diagnoses of personality disorders such as antisocial, passive-aggressive, schizoid and several others. Six reported histories of psychiatric hospitalization and seven had substance abuse problems. More than two-thirds described at least one major

family disruption during childhood including divorce/separation of parents, death of parent, mental illness and alcoholism of parent, and abuse. Thirty-three percent of the mothers reported that they had been physically abused as children. Another remarkable finding in this study was that 74% reported no family relationships and 73% reportedly had no friends to provide support. Those with a history of psychiatric hospitalization were even more disconnected, with more than 90% reporting neither friends nor family.

Of the 151 children in this study, 81 were five years or younger. Based on the Denver Developmental Screening Test, 47% of the children five years and younger were delayed in at least one area of functioning and 33% had two or more developmental lags. Based on the Simmons Behavior Checklist, 55 children aged three to five years scored higher than the overall mean on the following factors: shyness, dependent behavior, aggression, attention span, withdrawal and demanding behavior. They scored less than the mean on sleep problems, coordination, fear of new things and speech difficulties. Of the 13 children in the 12 to 16 year age group, more than one-third required psychiatric referral. Based on parental reports, 12% of the children had ongoing medical problems while one-fourth were described as having emotional or developmental problems. Ninety percent of the families in this study were headed by single, divorced or separated women.

Bassuk and Rubin (1987) in further describing their earlier Massachusetts study note that all school age children were

attending school. Parents indicated, however, that 43% were failing or performing below average work. Twenty-five percent were reported to be in special classes and 43% had repeated a grade. In a further review of this same study, Bassuk and Gallagher (in press) state that the preschoolers from the Boston area were in the most trouble with almost three-fourths exhibiting at least one developmental delay. It is not stated whether there were other significant differences between the inner city population and greater Massachusetts population, leaving questions about what other factors may have impacted on these children. These data, while significant, also have a serious drawback when attempting to draw conclusions since interviews with mothers and the testing of the children were conducted in common areas of the shelters, thereby not allowing the privacy necessary, especially for developmental screening of young children.

Bassuk and Rosenberg (1988) undertook still another study in Massachusetts to compare their original findings on mothers and children who were homeless with mothers and children of similar socio-economic status who were housed in single family dwellings. On the Denver Developmental Screening Test, only 16% of the housed children showed one lag, compared with 47% of the homeless children. Nine percent of school aged housed children exhibited need for further psychiatric evaluation compared with 31% of the homeless children. While both studies had problems related to sample selection and interview sites, the findings are interesting and represent some of the initial data looking at housed vs.

homeless families. The findings are not able to distinguish among problems associated with chronic poverty and deprivation and those problems associated with homeless life per se. Bassuk and Gallagher (1988) provide some anecdotal information that some children may seriously regress when faced with shelter living. They also discuss the stress of shelter living on children where there is no privacy either for oneself or from the emotional and behavioral problems of other families.

Another recent study done in the Boston area reports different findings concerning the developmental status of young children who are homeless. Lewis and Meyers (1989), reviewed data collected by a pediatric nurse practitioner on families with young children (213 in all) entering emergency shelters in Boston. These data included family demographics, height and weight information, and results of Denver Developmental Screening Test (DDST) administration. Of significance, they found the vast majority of families were headed by women, were black and were homeless for less than one year (with a median of three months). DDST scores were found to be abnormal or questionable for only 4.7% of the children under age six. Although the study was done retrospectively by chart review, which may be a limiting factor, findings on the DDST screenings were significantly different from earlier studies emerging from the Boston area.

One further study has reported significant developmental delays in children who are homeless. The Salvation Army in St. Louis has developed an ongoing developmental screening program in

their family shelter. A report by a program consultant on 107 children tested states that these children were displaying cognitive/developmental problems at a rate three times that of the general population, and that 80% of these children displayed significant language deprivation ("A report by", 1987).

Information from the school system in New York City indicates that 25% of that city's nearly 6000 homeless school aged children are two to three years behind in their work (Daley, 1987). School officials also note that many of the children who are homeless are becoming deeply troubled, exhibiting psychological problems ranging from withdrawal to hyperactivity.

Few other published studies focus on the developmental and emotional lives of children who are homeless, although there has been some research looking at health and nutritional parameters of these children. Acker, Fierman and Dreyer (1987) found that homeless children in New York City are at risk of inadequate immunization. They also found that homeless children aged six months to two years are at increased risk for iron deficiency anemia. Alperstein, Rappaport and Flanigan (1988) compared children who are homeless in New York City with domiciled children in the same socio-economic group and found that while there was little difference between the groups on growth parameters and free erythroprotoprophyrin levels, there were higher reported serum lead levels for the homeless group. There was also a significant delay in immunizations for homeless children. Higher rates of reported child abuse and neglect were also found with more

hospital admissions than for those in the comparison group. These data were obtained by retrospective analyses of charts of children attending St. Lukes's-Roosevelt Hospital Pediatric Primary and Ambulatory Care Clinic. These last findings need to be viewed with caution because of possible different usage levels of emergency rooms in the two groups and because of possible reporting bias by emergency room staff. Both studies fail to note that in regards to immunization status, highly mobile populations tend to lose immunization records and children reported to be underimmunized may actually be overimmunized because of repeated efforts to "catch them up."

Homelessness in Jackson County, Oregon

To this point, the literature review has focused on homelessness in general and more specifically on the social and health related characteristics of women and children who are homeless. The remainder of this review focuses on the small amount of information available about those who are homeless in a less densely populated part of the rural state of Oregon and will present data from a particular area for illustration.

Jackson County, Oregon, includes a number of small and medium sized principalities, the largest of which is Medford, with a population of 43,000. Shelter and other services to the homeless of the area are concentrated in Medford. Because the three shelters, the Salvation Army, St. Vincent DePaul, and the Gospel Mission concur that the same individuals utilize all three shelters, a number estimate of users can be made by looking at

just one of these shelters, the Salvation Army. In 1987, the Salvation Army provided 10,128 bed nights. Fifty percent of that figure or 5,064, represents unduplicated utilization. Of this figure, 156 were single women, 441 were individuals in family units, 472 were single women with minor children and 3,995 were single men (Crowley, 1988). This number represents 3.6% of the total Jackson County population which seems inordinately high given the nationwide prediction of 0.5 to 1% (Nichols, 1986). Because Medford/Jackson County lies in the "I-5 corridor", en route between major metropolitan areas to the North and to the South, this figure can be seen to represent a significant number of highly transient individuals who may also be included in statistics gathered in other locales.

Burton, Donlon, Meyer, and Stevens (1988) interviewed a convenience sample of 59 adults who were homeless in Medford while conducting a health needs assessment of the homeless in the spring of 1988. Thirty-four percent of the sample were women. This percent was higher than the 18% of women found in the Salvation Army data. The mean age of respondents reflected national data at 37 years. There were 24 children living with these adults, 54% of whom were five years and under. The racial composition of the sample does not reflect national data with only 5% minorities. Only 37% claimed Jackson County as their home reflecting a large transient population. Education level is also higher than national data in this sample group with 69% having obtained a high school degree, GED or beyond. Twenty-nine percent had been

homeless for one month or less. Parents reported that 36% of the children had health problems including chronic metabolic disease, allergies, asthma, speech delay, emotional problems and chronic ear infections. Well child care was received by 54% and 96% were up-to-date on immunizations. Drawing conclusions about the general population of homeless in this area based on this needs assessment is difficult because of the sampling method and because interviews were often conducted in less than private surroundings. It is, however, the only in-depth look available at people who are homeless in Jackson County.

Summary

The literature is consistent in its description of the numbers of homeless presently in the U.S. and of the precipitating causes for recent rises in numbers. There are discrepancies, however, in the reported demographics with wide variations in the reported numbers of women and family units who are homeless, and also in racial composition of this group. These discrepancies can be seen as a function of where the data were gathered, with different areas having different population compositions. There is also a discrepancy in the literature pointing to high unemployment rates as a causative factor of homelessness. Most of these studies were done in the early to mid 1980s when unemployment rates were indeed rising. In the past few years, however, the overall unemployment rates have been falling, with the U.S. unemployment figure at 5.2% in November of 1988 (Bureau of Labor Statistics, 11/16/88).

There is a growing body of information on women who are homeless but much of this literature fails to report anything about their children. Much of the available information about children who are homeless is from a single source, Ellen Bassuk, a Boston psychiatrist, who has written with a variety of colleagues. It is also evident that much, if not all, of what information is available on children who are homeless is based on studies done in large metropolitan areas of the country. This study was designed to collect more information on children and their families who are homeless in a less densely populated area of the country.

Conceptual Framework

It is recognized that developmental disabilities are the most prevalent of childhood health disorders (Katoff and Reuter, 1980). It is also obvious that early in life is the ideal time to identify developmentally disabled children for purposes of prevention and effective treatment. The need for early intervention and treatment for children with developmental disabilities has been recognized at both the federal and state level. On the federal level, in 1967, Public Law 90-248 established the Early Periodic Screening Diagnosis and Treatment program to ensure services to children at risk or suffering from health or developmental problems.

In Oregon, HB2021 mandates early intervention services be available to Oregon children who demonstrate significant functional delays in gross motor, fine motor, receptive and expressive languages, self help, social and/or cognitive areas. A

significant delay is legally defined as 25% delay in three areas, 45% delay in two areas, or 60% delay in one area (B. Kozol, personal communication, October 10, 1988).

In Jackson County, services for developmentally handicapped or delayed children are available through the Jackson County Early Intervention Team at the Child Development Center. Funds are provided by Jackson County school districts and the Oregon Mental Health Division. Because the program serves children who are referred for services by their physician or by other social services agencies, many children who are not seen by a regular family physician or the social service agencies do not receive this essential service.

The literature has indicated that children who are homeless may be at particular risk for developmental delays. Studies indicating this risk have been done in urban areas. It is not known the extent to which children and families in non urban areas show a similar risk.

Research Questions

1. What are the family demographics of selected preschool children who are homeless in a non-densely populated area of Oregon?

2. Do selected children who are homeless five years and younger in a non-densely populated area of Oregon show evidence of developmental delays?

   a) Are delays evident in the area of fine motor adaptive?

   b) Are delays evident in the area of gross motor?

c) Are delays evident in the area of language?

d) Are delays evident in the area of personal/social?

3. What are the parent/s reactions to the developmental screening of their children?

Developmental delays will be defined utilizing the criteria of the Denver Developmental Screening Test (Frankenburg, Dodds, and Fandal, 1973) (Appendix A). Fleming (1981) quotes Kessen as stating that a "characteristic is said to be developmental if it can be related to age in an orderly or lawful way."

Chapter II

Methods

Overview

In order to ascertain the developmental status of selected children who are homeless in Jackson County, Oregon, a convenience sample of thirty-one preschool children were assessed utilizing the Denver Developmental Screening Test. The parent/s of these children, twenty families in all, were interviewed about specific demographic information. The study is descriptive in design and includes case studies of selected families. Data collection for this study occurred from mid-April, 1989 through mid-September, 1989.

Setting

Jackson County, Oregon, is a non-densely populated county with a population of 141,700 people; the largest city, Medford, has a population of 43,000 (Center for Population Research and Census, 1988). The Medford area was designated a Standard Metropolitan Statistical Area (SMSA) in 1980, by far the smallest of Oregon's four SMSA's (Bureau of the Census, 1980). The nearest large metropolitan areas are San Francisco, 400 miles to the south, and Portland, 300 miles to the north. The main industries in the area are agriculture, timber, and tourism, all industries that hire people for seasonal rather than full time work with associated benefits. A study done by the Oregon State Health Planning and Development Agency (1986) listed Jackson County among

the counties with seriously high rates of unemployment and a significant number of people who have not completed high school. In recent years, the unemployment rates on the national and state levels have been consistently falling. In August, 1988, both the state of Oregon and federal statistics showed an unemployment level of 5.4; Jackson County at this same time had a level of 6.4, a full percent higher (Labor Trends, September, 1988). Ten percent of the county population falls below the poverty level for income (Oregon State Health Planning and Development Agency, 1986).

The families were interviewed and the testing was conducted in two of the four local emergency shelters and at the Medford Community Health Center, a non-profit agency that provides primary health care to the low income and indigent of the county. Access to the other two emergency shelters was not permitted.

Subjects

The 31 children screened for the study were all residing in Jackson County with their families and all met the following criteria for inclusion:

1. Homeless
2. Aged two weeks to the sixth birthday
3. Consent by parent to participate
4. Not febrile or seriously ill at time of screening

The fourth criterion was revised from its original wording, "not ill at time of screening" to allow for inclusion of afebrile children who were recovering from minor illnesses or health problems at the time of the screening.

A literal definition of homelessness was not used for this study; rather, use was made of a description of subpopulations of homeless described by Rossi and Wright (1987) in their in depth study of the homeless in Chicago. This description distinguishes between (1) the literal homeless--persons who obviously have no access to a conventional dwelling unit and who would be considered homeless in any conceivable definition of the term, and (2) the precariously (or marginally) homed, persons with tenuous or very temporary claims to a more or less conventional dwelling. The latter group would include those individuals and families staying without rent in family or friends homes for brief periods of time and those staying for brief periods of time in motels. Both of these groups were included in this study.

Instruments

The main screening device utilized was the Denver Developmental Screening Test, a tool developed by Frankenburg and Dodds in 1967. The DDST is a scale consisting of 105 items, each defining a different developmental milestone. A horizontal bar represents each item and a scale indicates the ages at which 25, 50, 75 and 90 percent of the standarized population was able to perform the item. The test is designed to measure four dimensions of development in pre-school age children: fine motor adaptive, gross motor, language, and personal/social. The scale enables the examiner to determine whether the child is within the normal range of milestones, which are shown in graphic form. The DDST is intended as a screening test only. It aids in identifying areas for further study.

The DDST was originally standarized on 1,036 normal children, two weeks to six years of age whose families reflected occupational and ethnic characteristics of the population of Denver and Frankenburg, Camp, & Van Natta (1970) found that the DDST correlated highly with the Yale Developmental Examination. However, Appelbaum (1978) reports the standardization sample may have contained a significantly higher proportion of white children from upper socioeconomic groups than the census would warrant.

After introduction of the original DDST, a validity study, a stability study and a cross validation study were done resulting in a revised method of interpretation for the DDST (Fleming, 1981). This revised method of interpretation resulted in screening results rated as abnormal, questionable, and normal (Appendix B). The results of the studies also indicated the correlations obtained with the DDST and the criterion tests varied between .96 and .97; interexaminer reliability ranged from 80 to 95 percent (Frankenburg, Goldstein & Camp, 1971). Because of heavy reliance on parent reporting of items on the DDST (47%), some researchers feel the Denver is most useful for children over thirty months (Applebaum, 1978). Fleming (1981) addresses the issue of cultural bias with the DDST and notes that as long as it is used for screening and not for definitive diagnosis, it appears to be valid and reliable.

The DDST has been a widely accepted tool for developmental screening, partly because of the ease of administration. Time involved is generally 15-20 minutes. The test can easily be

performed by trained lay people. Currently, two forms are used for DDST screening, the original form and a revised form. The original form has items arranged horizontally; on the revised form, items are arranged like a growth chart. Both forms contain identical items and norms; administration is also identical. Use of forms depends on personal preference. This study used the revised DDST forms (Appendix A).

The interview with the parent/s was conducted utilizing an interview guide created by the researcher to obtain the specific demographic information desired for this study (Appendix C).

Data collection was conducted by either the researcher or by a registered nurse who had been trained in the specific data collection methods pertinent to this project, using both the Denver Developmental Screening Test and the questionnaire for parent/s. Procedures were standardized to avoid the bias possible in using more than one screener. The procedure for the Denver Developmental Screening Test was reviewed and practiced with non-participant children prior to use with participating children.

Procedures

All families were selected by convenience sampling methods as there were rarely more than one appropriate family available at a time at any site. Participation was entirely voluntary, no monetary incentives were offered.

Shelter personnel were very cooperative with this project. The researcher called or stopped by one of the shelters three or more times weekly to check on the availability of families with

young children. When families were present, shelter personnel provided a brief introduction and a quiet space for the interview and screening to take place. Access to the other shelter was arranged on an individual basis when appropriate families were known to be present.

When families at the Community Health Center were approached about participation in the study, care was taken to talk with them about this project only after their health care needs had been met.

The screenings took place in private settings in all locations to alleviate the problem of distraction during developmental screening of the children and to provide a more confidential place for interviewing the parent/s.

A brief interview was conducted with parent/s of the subject to verify criteria for inclusion in the study. Information about the research project was explained and written consent to participate was obtained according to guidelines approved by the Oregon Health Sciences University Human Subjects Committee. Then, a more in depth interview was completed to obtain specific demographic information about the child, the parent/s, living arrangements of the family, known growth and development problems of the child, and current health status of the child. After interviewing the parent/s, the screener interacted/played with the child until sufficient rapport had been established to allow administration of the Denver Developmental Screening Test. The result of the developmental screening was immediately available

and was shared with parents. Appropriate referrals were made for children exhibiting delays.

Following the developmental screening, further interviewing of the parent/s occurred to ascertain attitudinal information surrounding developmental screening.

As anticipated, the entire process took no more than one hour of time for each subject and family. Because of the short term nature of shelter stays for most of these families and because of the design of the study, repeat testing did not occur for those children with questionable results.

During the process of the questionnaire and screening, many parents spontaneously shared much more about their lives than had been originally requested. This information was added in narrative form on the questionnaire after the time with the family was completed.

Analysis

Details of the demographic information collected is presented in a series of tables. The DDST data is analyzed according to standards set forth in the DDST instruction manual.

Case descriptions were included based on information shared by individual families.

Chapter III

RESULTS AND DISCUSSION

The literature has indicated that children who are homeless may be at increased risk for developmental delays, emotional problems, immunization delays, anemia, child abuse and neglect, and hospital admission (Acker, Fierman and Dreyer, 1987) (Alperstein, Rappaport, and Flanigan, 1988) (Bassuk and Rubin, 1987). It has not been known, however, if these risks apply to children who are homeless outside of major metropolitan areas. This study takes a closer look at these children and their families in relation to three research questions and illustrates the diversity of families who are homeless in a less than metropolitan area through presentation of five case descriptions.

I: "WHAT ARE THE FAMILY DEMOGRAPHICS OF SELECTED PRESCHOOL CHILDREN WHO ARE HOMELESS IN A NON-DENSELY POPULATED AREA OF OREGON?"

Of the 20 families, eight were two parent families, one was a single father family and 11 were families headed by a single mother. (Table 1) Ninety-five percent of the families were Caucasian and 5% were Hispanic. No other ethnic group was represented.

Four women were pregnant at the time of the study. One woman, with three young children, who was interviewed early in the time frame of the study delivered during this time and her youngest child was also included at age 2 months.

Parents' educational level ranged from no school at all to college graduate. As many parents had less than a high school

Table 1

Demographics of Homeless Families Including Ethnicity, Education, Employment and Family Constellation

Family Characteristics	Percent (%)	N
Family Constellation		
Single mother	55%	11
Single father	5	1
Two parent	40	8
Ethnicity		
White	95	19
Hispanic	5	1
Education		
Grade school or less	20	7
Partial high school	37	13
HS grad/GED	20	7
Some college	23	8
Substance abuse by at least one parent		
Alcohol alone	10	2
Drugs alone	5	1
Drugs and alcohol	20	4
Either parent presently employed		
Yes	20	4
No	80	16

education as had a high school diploma or more. Four of the families had a presently working parent. Several of the parents had a professional background, a few were experienced in the trades and most worked as unskilled labor when employed.

Nine (45%) of the 20 families reported a family member (mother, father or grandparent) with current or past substance abuse problems. Three mothers spontaneously offered the information that they had been sexually abused by an older male member of their family and three parents added that a family member suffered from mental illness.

Length of homelessness ranged from a few days to 1 year with the majority reporting 3 months or less. (Table 2) Reasons given for family homelessness fell into four major categories: many of the families had recently moved to the Rogue Valley, ran low on money and found themselves unable to secure housing; several women had recently left abusive spouses or reported homelessness due to marriage break-up for reasons other than abuse; and several families reported eviction from their home for a variety of reasons including being behind on rent, having an altercation with their landlord and having had the property on which they lived sold.

Seventeen of the families were staying at emergency shelters and four were staying either in motels or with family or friends. One family was interviewed twice, once at the Community Health Center while staying with friends and once, months later after the birth of their youngest child, while staying at an emergency shelter.

Table 2

Characteristics of Family Homelessness Including Length of And Reasons for Homelessness and Present and Past Residences

Characteristics	Percent (%)	N
Length of homelessness		
Less than 1 month	35	7
1 to 3 months	55	11
8 months	5	1
1 year	5	1
Present living situation		
Emergency shelters	80	17
Motels	10	2
Friends or family	10	2
Most recent place of residence		
Rogue Valley	45	9
Oregon, other	5	1
California	30	6
Honduras	5	1
Other states (Wash., Utah, Ariz.)	15	3
Reasons for homelessness		
Migration, ran out of money	45	9
Left abusive spouse	20	4
Marriage break-up, other reasons	10	2
Eviction from home	25	5

Nine families listed the Rogue Valley as their home for at least the last year. Ten of the remaining 11 families expressed plans to make the Rogue Valley home. These families listed as their most recent residence a variety of West Coast locations.

The 31 children included in the study ranged in age from 2 weeks to 5 years 10 months and included one set of twins and one family with four children under the age of 4 years. There was a nearly even distribution of sex with 14 girls and 17 boys. (Table 3)

Illness was reported for 18 (58%) of the participating children with illnesses including teething, ear disease, URIs, resolving pneumonia, diaper rash, anemia and dermatitis. Twenty-six percent were reported to be on medication at the time of their screening. Medications included iron supplements, vitamins, antibiotics, skin salve and cough syrup. None were seriously ill or febrile at the time of participation.

Six children were reported by parents to have had growth or development problems including two who were reported to be "small for age", two who were reported to "have difficulty gaining weight", one who was reportedly followed by the Child Development Center in the past for developmental delays, and one child who had been diagnosed as autistic.

Immunizations were reportedly current for 15 of the children and lagging behind for 16.

Eight of the children were reportedly born prematurely, with a range from just over 3 weeks to over 3 months early. No major surgeries or hospitalizations were reported with the exception of an

Table 3

Characteristics of Homeless Children (Health Problems, Age, and Immunization Status)

Characteristic	Percent(%)	N
Age		
0-1 years	26	8
1-2	23	7
2-3	6	2
3-4	13	4
4-5	16	5
5-6	16	5
Current health problems		
Teething	10	3
URI/Resolving Pneumonia/Ear Disease	39	12
Diaper rash/Dermatitis	6	2
Anemia	3	1
Growth or development problem (by parent report)		
G or D problem in past, resolved	3	1
Small for age	13	4
Autism	3	1
Premature birth	26	8
Currently taking medication	26	8
Immunization status		
Current	48	15
Lagging	52	16

extended stay in the hospital after birth for the child born over 3 months prematurely.

II: "DO SELECTED CHILDREN WHO ARE HOMELESS FIVE YEARS AND YOUNGER IN A NON-DENSELY POPULATED AREA OF OREGON SHOW EVIDENCE OF DEVELOPMENTAL DELAYS?"

Of the 31 children tested with the DDST, 28 were scored as normal, two (6.45%) were scored as questionable, none were scored abnormal and one child (3%) was untestable. (Table 4)

One child exhibited delays on test items in the language sector alone, and one child exhibited delays on test items in both the language and the fine motor-adaptive sector. There were three other children who exhibited one delay on a test item, however, because of the distribution of their delays, these tests were scored as normal.

III: "WHAT ARE THE PARENT'S REACTIONS TO THE DEVELOPMENTAL SCREENING OF THEIR CHILDREN?"

The original intent of this question was to explore how important developmental issues of their chilren were to these parents. The questionnaire included four questions intended to answer this question. It was soon determined that all parents answered these questions the same and that they added no new or useful information to the study. The design of the questions led to simple "yes" or "no" answers and did not promote elaboration from any participant. For that reason, this section was deleted from the interview.

Table 4

DDST Results for Children Aged 5 and Under Who Are Homeless in Jackson County, Oregon

Denver Developmental Screening Test Results	Percent (%)	N
DDST results		
Normal	90	28
Questionable	6	2
Untestable	3	1
Abnormal	0	0
Number of developmental lags		
None	81	25
1	10	3
2	6	2
3	0	0
4	3	1
Skills Affected		
Language	6	2
Personal-Social	3	1
Gross Motor	6	2
Fine Motor-Adaptive	6	2

Case Descriptions

Because so many of the participating families added additional information about their lives and because of the diversity of families involved, it was decided to add case descriptions to this analysis. Through the use of these case studies, this study will give a broader view of who homeless families are in Jackson County. The case descriptions also raise questions for further study into the issue of family homelessness and give insight into implications for nursing practice.

FAMILY 1

John and Ann were a young couple staying at an emergency shelter with their 19 month old son, Joey. Originally from a small town in Washington state, they decided to leave his job when they received their 1988 tax return and travel to the midwest to see family. After two months of travelling, they made their way back to the West coast and were visiting family in Jackson County when their funds ran out. They liked the area and decided they wanted to make it their home but had no way to secure housing. They planned to stay in the family unit of the shelter until they could save enough money to obtain "decent housing." Ann had worked as a dental hygienist until Joey's birth. She was not presently looking for work as she was 2 months pregnant with their second child and wanted to be home with her children. John had an eighth grade education and was an experienced tow truck driver. He had been able to secure work in Medford the first day that he looked. He was quite proud of his abilities in his field of work and felt confident that he would

never lack for work. Both parents were present for the screening of Joey. They were proud of his abilities, their room was filled with new appearing Fisher-Price toys and much time was spent holding and cuddling the baby. His screening test was normal. This family spent approximately 3 weeks in the shelter before moving into their own apartment.

FAMILY 2

Maureen was the 24 year old mother of four boys under the age of 7 years who was staying at the emergency shelter. Her children were 7, 3 and twins who were 5 years of age. She and her husband were originally from Coos Bay, Oregon, but had spent the last several years in the San Francisco Bay Area. They had recently moved back to Oregon with plans to settle in Medford. They rented a house and he found work at Denny's Restaurant in a management position. She stayed home with the children.

This is her second marriage, her first marriage having failed during her last pregnancy. She related that the father of her children had a severe problem with drugs and alcohol and had been hospitalized for mental problems. She had not seen him in 3½ years. Maureen had stayed with her children once before in an emergency shelter just after leaving her first husband.

Shortly after arriving in Medford, Maureen and her husband had an altercation with their landlord which led to their eviction. Because the weather was nice, they decided to camp out in order to save money. They were caught in a storm, the children became sick and Maureen insisted that they seek help at the shelter. They

planned to stay for a few weeks if possible to save enough money to get back into housing.

Maureen's children appeared well cared for and loved. She was patient and attentive to them and they in turn were well behaved, inquisitive and supportive of each other. All scored normal on the DDST. Maureen stated that what would help her family the most is more available low-income housing.

Maureen and her family were found several months later to be in the shelter again. Shelter clinic personnel related that she and her husband had again lost their housing, this time because of a housing condemnation. Maureen was now 2 months pregnant with her fifth child.

FAMILY 3

Cherie was a 19 year old mother of three children when she was first interviewed at the Community Health Center. At that time she was pregnant; she and her husband and children were staying with friends in a small house since they had been evicted from their own home for falling behind in their rent. There was another couple who had also been recently evicted staying in a small trailer in the front yard of this house. Cherie came from a family where both parents were alcoholic. She completed the eighth grade, ran away from home, married and started having babies. "I always wanted to be a mom, I love being a mom." Cherie married a man whose parents also had problems with alcohol and whose mother had been in shelters for battered women at times during her marriage although at this point she was back with her husband. Cherie had a plan for the

future. She was saving her husband's paychecks (he worked on and off as a laborer on a construction crew) and was planning to move in with her in-laws when the new baby was due to further save money. She was also planning to continue having babies until she had a girl. Cherie's three boys were wild and unruly in the clinic's waiting room and she spent most of her time yelling orders at them which they proceeded to ignore. They all scored normal on DDST screening and seemed to lap up the attention of the examiner.

Cherie was seen again 5 months later, 2 months after the birth of her fourth son. She and her children were at that time housed at the local battered women's shelter. It was her second recent stay at this shelter and her fourth stay over the past year. She first went to the shelter claiming that her mother-in-law was beating her and her children, her husband had spent all their money on drugs and she had no where to go with her children. Her most recent stay at the shelter was precipitated by her husband physically abusing her. She again talked of how much she loved being a mother, although she consistently ignored her crying infant. She again reiterated that she planned to continue having children until she had a girl. When last seen, she was leaving with her parents who had come from Washington state to take her and her children home with them.

FAMILY 4

May was a 22 year old woman who was at a local shelter with her three children aged 3½ years, 2 years and 3 months. This was her second stay at the shelter, both times were precipitated by the physical abuse of her spouse. Her prior stay was 1½ years ago. She

returned home after that stay and became pregnant with her third child. May felt certain that her husband was not only abusing her but was sexually abusing their 2 year old daughter. She had a restraining order on him and stated she would not go back to his house again. Shelter personnel related that May left her husband because of threats from Children's Services that she would lose her children if she stayed with their father.

May had grown up in a small town on the coast with two alcoholic parents. She left at age 16 because of physical and sexual abuse by her father. She lived in a child detention center for a period of time and went through a job training program where she met her husband. He was also the product of a violent home and had been sadistically abused by his father. An accident at age 19 left him with a disability and with a penchant for drug and alcohol abuse. May was his second wife and it was the second time he had been an abusive partner.

May was worried about the emotional and physical outbursts of her son. At 3½ years, he seemed to display many attributes of his father. During the interview and screening process, he was seen to throw himself on the floor in angry fits and strike out at other children. He and his siblings received normal scores on the DDST to the relief of their mother who stated she "worried about them." May was staying at the shelter awaiting assistance from AFS which would enable her to obtain independent housing.

FAMILY 5

Pam was a 20 year old mother of two children, aged 21 months

and 7 months who was interviewed at an emergency shelter. She was in the process of trying to relocate to the Rogue Valley having hitchhiked here from a small town outside of Santa Barbara. She stated that she chose the Rogue Valley because she had "always heard that Oregon was beautiful."

Pam grew up "on the road" with two alcoholic parents. She related that her family lived out of a truck or trailer a good part of the time and that this style of life suited her fine until she had children. She now wanted something more stable. This was her third stay in a shelter, the first being when her oldest child was 2 months old. She had stayed in a shelter in Grants Pass prior to this stay. She was apparently evicted from the Grants Pass shelter after an altercation with the manager. All of Pam's possessions fit in a stroller with her babies which she pushed around to her various appointments with AFS. She and the children were barefoot and dirty. Pam never stopped smiling and laughing during the interview. She held and cuddled her babies a lot and was generally optimistic about her life. Her children were active and inquisitive and had normal scores on the DDST. She stated that the children's father was still in California and planned to join her once she had a place to live.

DISCUSSION

In order to place the 20 families interviewed for this study in some context of overall numbers, it will be mentioned at this point that from May through October of 1989, 102 families with children under 12 years stayed in the most frequently used shelter which

provides services to families who are homeless in Jackson County. Numbers are not kept specifically on families with children under 6 years of age. Fourteen of the 20 families in the study were interviewed at this particular shelter during this same time period. Of the families approached about participation in this study, four declined participation.

Demographics

Data on families with young children who are homeless in Jackson County, Oregon, indicate that 45% of these families consider Jackson County their home. Another 50% state they are in the process of relocating to Jackson County. The remaining 5% represents one family which planned to return to their original location in California. This means that of the 20 families interviewed, only one could be considered transient based on responses, the other 19 either considered Jackson County home or planned to make their home in the area. These data do not support the locally held assumption of transience of the homeless in Jackson County, at least for those who are in family units. However, the assumption of Jackson County being only a stop off on the I-5 corridor may apply to single homeless males.

According to Wright and Lamb (1987) the fraction of the homeless that is white has dropped from 49% to 15%. Ninety-five percent of this study sample of families was reported as white with the remainder being Hispanic. While this data differs significantly from national statistics, it does reflect racial composition of this area. It is also a reflection of the sites chosen for data

collection which are not likely to be utilized by the main racial minority of this area.

Family composition of this study sample also differed from what would be expected with only 55% of the families headed by single females and another 40% headed by two parents. Other studies have found the vast majority of families in shelter situations are headed by single females (Bassuk and Rubin, 1987) (Lewis and Meyers, 1989). Perhaps this figure was affected by the fact that 70% of the study sample was accessed through an emergency shelter which is particularly geared towards two parent families. If families had also been accessed through several of the other local shelters as originally planned, this figure may have looked different. This also could represent an important difference between the composition of homeless families in major metropolitan areas and those outside metropolitan areas.

Reasons for homelessness reported by the families in this study reflect closely what national data have indicated. With the exception of deinstitutionalization of the mentally ill, other major causes of rising homelessness were reported by these families: lack of available low-income housing, decreases in social welfare programs, substance abuse and domestic violence. While unemployment was not mentioned specifically by these families as a reason for their homelessness, many were looking for work and those who were working had minimum wage jobs which do not go far to cover a family's needs. It needs to be kept in mind that Jackson County has a higher than state and national figure for unemployment so families

new to the valley will not necessarily have an easy time finding any type of employment.

The educational level of homeless adults has been said to be rising (Wright and Lam, 1987). The educational level of parents in this study sample is consistent with national reports with an average education of 11.3 years for the mothers and an average of 10 years for the fathers.

Chavkin, Kristal, Seabron, and Guigli (1987), in looking at the reproductive experience of homeless women in New York City, note that these women had overall fewer prenatal visits and a high incidence of low birth weight infants. While these specific questions were not asked of the women in this study, it is interesting to note that of the 31 children in the study, 26% were born prematurely (defined as birth before the 37th week of gestation) which is well above the state average of between 6% and 10% (Oregon Department of Human Resources, 1984). The reason for this is not at all clear from the information gathered in this study. It is, however, an alarming figure, and makes one wonder about the quality and quantity of prenatal care received by these women.

Substance abuse is repeatedly mentioned in reference to homeless adults and increasingly recognized as a national problem. Chemical abuse of either drugs, alcohol or both substances was reported as a significant problem for one or both parents in 7 of the 20 families in this study. When grandparents are included in the family constellation, the number rises to nine families. One

young woman reported substance abuse by herself and her husband, her husband's brother and sister, her own father and her grandmother. She left her home with three small children because of an abusive situation that she related to her husband's alcoholism.

The immunization status of homeless children in New York City was found to be delayed in 49% of children studied (Acker, Fierman, & Dreyer, 1987). This figure is very close to the 52% with delayed immunizations in this study sample. While immunization status was gathered by report only and not by reviewing immunization records, the rate of delay is alarmingly high.

It was noted that 58% of the children screened had a minor illness or health concern. This seems to be an high figure although it must be kept in mind that the illnesses range from minor diaper rashes to resolving pneumonia. Perhaps this figure is high because of the stress of recent moves and the unstable living situations. However, data were collected during the six months of the year when the least illness is expected. It should be mentioned that of the three children found to have other than normal scores on the developmental screening, two were healthy and one was recovering from a mild URI.

As mentioned earlier in defining homelessness for this study, a description of subpopulations described by Rossi and Wright (1987) was used which distinguishes between (1) the literal homeless--persons who obviously have no access to a conventional dwelling unit and who would be considered homeless in any conceivable definition of the term, and (2) the precariously (or

marginally) homed, persons with tenuous or very temporary claims to a more or less conventional dwelling. Both of these groups are included in this study. Eighty percent of the families in this study would, by this view, fall into the first category as they were housed by local emergency shelters. Twenty percent of the families would be in the second category as they were staying with friends, family or in motels for short periods of time.

A second way of looking at subpopulations of families who are homeless is suggested by the data collected in this study. This way would distinguish between (1) the short term, low need families who are basically quite functional and with a minimal amount of assistance will be back in regular housing, and (2) the longer term or recurrent, high need families who require a great deal of intervention from multiple agencies to acquire independence. Examples of these two subpopulations can be seen in the families described in the case descriptions. This approach can be seen as useful in decision making about resource allocation.

DDST Status

The decision to initiate a study of the developmental status of children who are homeless in a less than urban environment was based in part on a study done by Bassuk and Rubin (1987). In their study, based on DDST screening, 47% of the children 5 years and younger were delayed in at least one area of functioning and 33% had two or more "developmental lags". It is important to note at this point that the DDST is not scored by the number of "developmental lags". A child may have one or more failed items and still have a normal

test outcome. It was not reported in the Bassuk and Rubin data what the final DDST test results were. For the sake of comparison, data in this study will be looked at both with the DDST scores of "normal", "questionable", "abnormal" and "untestable", and in simply counting "lags" or delays in passing an individual item.

Six children failed at least one item and three children failed two or more items. (Table 4) Using the standard DDST scoring, two children (6.45%) had questionable results, one child (3%) was untestable, none were abnormal and 90% had normal test scores. The one child who was scored as untestable had been diagnosed as autistic this year. She refused a number of items thus giving her a score of "untestable". A comparison of this data and the Bassuk data is found in Table 5.

Table 5

Comparison of DDST Results With Data From the Study by Bassuk, Rubin, and Lauriat (1986).

Number of Developmental Lags	Percent (%)	
	Bassuk, Rubin, Lauriat (N=81)	Burton (N=31)
None	53	81
1	14	10
2	17	6
3	3	0
4	14	3

A more recent study looking at DDST scores of homeless children entering emergency shelters in Boston reported findings according to

standard DDST scoring (Lewis and Meyers, 1989). They found 4.7% of these children to have either questionable or abnormal scores which is similar to the 7% of children found with questionable or abnormal scores in the DDST validation study of 2000 indigent children in Denver done by Frankenburg, Goldstein, & Camp (1971). (Table 6)

Table 6

Comparison of DDST Results With Data From Study by Lewis and Meyers (1989)

DDST Results	Percent (%)	
	Lewis and Meyers (N=213)	Burton (N=31)
Normal	95	90
Questionable	4	6
Untestable	0	3
Abnormal	1	0

The incidence of other than normal scores in the study being reported is very close to that which would be expected in any population. This needs to be viewed with caution because of the small numbers of children included in this sample. Keeping this caveat in mind, these figures indicate that children who are homeless in this less than large metropolitan area are similar in developmental status to other children.

CHAPTER IV

SUMMARY AND CONCLUSIONS

In order to ascertain the developmental status of children who are homeless in a non-metropolitan area, a sample of 31 preschool children from families who are homeless in Jackson County, Oregon, were assessed utilizing the Denver Developmental Screening Test (DDST). The parent/s of these children, 20 families in all, were interviewed about specific demographic information. The families included were selected by convenience sampling methods. All were staying in local emergency shelters, in low cost motels or with family or friends. The scores of these children were similar to those expected of any children on developmental screening. Unlike children who are homeless in major metropolitan areas, these children were from mostly white families, a good number of whom were two parent families. There was a higher than average rate of premature births noted with these children and over half were under immunized. Almost all of the families were non-transient, either having lived in Jackson County for some time or being in the process of relocating to the area.

Stated reasons for homelessness were similar to what has been found in the literature and included: rising housing costs, decreases in social welfare programs, unemployment, substance abuse and domestic violence. Five case descriptions are presented in the study to illustrate the diversity of families who are homeless in this particular non-metropolitan area.

Strengths and Weaknesses of the Study

The descriptive design of this study allowed for collection of data about the phenomena of family homelessness in a non-metropolitan area and allowed for a depth of understanding that would not have been possible with a strictly quantitative approach. Inclusion of case descriptions in the study permits the reader to more fully appreciate the individuals behind the numbers. Inclusion of families who were not staying in local emergency shelters helped to expand this study's selection of varying types of families who are homeless in the area.

The major limitation of this study is the small number of both individual children and families included. It would be an error to draw conclusions based on a sample of 31 children from 20 families. Sampling method is another limiting factor. While it is felt by shelter workers in the valley that all the shelters service similar if not the same people, there is no way to know this without access to all the shelters. Sampling was also limited by the time constraints of the researcher and her assistant who were not available all days and therefore missed some families during the time frame of the study. This is neither a random nor a complete sample.

The final limitation to note is the exclusion of migrant farmworkers from this study. During harvest season, there is a large number of migrant families who pass through this area, most of whom are Hispanic. This group was purposely excluded from this study because of problems with access, language and because of the

additional dilemma this group presents in defining who and what is homelessness.

Recommendations for Future Research

The results and problems encountered during this study suggest several possibilities for future research. The present study includes 31 children from 20 families. More valid results would be obtained from a larger sample. Validity of results would also be increased by obtaining access to all emergency shelters in the county.

Analysis of data from this study also lends to suggestions for questions to be included when interviewing families who are homeless. This would include collecting further information on prior homelessness to the present episode, on drug and alcohol issues, and on pre- and perinatal care.

This study used only the DDST to evaluate the children. It would be of interest to repeat a similar study using tools to generate data on the emotional and behavioral attributes of these same children.

Insufficient data were obtained in this study to attempt correlation of DDST scores with family situation. It would be useful in further studies to attempt to determine if there was a relationship between DDST scores and the general well being of the family, e.g., drug and alcohol issues, family violence, education of parents, and repetition of homeless episodes.

Implications for Nursing Practice

Regardless of their specific area of practice, most nurses will

interact with families who are homeless. It is imperative that nursing as a profession become more aware of the issue of homelessness and its impact on the individual and on families. What power we have as a profession can be used on the political plane when legislation affecting this issue is being debated.

On the individual level, knowledge of the issue is important when formulating care plans to deal with both individuals and populations. Data from this study indicate that many of these families are dealing with drug and alcohol issues, that over half the children are underimmunized and that premature birth rates were higher in this population than usual. This would suggest areas of focus for the public health nurse, the emergency room nurse who may be seeing these families for emergent care needs, and for the nurse practitioner who sees families who are homeless in the county well child clinics and in primary care sites.

Increased communication among agencies providing health care to families who are homeless is an important step in enhancing the effectiveness of existing programs. Direct care providers need to stay in touch with what other agencies can and do provide. Referrals are difficult for clients to follow through on in the best of situations and inappropriate or multiple referrals for a homeless individual only furthers alienation.

Data from this study lends support for continuation of the outreach nursing clinic provided at a local emergency shelter in Jackson County. Nurses who work in this on site clinic are in a unique position to evaluate families who are residing at the

shelter. Many situations require referral to other agencies but many others can be dealt with effectively by the nurse on site. Basic health teaching, nutritional information and well child advice is best provided by nurses. Basic developmental screening of young children can easily be provided along with age appropriate information for developmental stimulation. The Pre-Denver Questionnaire (PDQ) system is provided by the developers of the DDST for rapid developmental screening and could be easily implemented in this setting.

Most importantly, it needs to be kept in mind that nurses are in a unique position to both study the issue of family homelessness and to provide appropriate care for these families by incorporating research into practice.

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APPENDICES

APPENDIX A

Revised DDST Form

DA FORM 5694, MAY 1988

DENVER DEVELOPMENTAL SCREENING TEST

REVISED DDST-R

STO. = STOMACH
SIT. = SITTING

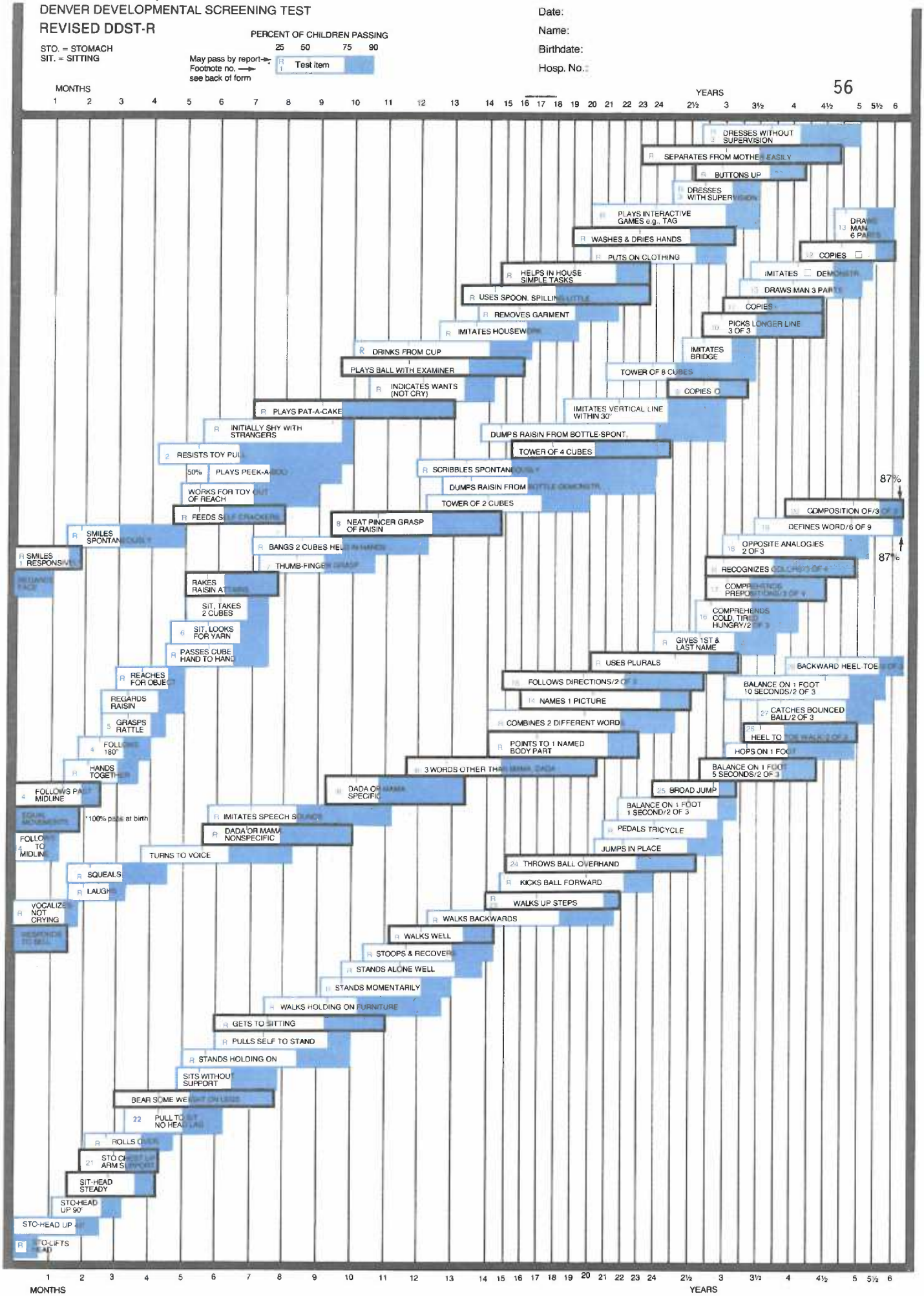
PERCENT OF CHILDREN PASSING
25 50 75 90

May pass by report→
Footnote no. →
see back of form

R 1 Test Item

Date:
Name:
Birthdate:
Hosp. No.:

56



For use of this form, see HQDA Ltr. 40-88-5, the proponent agency is TSG

APPENDIX B

DDST Interpretation Instructions

DDST Interpretation Instructions

The DDST is interpreted as NORMAL, QUESTIONABLE, ABNORMAL and UNTESTABLE, based on the number of delays on each test. To properly interpret the results of a test, follow the steps listed below, remembering that a delay is any failure which falls completely to the left of the age line:

Step 1. Mark each delay by heavily shading the right end of the bar.

Step 2. Count the sectors which have 2 or more delays.

Step 3. Count the sectors which have 1 delay and no passes intersect the age line in that same sector.

Step 4. Use the formula shown below to interpret the results.

ABNORMAL . . . . .2 or more sectors with 2 or more delays.

ABNORMAL . . . . .1 sector with 2 or more delays plus 1 or more sectors with 1 delay and in that same sector no passes intersect the age line.

QUESTIONABLE . . .1 sector with 2 or more delays.

QUESTIONABLE . . .1 or more sectors with 1 delay and in that same sector no passes intersect the age line.

UNTESTABLE . . . .When REFUSALS occur in numbers large enough to cause the test result to be QUESTIONABLE or ABNORMAL if they were scored as failures.

NORMAL . . . . . .Any condition not listed above.

Taken from the Denver Developmental Screening Test manual/workbook for nursing & paramedical personnel (Frankenburg, Dodds, & Fandal, 1973).

APPENDIX C

Parent Interview Form

INTERVIEW

Participant

Age _____

DOB _____

Current health problems _____

Growth or development problems _____

Current medications _____

Immunizations current _____

Problems during pregnancy _____

Prematurity _____

Problems after birth _____

Health History
(family includes blood relatives only)

	pt	fam		pt	fam
anemia			ulcer		
asthma/lung disease			cancer		
diabetes			hepatitis/liver problems		
epilepsy/seizures			blood disease		
heart disease			kidney disease		
mental illness/ depression			tuberculosis		
			alcoholism		
headaches					
rheumatic fever			drug abuse		

Prior surgeries _____

Prior hospitalizations _____

Family

Siblings ages _____

With family? _____

Family living situation _____

_____

Do you consider this area home? _____

Where do you consider home _____

APPENDIX D

Consent Form For Human Research

Oregon Health Sciences University

CONSENT FORM

Mary Beth Burton, RN, BSN, is conducting a research project entitled: Assessment of Children in Transitional Housing. The purpose of the study is to determine the developmental status of children residing in transitional housing in the Rogue Valley.

You are being asked to consent to the participation of yourself and your child. Participation involves a brief interview of the parent and a screening test of the child. The screening test involves questions to the parent or child (if old enough). It is a test of your child's development.

Potential benefits include a better understanding on your part of the mental and physical development of your child at this point in time. The only potential inconvenience to you and your family may be the use of an hour of your time. There is no cost for participating in this project.

Neither your name nor your identity will be used for publication or publicity; all information is held in strict confidence. Mary Beth Burton or her assistant has offered to answer any questions you might have. You may refuse to participate or withdraw from this study at any time without affecting your relationship with or treatment at the clinic or shelter.

Your signature below indicates that you have read the foregoing and agree to participate in this study.

Parent/Guardian _____Date_____

Witness _____Date_____

AN ABSTRACT OF THE THESIS OF

MARY E. BURTON

FOR THE MASTER OF NURSING

Date receiving this degree: June 8, 1990

Title: ASSESSMENT OF HOMELESS CHILDREN AND THEIR FAMILIES IN A NON-METROPOLITAN AREA

Approved: [redacted]

Donna B. Jensen, RN, PhD, Thesis Advisor

Much research has been generated in recent years focusing on people who are homeless in this country. More is being learned about the changing demographics of homelessness and reasons homelessness is on the rise. From this information it is evident that there are increasing numbers of families with tenuous or no claim to conventional housing. Many of these families have very young children. Literature on the effects of homelessness on children is sparse, and much that is available is from large metropolitan areas. The purpose of this study was to gather demographic information about selected families of preschool children who are homeless in a less densely populated part of the country and to evaluate these children for developmental delays.

A convenience sample of 31 children from a total of 20 families were included in the study which took place in Jackson County, Oregon. These families were staying in local emergency shelters, in low cost motels or with family or friends. The children ranged in age from 2 weeks to 6 years.

Of significance, the scores of these children on screening with the Denver Developmental Screening Test were similar to those expected of any children on developmental screening. These children were from mostly Caucasian families, a good number of whom were two parent families. There was a higher that average rate of premature births noted with these children and over half were under-immunized. Almost all of the families were non-transient, either having lived in Jackson County for some time or being in the process of relocating to the area.

Stated reasons for homelessness were similar to what has been found in the literature and included: rising housing costs, decreases in social welfare programs, unemployment, substance abuse and domestic violence. Five case descriptions are presented in the study to illustrate the diversity of families who are homeless in this particular non-metropolitan area.

Further research strategies are suggested and conclusions are drawn. Implications for the practice of nursing are included.