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**A Profile of Children Living in Shelters: Parents' Perspectives on Their Children's Health and
Factors That Influence It**

By

Paula M. Robeson

**Thesis Submitted to the Faculty of Graduate and Post Doctoral Studies in partial fulfilment of
the requirements for the degree of Master of Science in Nursing**

University of Ottawa

June 2002

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0-612-76632-2

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Abstract

Objective: To describe a profile of school-aged children (5-14 years) living in shelters in Ottawa including risk and protective factors commonly associated with health related outcomes in children.

Design: A descriptive research study using a pre-tested survey questionnaire designed by the researcher, based on the literature, and guided by a resilience framework.

Setting: Three emergency family shelters in Ottawa.

Participants: 34 parents with 61 children (aged 5 to 14 years) living at the shelters.

Results: For 86.8% of children, their health was reported to be excellent to good, however 83.6% experienced a decline in health status since living at the shelter. Concerns were raised about the development (52.5%), emotional health (91.8%), and behaviour (65.6%) of the children; yet most had never been assessed. Parents reported that 67.6% of the children were in need of services they were not getting. While 58.8% of families had a regular health care provider, children's emergency and hospitalisation rates were higher than the general population. Over half (65.6%) of children were covered by dental insurance, but 24.6% had never seen a dentist. Most children (80.3%) were not involved in any extra curricular activities and had limited social networks. Most (80.3%) had never repeated a grade, but 11.5% were not attending school. Approximately 65% of their parents reported mental health concerns and stress levels that impacted their parenting abilities. Children's strengths included personality traits, cognitive ability, and helpfulness. Over 11% of parents could not identify any of their children's strengths. Academic success, housing stability, health, and happiness were goals most frequently cited by parents for their children. The opportunity to play and develop relationships was an aspect of the shelters most frequently cited as positive. Negative aspects of

the shelters included the perceived inadequacy of staff, lack of cleanliness, and other living conditions.

Conclusions: Risk and protective factors at the individual, family, and community levels are presented. Protective factors of children living in shelters should be recognised, strengthened, and maintained. Efforts to minimise the risk factors should be undertaken. Implications for nursing practice and research are discussed.

Acknowledgements

I would like to thank the many people who have made significant contributions to the success of this thesis. First, my thanks and gratitude are extended to the parents who provided some of their precious time to participate in this study. They allowed themselves to trust me enough to invite me into their lives. Their stories are forever in my heart. To their children, who gave me some time with their parents and many wonderful drawings for my refrigerator, I am forever grateful. I am grateful to the managers, supervisors, and staff of the shelters whose support enabled me to meet these wonderful families.

I am grateful to my entire thesis committee for allowing me to benefit from their wisdom and experience and for their critique, guidance, and encouragement. To my thesis supervisor, Dr. Denise Alcock, I thank you for all I have learned from you, for your kindness and caring, and for those gentle pushes when I needed them most. My colleagues in the graduate program were an important part of my journey. I have learned so much from so many of them. In particular, I would like to thank Dawn Stacey, whose friendship, support, and encouragement have been a blessing.

Lastly, I extend my undying thanks to my family. Mom and Dad, I am grateful for your guidance and never ending support. You taught me the value of education, hard work, and perseverance. Even across the miles, I have always benefited from your words of encouragement and sound advice. To Brian, my brother and friend, thank you for making time, once again, to help an anxious sister. All siblings should be this lucky. To my husband, Brad, what would I have ever done without you? You have carried more than your share of the load for a long time. Your love, level-headedness, and support were unending and invaluable. And finally, to Hannah, my darling daughter and most valuable teacher, thank you for constantly reminding me of what is really important in life.

Table of Contents

Abstract	ii
Acknowledgements	iv
List of Tables	ix
List of Figures	x
List of Abbreviations	xi
Chapter One – Introduction	1
Organisation of Thesis	1
The Issue	1
Purpose	2
Chapter Two – Literature Review	4
Searching the Evidence	4
Homeless Children	4
Health outcomes	4
Access to health and community services	8
Characteristics	9
Social support	10
Shelter living	11
Resilience and homeless children	12
Summary of Findings	12
Conceptual Framework	13
Chapter Three – Methods	17

Research Design	17
Study Setting	17
Sample	17
Data Collection	18
Ethical Considerations	20
Data Analysis	21
Chapter Four – Results	23
Response Rate	23
Child and Family Demographic Characteristics	23
Health Status	27
Physical health	27
Development	28
Emotional status	29
Behaviour	29
Academic achievement	29
Social Support	32
Life in the Shelter	33
Health and Community Services	37
Health services	37
Community services	39
Facilitators of access and use of services	40
Barriers to access and use of services	40

Child Strengths	41
Parent Concerns	42
Parents' Goals for Their Children	43
Additional Parent Comments	44
Chapter Five – Discussion	46
Demographic Characteristics	46
Health Status	47
Risk Factors	50
Individual and family level risk factors	51
Community level risk factors	53
Protective Factors	55
Individual level protective factors	56
Family level protective factors	56
Community level protective factors	57
Implications for Nursing	57
Limitations of the Study	62
Recommendations for Future Research	64
Conclusion	67
References	68
Appendices	80
Appendix A: Description of Three Family-Serving Shelters in Ottawa	80
Appendix B: Letter of Invitation	82

Appendix C: Consent Form	84
Appendix D: Questionnaire	86
Appendix E: Research Ethics Board Letter of Ethical Approval	104
Appendix F: Letter of Approval from the City of Ottawa	106
Appendix G: Letter of Approval from the YMCA/YWCA	108

List of Tables

Table 1	Common Risk and Protective Factors Associated with Resilience in Children	15
Table 2	Family Demographic Characteristics	24
Table 3	Study Participants' Length of Time in the Shelter	26
Table 4	Reasons for Coming to the Shelter	27
Table 5	Adults Important to Children	32
Table 6	Likes and Dislikes about Shelter Living	33
Table 7	Additional Parent Comments	44

List of Figures

Figure 1	Types of housing in the 12 months prior to arrival at the shelter	26
Figure 2	Schools attended in past 12 months	31
Figure 3	Parents' perceptions of the impact of shelter living on child health	36

List of Abbreviations

ACPH	Federal, Provincial, Territorial Advisory Committee on Population Health
ADD	Attention Deficit Disorder
APN	Advanced Practice Nurse
CCSD	Canadian Council on Social Development
CICH	Canadian Institute of Child Health
CYHNEO	Child and Youth Health Network of Eastern Ontario
ER	Emergency Room
HIFIS	Homeless Individuals and Families Information System
HIP	Health Information Partnership – Eastern Ontario
HPP	Healthy Public Policy
MHATF	Mayor’s Homelessness Action Task Force
NP	Nurse Practitioner
OCDSB	Ottawa-Carleton District School Board
ROC	Region of Ottawa-Carleton
SPCOC	Social Planning Council of Ottawa-Carleton
SPSS	Statistical Package for Social Sciences Software
UK	United Kingdom
US	United States

Chapter One

Introduction

This chapter provides an overview of the organisation of this thesis. An introduction to homeless children, their health, and factors that have been found to influence it is provided. This chapter also provides a rationale for the development of a profile of children living in shelters. It concludes with a summary of the purpose for and objectives of the study.

Organisation of Thesis

This thesis is divided into five chapters. Chapter Two provides an extensive review of the research relevant to the health of children living in shelters and a description of the conceptual framework on which this thesis is based. Chapter Three describes the design of the study. The results of the study are presented in Chapter Four, and a discussion of the results is found in Chapter Five.

The Issue

Homeless children are those without housing and living on the streets, in motels, or in emergency shelters. Children constitute a growing, if not the largest growing and least visible, segment of the homeless population in the United States (US), United Kingdom (UK), and Canada (Bassuk, Rubin, Lauriat, 1986; Canadian Institute of Child Health [CICH], 2000; City of Toronto, 2000; Edmonton Homelessness Count Committee, 2000; Kauppi & Bélanger, 2001; Mayor's Homelessness Action Task Force [MHATF], 1999; Social Planning Council of Winnipeg, 2001; The City of Calgary, 1998).

Based on 1996 Census data, the Social Planning Council of Ottawa-Carleton [SPCOC] (2000) reported that 1194 children and 632 adults were homeless in Ottawa. In 1998, more than 375 homeless families with a total of 901 children used family shelters in Ottawa (Region of

Ottawa-Carleton [ROC], 1999). Over the period of 1995 to 1998, while adult shelter use remained stable, there was an increase in the number of shelter beds used by children. Approximately 65% of the population in homeless family shelters in Ottawa are children (SPCOC, 2000) and these children represent 18% of the entire population of shelter users in Ottawa (ROC, 1999). US studies have suggested that homeless children and their families comprise as much as 40% of the homeless population (Shinn & Weitzman, 1996).

Two reports provide an excellent baseline of relevant Canadian data for certain subgroups of the homeless population (Farrell, Aubrey, Klodawsky, & Pettey, 2000; MHATF, 1999). Another study provided information on shelter and service needs of homeless children and youth in Canada (Canada Mortgage and Housing Corporation [CMHC], 2001). Yet, little data is available related to the characteristics and health status of homeless children in Ottawa or in Canada as a whole. In fact, the CMHC study recommended future research to ascertain the health status of children living in shelters. In Ottawa, there are few programs and services directed specifically at improving health outcomes for homeless children, especially those of school age. This paucity of data is noteworthy in light of research findings indicating that homeless children are at greater risk for poorer health outcomes, in a variety of domains that include physical health, mental health, behaviour, and social and academic functioning, than the general population of children or those of similar socio-economic status who are permanently housed (Alperstein, Rappaport, & Flannigan, 1988; Bass, Brennan, Mehta, & Kodzis, 1990; Bassuk & Rubin, 1987; Fox, Barnett, Davies, & Bird, 1990; Parker et al., 1991; Rescorla, Parker, & Stolley, 1991; Wagner & Menke, 1991; Zima, Wells, & Freeman, 1994).

Purpose

The identification of the health status and unique service needs of this subgroup of the

homeless population is vital in order that effective, efficient policies and programs are developed to address the issues facing these children (Mayer & Greenwood, 1980). To this end and given the dearth of relevant data, the purpose of this study is to describe a profile of school-aged children living in shelters in the City of Ottawa. In this study, homeless children are those between the ages of five and 14 living in emergency shelters with at least one parent or legal guardian. The specific objectives of this study are, from the perspectives of a parent or legal guardian, to: a) describe the characteristics of these children; b) determine their health status; c) find out where and from whom they access health and community services; and d) identify the presence of risk factors and protective factors commonly associated with health-related outcomes in children.

Chapter Two

Literature Review

This chapter briefly identifies the search methods used, followed by a summary of the research regarding homeless children, their health status, and factors that influence it. The conceptual framework of the study is discussed.

Searching the Evidence

A review of the literature was completed via a search of various electronic databases and websites. The electronic bases included CINAHL (1982-2002); Dissertation Abstracts (1990-2002); Medline (1966-2002); PsychInfo (1984-2002), ERIC (1966-2002), and Sociofile (1974-2002). The following data base index terms were searched: homeless (child, family, mother), poverty, health, resilience, risk factors, protective factors, psychosocial, mental health, emotional, behaviour, physical, growth, nutrition, school, education, stress, and coping. Additionally, a hand search was conducted by examining reference lists of the relevant published material. Articles and reports were searched through consultation with experts in the field of homelessness particularly in Ontario. Further, an Internet search was conducted to access current information and statistics related to homeless children in Ottawa, Ontario, and more broadly in Canada.

Homeless Children

A review of relevant literature related to health outcomes, access to health care, and characteristics of homeless children to identify possible risk and protective factors is presented in this section.

Health outcomes. Homeless children are a high needs group, experiencing more acute and chronic health problems such as ear infections, dental problems, asthma, vision difficulties, musculoskeletal complaints, stomach pains, headaches, elevated lead levels, and injuries when

compared with other low-income children and the general child population (Alperstein et al., 1988; Bass et al., 1990; Berti, Zylbert, & Rolnitzky, 2001; Efron, Sewell, Horn, & Jewell, 1996; Parker et al., 1991). Parents of homeless children are more likely to report their children to be in fair to poor health than good to excellent health (Riley-Eddins, 1995).

Studies have reported that homeless children have a high prevalence of abnormal anthropometric measures that include obesity (Wood, Valdez, Hayashi, & Shen, 1990), weight below that of age standardisation, and lower height percentiles when compared to standardised norms or housed, low-income children (Fierman et al., 1991; Miller & Lin, 1988). Malnutrition and anaemia are more frequently reported in this population (Acker, Fierman, & Dreyer, 1987; Fierman et al.). Poor nutritional status in this population is attributed to several factors that include: a) the lack of sufficient quantities of appropriate food (Wood et al., 1990); b) deficient nutritional intake from all of the four food groups (Kelly, 2001); c) consumption of far less than the recommended daily allowance for iron, magnesium, zinc, folic acid, and calcium (Drake, 1992); d) consumption of higher than desirable quantities of fats (Drake); and e) food shortages (Wood et al.).

Homeless children have higher rates of depression (Bassuk & Rosenberg, 1990; Bassuk et al., 1986), anxiety (Bassuk et al., 1986), sleep problems (Bassuk & Rubin, 1987), stress levels (Davey, 1998), and/or behavioural concerns (Amery, Tomkins, & Victor, 1995; Bassuk & Gallagher, 1990; Efron et al., 1996; Vostanis, Cumella, Briscoe, & Oyeboode, 1996) than the general child population and in comparison to housed low-income counterparts (Bassuk & Rubin; Fox et al., 1990; Rescorla et al., 1991; Wagner & Menke, 1991; Zima et al., 1994). In a study of 118 families in homeless shelters, their school-aged children were found to have a high level of exposure to various severe psychological stressors that correlated significantly with

several child behaviour problems and depressive symptom indicators (Zima et al., 1999). In a study of 31 children aged two to 16 years from 14 families living in shelters, more than 33% had mental health problems severe enough to warrant referral for treatment and at least one child from 78% of families had clinically significant mental health concerns (Waldron, Tobin, & McQuaid, 2001). A longitudinal study of 58 homeless families before and after housing reported that mental health problems remained significantly higher in mothers ($p = .04$) and children ($p = .003$) than in the comparison group of 21 low-income housed families (Vostanis, Grattan, & Cumella, 1998). Despite the frequent findings of higher rates of psychological concerns among homeless children, research has found that many of the children with psychological concerns do not receive the necessary care (Vostanis et al., 1996).

Developmental delays in language, cognitive, and visual-motor skills are reported as more common among homeless children than the general child population or low-income housed children (Bass et al., 1990; Bassuk & Rubin, 1987; Bassuk et al., 1986; Cumella, Grattan, & Vostanis, 1998; Fox et al., 1990; Parker et al., 1991; Rescorla et al., 1991; Rubin et al., 1996; Whitman, Accardo, Boyert, & Kendagor, 1990). Bassuk and colleagues (1986) reported that about half of the 151 children in Massachusetts's shelters had developmental delays. Rescorla and colleagues (1991) found that homeless children were significantly more delayed in receptive language skills ($p < .05$) and visual motor skills ($p < .05$) when compared with poor domiciled peers. In contrast, others report no significant differences in rates of general developmental delay and major physical illness (Masten, Miliotis, Graham-Bermann, Ramirez, & Neeman, 1993; Vostanis, Grattan, Cumella, & Winchester, 1997), or adverse behaviours (Bassuk, Weinreb, Dawson, Perloff, & Buckner, 1997) for homeless children compared with housed controls. Compared to standardised norms, homeless children have been reported to be at increased risk

for delayed social and emotional development (Bassuk et al., 1986).

Irregular school or pre-school attendance, repeated grades, and poor school performance are reported for homeless children (Bassuk & Rosenberg, 1990; Bassuk & Rubin, 1987; Bassuk et al., 1986; Cumella et al. 1998; Fox et al., 1990; Parker et al., 1991; Rafferty, 1991; Rescorla et al., 1991; Rubin et al., 1996; Vostanis et al., 1997; Wood et al., 1990; Zima et al., 1994; Zima, Bussing, Forness, & Benjamin, 1997). In a controlled study of 102 homeless and 178 housed children and their mothers, the homeless children had significantly lower academic achievement scores in reading ($p = .003$), spelling ($p = .001$), and mathematics ($p = .0001$) with 75% of homeless children compared with 48% of housed children falling below grade level (Rubin et al., 1996). Similarly, 43% of homeless children who participated in a phenomenological study of their perspectives on being homeless were reported by their parents to be performing below grade expectations (DeForge, Zehnder, Minick, & Carmon, 2001). A US study of 400 homeless school aged children, found that the homeless children who attended school regularly felt less lonely ($p < .000$) and had higher self esteem ($p < .000$) as compared with their peers who were not enrolled in school or did not attend at least half time (Timberlake & Sabatino, 1994).

High frequencies of learning disabilities and other conditions requiring special education evaluation or intervention are reported for homeless children (Bass et al., 1990; Bassuk et al., 1986; Rescorla et al., 1991; Rubin et al., 1996; Zima et al., 1997). While Rubin and colleagues report that significantly more homeless than housed children were in special education classes ($p = .004$), a cross-sectional study of 169 school aged sheltered homeless children in the US revealed that only 22% of those in need of academic services had ever received them (Zima et al., 1994; Zima et al., 1997).

Access to health and community services. Lack of access to and utilisation of health and community services are other risk factors for poor health outcomes in homeless children (Bass et al., 1990; Wood & Valdez, 1991). Homeless children in the US are less likely than other children to have a regular source of health care or to use preventative health services such as routine health assessments, preventative dental care, auditory screenings (Adkins & Fields, 1992; Bass et al., 1990; Hu, Covell, Morgan, & Arcia, 1989; Menke & Wagner, 1997; Miller & Lin, 1988; Newacheck, Hughes, Hung, Wong, & Stoddard, 2000; Riley-Eddins, 1995; Roth & Fox, 1990; Wood & Valdez), and more likely to have delayed or incomplete immunisations (Alperstein et al., 1988; Bass et al., 1990; Miller & Lin; Riley-Eddins; Roth & Fox). Often attributed to this lack of regular or preventative health care, homeless children in the US, compared with housed low-income children, are more likely to be admitted to hospital (Alperstein et al.; Bassuk et al., 1997) and to use emergency services (Alperstein et al.; Miller & Lin; Weinreb, Goldberg, Bassuk, & Perloff, 1998). Davey (1998) found that homeless children were involved in significantly fewer sports-related or other community-based social activities ($p \leq .05$ for boys, $p \leq .01$ for girls) when compared to normative groups. There is a dearth of Canadian and local data related to access to such health and community services.

Perceived barriers to access and use of services include: a) lack of transportation, b) cost, c) lack of knowledge regarding existing community resources, d) priority of securing food and shelter for the family, e) fear of labelling or rejection by service providers, f) language difficulties, g) having to take time off work with the associated loss of income, and h) wait times for and during appointments (Adkins & Fields, 1992; Berne, Dato, Mason, & Rafferty, 1990; Efron et al., 1996; Riemer, Van Cleve, & Galbraith, 1995; Wood & Valdez, 1991). In a study of 194 homeless and 196 housed poor families, such barriers were noted by Wood and Valdez to be

70% more likely to prevent homeless children from receiving care than housed low-income children. However, Hodnicki and Horner (1993) reported that all of the six mothers in their qualitative study used all of the resources available to them to care for their children.

Characteristics. In the US, the majority of homeless children are of ethnic minorities and pre-school aged, live in female-headed single parent homes, and have one to two other siblings living with them (Amery et al., 1995; Bassuk & Rubin, 1987; Bassuk et al., 1986; Vostanis et al., 1997).

Mothers of homeless children often have a high school education but are unemployed or under employed (Bassuk et al., 1986; Buckner & Bassuk, 1997; Masten et al., 1993), have experienced stressors in childhood such as abuse or major family disruption (Bassuk et al., 1986), have high rates of emergency department visits and hospitalisations (Weinreb, Goldberg, & Perloff, 1998), and suffer from psychiatric morbidity that is often untreated (Banyard & Graham-Bermann, 1998; Cumella et al., 1998; Efron et al., 1996; Parker et al., 1991; Vostanis et al., 1996; Zima, Wells, Benjamin, & Duan, 1996). Maternal depression ($p < .05$) and a lack of social support ($p < .05$) have been associated with adjustment difficulties in homeless children (Graham-Bermann, Coupet, Egler, Mattis, & Baynard, 1996). Parent reported stressors were found by Torquati and Gamble (2001) to significantly predict negative parenting ($p < .01$), externalising behaviours ($p < .01$), and internalising behaviours ($p < .01$). In a study of 14 families living in shelters, 70% of mothers scored in the critical range on measurements of the magnitude of stress in the parent-child relationship (Waldron et al., 2001). Homeless children who experienced the lower levels of parental and family stress exhibited better cognitive, academic, and behavioural outcomes (Danesco & Holden, 1998). In their unmatched case control study of 77 homeless and 90 low-income mothers with pre-school aged children, Bassuk and

colleagues (1997) found that mothers' distressed emotional status was among the strongest predictors of adverse behavioural outcomes. Yet, other studies have noted no difference in the incidence of chronic mental illness and substance abuse between homeless and low-income housed mothers (Bassuk & Rosenberg, 1988; Bogard, McConnell, Gerstel, & Schwartz, 1999; Graham-Bermann et al., 1996; Wood et al., 1990). The incidence of these two conditions, however, is reported to be higher in homeless mothers than the general population (Bogard et al., 1999). Homeless children are more likely to be involved with child protective services and to have experienced stressful life events, including exposure to family violence and child abuse (Bassuk et al., 1997; Bassuk & Rosenberg, 1988; Cumella et al., 1998).

Social support. Homeless children and their parents have limited perceived and actual support networks (Bassuk et al., 1986; Bassuk et al., 1997; Bassuk & Rosenberg, 1988, 1990; Letiecq, Anderson, & Koblinsky, 1996, 1998; Masten et al., 1993; Vostanis et al., 1998). Prior to becoming homeless, these children have made frequent moves with subsequent school, neighbourhood, and peer changes (Bassuk & Rosenberg, 1988; Bassuk et al., 1997; Buckner & Bassuk, 1997; MHATF, 1999). The moves are identified as sources of stress by these children (Sullivan, 1997) and have been shown to impact their social support networks, self-esteem, and sense of belonging (Anglin, 1998). In a study of 49 mother/child dyads residing in homeless shelters, mothers' perceptions of their child's social support were associated with better child health outcomes (Landow & Glenwick, 1999). Torquati and Gamble (2001), in their study of 38 school-aged homeless children, found that while the size of the social network was not significantly correlated with stressors or psychosocial adaptation, the satisfaction with support received was associated with a less negative effect on adaptation ($p < .01$).

Shelter living. Homeless children often live in shelter environments. In Ottawa, an average length of stay in family shelters is approximately 50 days (ROC, 2000). The shelter can represent potential risk or protection regarding resilient outcomes. Shelters have been associated with increased risk of various infectious diseases (Roth & Fox, 1997). Risk factors related to the long-term effects of shelter living on children's development include lack of privacy (Deforge et al., 2001; Huang & Menke, 2001), chaotic environments, a lack of structure or routine (Bassuk & Rubin, 1987); lack of developmentally appropriate toys, activities, and play spaces (Gewirtzman & Fodor, 1987); a lack of suitable areas in which to do homework (Gewirtzman & Fodor); victimisation by other children (Deforge et al., 2001; Huang & Menke, 2001) and a negative impact on parenting capacity (Torquati & Gamble, 2001). Other environmental factors, such as noise levels, bugs, and smells, are perceived by children as being stressful (Huang & Menke).

Shelter rules can leave children and their parents feeling more restricted and less in control of their lives than they had been in their previous living arrangements. This lack of control is described by homeless children as making their lives more difficult and creating stress for them and their parents for fear of such consequences as being asked to leave, if the rules are broken (DeForge et al., 2001; Huang & Menke, 2001). As well, such restrictions can negatively impact the age-appropriate development of independence and decision-making skills (Percy, 1995; Wiley & Ballard, 1993). Feeling embarrassed or teased at school and in other settings for living at the shelter can also be sources of stress for these children (Huang & Menke, 2001). However, in an ethnographic study of six mothers, Liff (1991) reported that the opportunities within the shelter for educational and employment training gave them a new sense of hope in their future.

Very little research has been conducted in determining the factors that are associated with

housing security post shelter discharge (Rocha, Johnson, McChesney, & Butterfield, 1996) or the long-term health status of homeless children post shelter. Longitudinal research is needed in these areas.

Resilience and homeless children. The concept of resilience and the related protective factors have not received much attention in research related to homeless children. The vast majority of studies related to homeless children have focused on deficits and risks. Limited research has focused on the identification of protective factors, competencies, and strengths in homeless children and youth (Berne et al., 1990; Dail, 1990; Graham-Bermann et al., 1996; Herth, 1998; Huang, 1995; Huang & Menke, 2001; Liff, 1991; Miliotis, Sesma, & Masten, 1999; Torquati & Gable, 2001; Voegler, 2000). The protective factors described in these studies include social support, good parenting, hope, coping, and adjustment. Rew, Taylor-Seehafer, Thomas, and Yockey (2001) in their study of 59 homeless adolescents' hopelessness and social connectedness explained 50% of the variance in resilience. These youth aged 15 to 22 years, however, did not reside with their families and the authors noted that resilience might be different in the two distinct subgroups of homeless youth. A study of 59 homeless African American families with children aged six to 11 found that close parent-child relationships and involvement in the child's education were significantly correlated with academic achievement and positive school behaviour (Miliotis et al., 1999).

Summary of Findings

Although research suggests that children constitute a significant portion of the homeless population, there is a paucity of knowledge about this population in Canada. No Canadian studies related to the health of homeless children were found. Further, knowledge is limited related to factors that are associated with healthier outcomes in homeless children.

The majority of research in the area of homeless children is from the US and to a lesser extent from the UK. Most of the research related to homeless children has focused on larger metropolitan centres in the US. The extent to which the results can be generalised to Canada is unclear, especially in light of differing population characteristics, health care, and funding systems. Additionally, comparisons among studies related to this population need to be considered cautiously given differing political issues, definitions, and methodologies.

There is a need to identify the characteristics, health needs, and strengths of homeless children and youth living with their families in shelters in Ottawa. This knowledge can enhance the ability of nurses and other health care professionals to develop effective programs and policies aimed at the optimisation of health for this vulnerable, under-served, and poorly understood population.

Conceptual Framework

To guide the development of a balanced profile of homeless, shelter-dwelling children in Ottawa, a resilience framework was chosen. The conceptual framework for this study is based upon the work of Kirby and Fraser (1997) and Stewart, Reid, and Mangham (1997). The combination of these two frameworks was chosen because of their commonalities and unique contributions. Kirby and Fraser provide an ecological framework that views resilience from multiple levels, the individual; the family, neighbourhood, and community; and the broader socio-political environment. Stewart and colleagues identify risk and protective factors commonly associated with resilient outcomes in children at the individual, family, and community levels and define resilience in terms of health outcomes in children.

For the purposes of this study and based on these two resilience frameworks, resilience is defined as the dynamic capacity of individuals, which changes over time and through

developmental stages, to have successful outcomes in the face of significant change, adversity, or risk and is improved by protective factors in the individual and environment (Kirby & Fraser, 1997; Stewart, Reid, & Mangham, 1997). Resilience, in this study framework, is measured by child health outcomes in physical and emotional health status, development, behaviour, and academic achievement. Risk factors are variables within the individual, family, and community that increase the likelihood of the onset, maintenance, or worsening of adverse health outcomes (Kirby & Fraser; Stewart et al.). Protective factors are variables in the individual, family, and community that modify or decrease the negative influences of risk factors on child health or operate independent of risk to promote positive health outcomes (Kirby & Fraser; Stewart et al.). Examples of these risk and protective factors, compiled based on the two frameworks, are found in Table 1.

Table 1

Common Risk and Protective Factors Associated with Resilience in Children

Level	Risk Factors	Protective Factors
Individual	<p>Individual characteristics Chronic illness/disability Male gender Minority racial status Foster care Experiences of abuse Perceived stressors Exposure to violence</p>	<p>Individual characteristics Problem-solving skills Helpfulness Positive self-esteem Coping skills and strategies Feeling of control over one's life Planning for future events Optimism Easy temperament Average or higher cognitive abilities Ability to be alert and autonomous Social competence Ability to gain positive attention Trust</p>
Family	<p>Parental characteristics Parental pathology or illness Young teenage mothers</p> <p>Family characteristics Prolonged separation from parents Life stressors such as poverty Overcrowded conditions Inter-parental conflict Poor parenting Child maltreatment Large family size Perceived family stressors</p>	<p>Parental characteristics Positive parent-child attachment and interactions Parent/caregiver expectations of a positive future for child Health of primary care giver</p> <p>Family characteristics Small family size Structure, rules and responsibilities</p> <p>Social support network Strong extended family network Positive alternative care giving adults Availability of sibling caretakers</p>
Community	<p>Environment Low socio-economic status or poverty High unemployment Violence or drug issues Racial discrimination and injustice Barriers in access to health and community services Few opportunities for education and employment</p> <p>Social support network Deviant peer group</p>	<p>Environment Access to health and community services Positive school experiences Responsibilities outside the home Participation in extracurricular activities</p> <p>Social support network Positive non-familial role models Accepts adult support and guidance Positive event before or after a stressor</p>

(Kirby & Fraser, 1997; Stewart, Reid, & Mangham, 1997)

The use of a resilience framework will facilitate the development of a profile of homeless, shelter-dwelling children in Ottawa based on the identification of several diverse, interrelated, and complex risk and protective factors potentially impacting health outcomes for these children. This profile may be useful for nurses, other health professionals, and community service providers to guide the development of appropriate interventions, programs, and policies that build on strengths, promote protective factors and processes, and minimise risk factors in an effort to promote healthy outcomes for homeless children living in shelters.

Chapter Three

Methods

This chapter describes the methods used to develop a profile of children living in shelters in the City of Ottawa. The research design, the study setting and sample, and procedures for recruitment, data collection, and data analysis are described. The ethical considerations of this study are presented.

Research Design

A descriptive research design using a survey questionnaire developed by the researcher, based on the literature, and guided by a resilience framework was used to collect the data. Descriptive studies are used to observe, identify, describe, and document the characteristics, prevalence, and intensity of a phenomenon as it naturally occurs, and especially when little is known of the phenomenon (Burns & Grove, 1999; LoBiondo-Wood & Haber, 1998; Polit & Hungler, 1999). As very little is known of the population of homeless children in Ottawa or of their health status and the factors that may influence it, an exploratory descriptive approach was deemed appropriate.

Study Setting

The research was conducted in three settings, the two family shelters in the City of Ottawa, Carling Family Shelter and Forward Family Shelter, and one emergency shelter that also serves families, the YMCA/YWCA Emergency Shelter. A brief description of the three shelters to be used in this study is provided in Appendix A. Participants were also offered the option of being interviewed in a mutually agreed upon location away from the shelter.

Sample

The most recent available data estimates that these three shelters serve approximately 370

families each year. However, because of a lack of available data, it was impossible to estimate the number of families, parents, or children that would be in these shelters during the data collection period from September 2001 to January 2002 or would meet eligibility criteria for participation in the study. Therefore, all parents or legal guardians who resided in these three family shelters in Ottawa during the data collection period and who met the inclusion criteria were invited to participate in the study. Only one parent per family, however, was included in the study. In the case of two parent families, the parents themselves decided which one of them would participate.

Parents or legal guardians were eligible for inclusion in this study if they: a) were without a permanent residence; b) were living in one of the three family shelters; c) had at least one child between the ages of five and 14, inclusive, living with them; and d) were able to communicate orally in English. Parents or guardians were chosen as sources for data collection because of their intimate knowledge of the children in their care.

Data Collection

Questionnaire construction was guided by Peterson (2000), Woodward and Chambers (1999), and the resilience framework on which the study was based. Both open and closed-ended questions were used in the questionnaire to collect information related to parents' perceptions of their children's health status, academic achievement, social support network, shelter environment, and use of and access to health and community services. Questions related to child and family demographic characteristics were also included in the questionnaire.

To evaluate the questions, format, sequence, and instructions of the questionnaire, it was pre-tested using two methods. A panel of experts was asked to review the questionnaire, note any errors in construction or content, and make suggestions for revision. This panel was comprised of

individuals with a) expertise in research methods, questionnaire development, and interviewing as a method of data collection, and b) experience working with homeless children and their families. Based on the feedback from this panel, revisions were made and the questionnaire reviewed again by panel members for content-related validity. Additionally, a convenience sample of four parents living in shelters was asked to pilot test the questionnaire following receipt of their informed consent. Participants in the pilot study were asked a series of questions about the interview to elicit their general impressions of the questionnaire and their comments related to content, wording, and relevance of each question. The pilot test included evaluation questions identified by Woodward and Chambers (1999). It had been planned that the researcher's thesis supervisor would be present during pilot interviews to observe and critique the interviewing technique and to code the questionnaire. However, as none of the four pilot test participants agreed to the presence of another individual during the pilot interviews, a mock interview was conducted during which time the appropriate feedback was provided.

Based on the results of the pilot interviews, two questions were removed and two reworded to facilitate participant understanding. These two questions were not altered in content but reworded for clarity. At the time of the interviews the researcher clarified the meaning of these two questions for the four pilot parents. Therefore, since the inclusion criteria were the same and the content of the questionnaire was unchanged, data from all study and pilot participants were included in the analysis.

Face-to-face recruitment by the investigator was employed during the September 2001 to January 2002 data collection period. Staff at each shelter were asked by their supervisors to provide the investigator with the names and room numbers of each eligible resident parent. Each family in the shelter whose name was provided received a visit by the researcher, at which time

their eligibility was confirmed, they were invited to participate, and were given and read a letter of invitation (Appendix B) and a consent form (Appendix C). The consent form was either signed at that time or the researcher scheduled a return visit within one week to gather signed consents, answer any questions that the potential respondents had, and book an appointment for the interview. If the participant agreed, reminder phone calls were attempted within two days of the scheduled interview appointment. The exception to this process occurred with those families who resided at YMCA/YWCA family shelter as per the preference of that facility's administration. These families, all of whom had access to a private phone with voicemail, received written and/or voicemail messages, copies of the invitation and consent forms left in their mailboxes, and the telephone number to which they could respond. Following the receipt of the signed informed consent, the data was collected using a semi-structured face-to-face interview guided by the pre-tested questionnaire (Appendix D).

Ethical Considerations

Participation in this study was completely voluntary. No form of coercion or manipulation was used. All eligible participants received a letter of invitation to the study and a consent form. Parents or legal guardians were offered the option of having both the letter and the consent form read aloud to them by the researcher. Those who chose to participate subsequently signed the consent form. Upon signing, copies of the letter and consent form were offered to each participant for their personal record and for their referral at any time.

The purpose of the study was explained to those parents or legal guardians who were invited to participate. They were told that there would be no immediate benefits to themselves or their children because they participated in the study and that they could refuse to answer any questions. They were informed that their participation was voluntary, they could withdraw from

the study at any time, and that this decision would not impact their residency or treatment at the shelter. They were informed that their privacy, anonymity, and confidentiality would be maintained through the data collection, analysis, and reporting phases of the study.

Confidentiality was assured and provided through careful management of the raw data and separation of the raw data from any identifying information. An identification number was assigned to each participant and their names were not written on any forms. All information, including a document that contains both the identification number and the names, were kept separately in a secure locked place in the Faculty of Health Science at the University of Ottawa and seen only by the researcher and her supervisor. The data will be shredded to destroy all identifying data following thesis defence and publication. Personal information will not be used in any written or verbal report or at conferences, and will not be released unless required by law in order to protect participants' anonymity and that of their children. Subjects were told of the circumstances under which information could be legally required to be released. The participant's signature on the consent form signified their voluntary participation in the study and their agreement with the use of the data.

Ethical approval for the conduct of this study was obtained from the University of Ottawa's Research Ethics Board (Appendix E). Subsequently, the Manager of Residential Services with the City of Ottawa and the Manager of Housing with the YMCA/YWCA provided administrative support and formal letters of approval (Appendices F and G) to have their facilities be sites and settings for this research.

Data Analysis

Data were entered, reduced, and analysed using the Statistical Package for Social Sciences software (SPSS 11.0, Windows Version). Quantitative data were coded numerically and

entered in the data file using the editor program of SPSS. The open-ended questions were analysed using the approach recommended by Miles and Huberman (1994). A provisional initial list of codes was created based on the conceptual framework and the purpose and objectives of the study. The initial data were written, reviewed line-by-line, respondent-by-respondent, and coded into themes by two individuals, the researcher and her thesis supervisor, who then compared their coding. There was an initial inter-coder agreement of 86%. Further discussion and clarification of the codes resulted in a final inter-coder agreement of 96%.

The data were then coded numerically and entered on to the data file using the editor program of SPSS. Verification of data entry was performed by visually comparing the numbers printed on a printout of the data file from the original questionnaires by a second person. Following data verification, descriptive statistics, frequency counts, percentages, means and standard deviations were calculated and used to describe the study sample, child health status, health and community services used, the child's social support network, and shelter life.

Chapter Four

Results

This chapter presents the results of the study. The chapter begins with a description of the response rates. Demographic characteristics for the children and their families are presented. Data pertaining to child health status, social support, shelter life, health and community services, and other child and family characteristics are provided.

Response Rate

Participants were recruited to this study from September 4, 2001 to January 16, 2002. Four parents were approached for the pilot phase of the study, all of whom agreed to participate. Following the pilot phase, the researcher was provided with the names of 50 potential participants. However, upon approaching them to participate, the researcher discovered that five of these participants did not meet the eligibility criteria in that they were unable to participate in the study as a result of their abilities in the English language. Of the 45 eligible parents or legal guardians who were approached for the study, 30 (66.7%) completed the interviews. Of the 30 parents who participated, nine (30%) required that appointments be rebooked at least once, and four (13%) required rebooking three or more times. Of those eight who moved out of the shelter prior to being interviewed, half had booked appointments for which they did not show on a least one occasion. An additional seven invited parents (15%) declined participation citing as reasons a lack of trust in the researcher, concerns about confidentiality, and having a current family crisis or other issues requiring more priority.

Child and Family Demographic Characteristics

The 30 parents or legal guardians (hereafter referred to as parents) who participated in the study and the four from the pilot study, together reported they had 107 children, 90 of whom

resided with them at the shelter, and 61 who were between the ages of five and 14 years. Of the children five to 14 years of age who were the focus of the study, 36 (59.0%) were boys and 25 (41.0%) girls. Family demographic characteristics are summarised in Table 2.

Table 2

Family Demographic Characteristics (N=34)

Variable	Frequency	Variable	Frequency
Parent gender		Relationship to children	
Male	3	Mother	30
Female	31	Father	3
		Grandmother	1
Parental age	<u>M</u> =34, <u>SD</u> =7.161, Range=22-50	Education	
20-29	8	Less than grade 6	2
30-39	15	Grade 6,7, or 8	5
40-49	10	Some high school (no diploma)	10
50 and over	1	High school diploma	10
		Vocation	1
		College or university	6
Marital status		Language spoken at home	
Single	12	English	19
Married	1	French	3
Separated	11	English/French	4
Common law	2	Somali	3
Divorced	6	Spanish	3
Widowed	2	Arabic	1
		German	1
Country of origin		Employment status	
Canada	19	Working full time	3
Somalia	3	Working part time	3
El Salvador	2	Unemployed	27
Jamaica	2	Disability	7
Sierra Leone	2	Looking after family	11
Yemen	1	Seeking work	3
Bosnia	1	Moved	2
Ghana	1	No reason provided	4
Dominican Republic	1	Full time in education or training	1
Lebanon	1		
Ireland	1		

There were three two-parent families, 30 lone-parent female-headed families, and one lone-parent male-headed family. One grandmother/legal guardian, three fathers, and 30 mothers were interviewed. Of the parents interviewed, their ages ranged from 22 to 50 with a mean age of 34 years ($SD = 7.161$). Three of the responding mothers (8.8%) were pregnant at the time of the interview. The families had a mean of 2.65 children ($SD = 1.276$) living together at the shelter, the number ranging from one to six.

Over three-quarters (79.4%) of parents reported that they were unemployed at the time of the interview. Almost one third of parents (32.4%) stated that they were not in the workforce in order to look after their children and 20.6% for reasons of disability. A further 17.6% of parents were employed either full time (8.8%) or part-time (8.8%). Social assistance was reported to be the primary income source for 79.4% of families. Two parents (5.9%) stated that their families were not currently receiving money from any source. The mean family income was reported to be \$811 per month (range = \$0 - \$1900/month). Approximately 56% (19) of respondents reported having been born in Canada. Of those not born in Canada, the mean length of stay in the country was 13.53 years ($SD = 9.949$) with a range of two to 45 years. English was the language most frequently spoken in 55.9% of families.

Over half of the 34 parents (55.9%) were from the Carling Family Shelter, 38.2% from the Forward Family Shelter, and 5.9% from the YM/YWCA. At the time of the interview, the greatest proportion of families (23.5%) had resided in the shelter between one and three months with a range from three days to 22 months. Table 3 provides the length of time study participants had been in the shelter at the time of the interview.

Table 3

Study Participants' Length of Time in the Shelter (N=34)

Length of time at the shelter	Frequency	Percent (%)
Less than one week	1	2.9
8-14 days	7	20.6
15-30 days	7	20.6
1-3 months	8	23.5
4-6 months	7	20.6
7-12 months	3	8.8
13 months – 2 years	1	2.9

In the 12 months prior to living in the shelter, families had lived in a mean of 2.79 places ($SD = 1.27$) with the number of places ranging from one (20.6%) to five (8.8%). The types of accommodation in which these families lived during that time period are summarised in Figure 1.

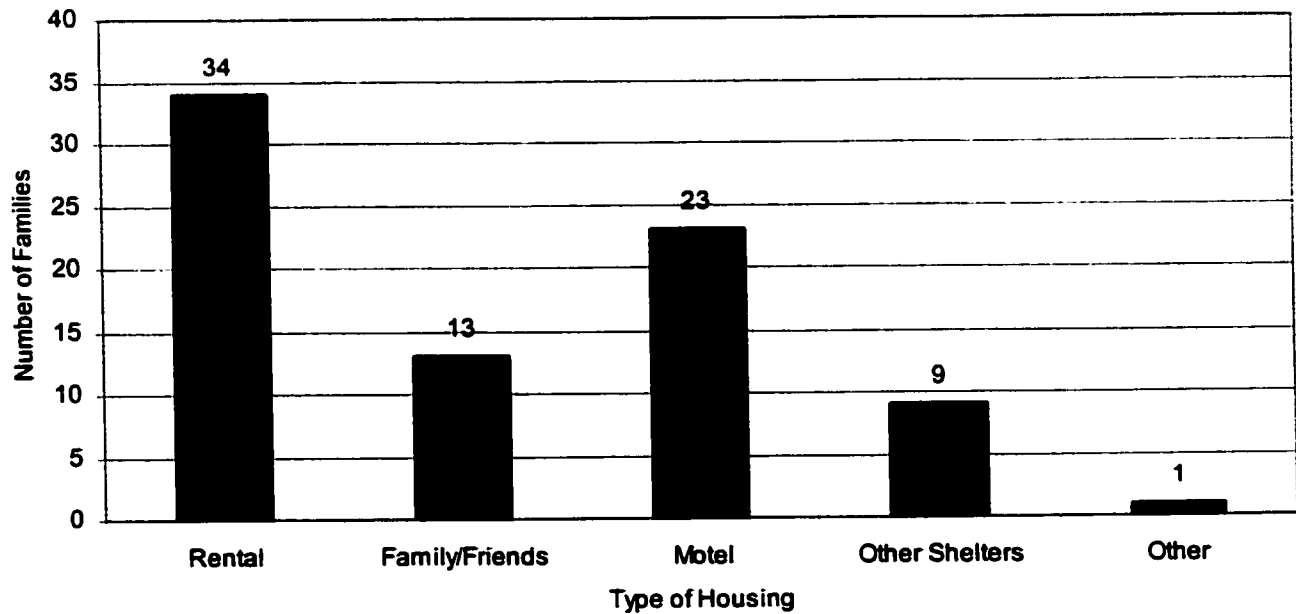


Figure 1. Types of housing in the 12 months prior to arrival at the shelter (N=34).

All families had been in at least one rental unit in the past 12 months. One family had stayed in a tent and an abandoned cabin prior to coming to the shelter.

Many parents reported multiple contributing causes for their current housing crisis, the most common of which was eviction (35.3%). The reasons that parents provided for coming to the shelter are summarised in Table 4.

Table 4

Reasons for Coming to the Shelter (N=34)

Reasons for coming to shelter	Frequency	Percent (%)
Eviction	12	35.3
Fleeing abuse	10	29.4
No longer able to stay with family/friends	9	26.5
Unable to afford housing	9	26.5
Unsafe housing or neighbourhood	5	14.7
New to city	5	14.7
Family breakdown	2	2.9

Health Status

Physical health. When rating their children's health status, parents reported that 29 children (47.5%) in the study were in excellent to very good health, 24 (39.3%) were in good health, and eight (13.1%) were in fair to poor health. However, parents reported that 37.7% of the 61 children had allergies; 34.4% had diarrhea; 31.1% had each of asthma, headaches, and other infections that included respiratory and throat infections; 29.5% had skin rashes; 27.9% had each of muscle problems and stomach pain; and 23.0% had ear infections. Additionally, parents reported that 29 children (47.5%) in the study had other conditions including head lice, Attention Deficit Disorder (ADD), dizzy spells, vitiligo, vomiting, mental health conditions such as Obsessive Compulsive Disorder and Tourette Syndrome, and developmental conditions such as hearing loss and speech delay. Sixteen children (26.7%) were on medications at the time of

the interviews for one or more of the following conditions: asthma, ADD, respiratory infections, skin conditions, depression, and enuresis. Three children had anaphylactic allergies to food or other allergens yet none had been prescribed epinephrine devices.

Parents reported that the health status of 51 children (83.6%) had changed since coming to the shelter; and for each this change was negative. Further, parents provided data on 47 children regarding the ways in which their health had declined since coming to the shelter, the most frequently cited of which was the increase in colds, flu, and other respiratory infections, reported for 20 children. Other such areas included: a) an increase in diarrhea and vomiting, b) greater emotional or behavioural concerns, c) weight and appetite changes, d) worsening of asthma, e) an increase in the frequency and severity of headaches, and f) an increase in other infections and skin conditions.

Immunisations were reported to be up to date in 59 children (96.7%). Parents reported that 46 children (75.4%) were getting less sleep in the shelter than was their usual amount. While not in response to a specific question, parents provided the following reasons for this decline in sleep: a) the noisiness of the shelter, b) the emotional impact of shelter living, and c) the sleeping arrangements in the shelter rooms. Parents reported having dietary concerns for 26 children (42.6%) and offered two main reasons for these concerns: the consumption of fewer healthy foods and more fast or processed food and a decrease in their children's appetite.

Development. The parents of 32 children (52.5%) in the study reported having at least one concern regarding their child's development. The three most frequently cited concerns related to learning difficulties, hyperactivity, and speech, language, and hearing. Of the children whose parents expressed concerns for their development, only 12 had been developmentally assessed. A further 11.8% were on waiting lists for an assessment.

Emotional status. The parents of 56 children (91.8%) in the study reported having concerns regarding their child's emotional health. Eight of these 56 children had seen a professional for these concerns.

Behaviour. Parents reported having concerns about the behaviour of over two thirds (65.6%) of the 61 children in the study. Of the 40 children for whom such concerns were expressed, 22.5% had received a professional consultation.

Academic achievement. While all the children who were the focus of the study were of school age, 11.5% did not attend school at the time of the interview. Three of these children (4.9%) had quit school since coming to the shelter. The other four had not yet been registered in a new school or were not attending because of the current family housing crisis. The vast majority of the 61 children (80.3%) were reported to never have repeated a grade. The reporting parents for two (3.3%) children were unsure whether or not the children had ever been held back in school. Two of the children (3.3%) had skipped a grade. Over half (55.7%) had attended nursery or pre-school.

Parents reported that the 61 children received at least some of the following grades in schools: A (39.3%), B (63.9%), C (44.3%), D (22.9%), and F (3.8%). However, parents of eight children (8.2%) did not know what kinds of grades their children were receiving. Parents reported that grades had been unaffected by the current housing situation for 26 of the 61 children (42.6%). For two of the 25 children whose grades were reported to have been affected, the grades actually improved. Parents were unsure of the impact on the grades of ten children (16.4%), either because they were unfamiliar with how their children were previously doing in school, shelter living was a very recent experience for them, or their children had quit school

since arriving at the shelter. Over one-third (34.4%) of the 61 children were receiving extra assistance in school. Four other children (6.6%) were on waiting lists for services at school.

The parents of six children (9.8%) reported that either they were unsure of what their children were best at in school or there was nothing at which their children excelled. Parents reported that five children (8.2%) had received awards in school.

Nine of the 34 parents (26.5%) reported that their children attended school in their pre-shelter neighbourhood located outside the school area for the shelter. Six of these parents commented on the sacrifices that they had made in order to keep their children in the same school. As one parent stated, *“I advocated strongly that they stay in the same school. It’s their only stability. I did it to reduce their fears. They were in programs there, individual programs for them.”* Another said, *“It takes me three city buses to get him to school. But I just couldn’t change him to a new school. It’s the only stability he’s got.”* Still another reported, *“She’s staying at the same school at significant sacrifice. We can’t get bus money or tickets to do this. I did it for her stability and so she could stay in the same programs and keep her friends.”* One parent (2.9%) reported that her children had remained in the same school, as it was also the one serving the shelter neighbourhood. Twenty-one parents (61.8%) reported that their children changed schools at the time of the move to attend school in the shelter neighbourhood.

Thirty-three parents provided data on their children’s mode of transportation to school. Children of 18 parents (54.5%) took the school bus, of six (18.2%) walked, of five (15.2%) took the city bus, and of one (3.0%) were driven. In the past 12 months, the 61 children attended a mean of 2.1 schools ($SD = .985$, range = 1 - 5) with 29.5% having been in only one school, 41.0% having attended two schools, 19.7% having attended three schools, and 9.8% having attended four or more schools. This information is summarised in Figure 2.

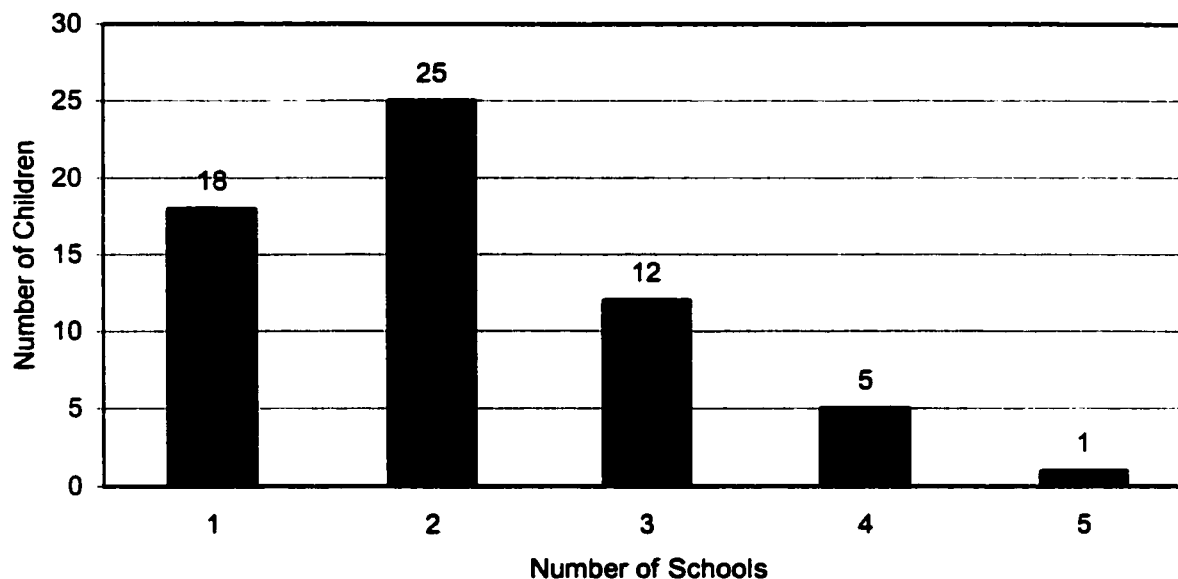


Figure 2. Schools attended in past 12 months (N=61).

Of the 34 parents, 25 (73.5%) reported that there were spaces at the shelter for their children to do their homework. However, only 15 parents (44.1%) described this space as appropriate. Children were reported to do their homework in their families' room and at the shelter's homework club. One parent commented that while the homework club was appropriate and her child enjoyed her experience there, it was run too infrequently at only two times per week. Another stated that the homework club was more of a social drop-in and too noisy to properly complete homework, *"They claim to have a homework club, but doing homework isn't mandatory. It's more like a youth program. All they really do is play."* Others stated that their children do not participate in the club because they do not speak English, the only language in which the group is conducted, or because the club is geared toward older school-aged children. The family rooms were reported as inappropriate for homework completion by a number of parents because of the lack of adequate workspace and crowding. A mother commented that in order for her child to complete homework, she needed access to a computer that was currently

not available to children at the shelter. Of the benefit of homework support, several parents made statements that are exemplified by this mother's comment, "*He needs help in school that I cannot give him. How am I supposed to help him in school? I cannot read or write well. I quit school so young.*"

Social Support

Based on the perceptions of the parents, 85.2% of the 61 children in this study discuss their problems or worries with their parents at least some of the time. Thirty-nine children (63.9%) were reported to have at least one close friend. Parents approved of at least some of the friends of 32 of these children. According to parent reports, 43 children (70.5%) had made new friends while staying at the shelter. However, parents of 32 of these children did not approved of their shelter friends. The most frequently cited reasons for disapproval of these friends was their poor behaviour and negative influence on their children and the victimisation of their children by these "friends".

Parents reported that children in this study had a mean of 2.25 (SD = 1.26, range = 0 - 6) adults in their lives that are important to them (Table 5).

Table 5

Adults Important to Children (N=61)

Number of important adults	Frequency M=2.25, SD=1.26	Percent (%)
1	18	29.5
2	13	21.3
3	17	27.9
4	9	14.8
6	1	1.6
0	3	4.9

Most frequently, children were reported to only have one important adult in their lives. For all of these children, this was the reporting parent. Parents were unable to name any important adult for

4.9% of children in this study. Only three children (4.9%) were reported to have an important adult outside of the family, in two cases this was a Children's Aid Society worker and a teacher for the third.

Life in the Shelter

Parents were asked what things they liked most and least about the shelter with respect to their children. A summary of parents' responses is provided in Table 6.

Table 6

Likes and Dislikes about Shelter Living (N=34)

Criterion	Frequency	Percent (%)
Liked most		
Opportunities to play and develop relationships	14	41.2
Nothing	12	35.3
Supportive adults	9	26.5
Safety/roof over head	9	26.5
Liked least		
Perceived inadequacy of staff	21	61.8
Lack of cleanliness	19	55.9
Other living conditions	18	52.9
Negative interpersonal relationships	16	47.1
Rules	14	41.2
Racial/cultural issues	4	11.8

The opportunity to play and develop relationships with other children and safe adults was the most positive response (41.2%). *"He meets other children in the same situation here – some peer support."* *"The (child/youth) program is really nice. They do crafts and cooking. It's educational."*

Having a roof over their head and being in a safe environment was the positive feature reported by 26.5% of parents. As one woman stated, *"There's a roof over our heads. I can hide from (my abusive husband) here and the kids are safe from him here."*

Being around supportive or care providing adults was reported by 26.5% of parents. Of the shelter supervisor, one parent commented, *“We can go to her with any problems or concerns or just to vent. She is an excellent role model for parenting.”* Another parent stated,

There are a lot of people to help them here when they need it. There are three or four staff members here who really understand. I am getting help to find a house so we don't get stuck here forever.

However, 35.3% reported that they found nothing or very little that they liked about the shelter for their children.

The most commonly cited reason for disliking the shelter environment for their children was parents' perception of the inadequacy of staff (61.8%).

We do not get respect as a human being. Many (staff) make an effort. We can't go directly to the supervisor – supposed to go to staff first. But that feels like we are putting our life on display. I don't feel like staff keep our confidence. Personal issues are discussed among staff and outside work. I don't feel like I can trust anybody in here.

Can't go to the supervisor. She's often too busy. She never has time. We have to beg to get things when I reach out for help. Staff never reach out. We have to watch our step for fear of retribution.

Over half of parents reported having disliked the lack of cleanliness of the facility (55.9%) and other living conditions (52.9%) which included noise, overcrowding, lack of privacy, and rooms that were considered to be too small with poorly regulated temperatures, ventilation, and humidity levels. Of the 30 parents who rated the kitchen facilities within the shelter, 25.8% rated them as good, 71.0% rated them as fair to poor, and one other parent (3.2%) did not know as she had not yet visited the kitchen. A lack of cleanliness, reported by 18 parents,

and safety concerns, named by four, were the most frequently cited reasons for the fair to poor ratings.

Sixteen parents (47.1%) reported that exposure to negative interpersonal relationships between shelter residents, including those between adults, between adults and children, and between children, some of which included violence, had a detrimental impact on their children. Certain rules at the shelter were perceived by 14 parents (41.2%) to be restrictive or punitive and thus negative for their children. *"The rules, we have no rights, no control."* Two examples of parents' perspectives on these rules are listed below.

The rules, like we're not allowed out for two nights except for medical reasons. That was my sanity – getting out of here. Curfew is 11:45 but on weekends it should be longer. We are not being treated like adults.

The rules, the limitations on children, it's too much. I have to be right there. I can't leave them in the care of anyone else. He (one study child aged 14 years) can baby-sit her (his sibling) at home, but not here. They need space from me and me from them.

Issues of racism and what one parent described as *"culture clashing"* were reported by four parents (11.8%) to be negative aspects of the shelter environment for their children. These racial or cultural issues related most frequently to hygiene practices, verbal expressions of racism, and what was perceived as inequality in the treatment of residents of certain cultures by staff.

Parents' perceptions of the nature of the impact, if any, living in the shelter had on their children's health is summarised in Figure 3.

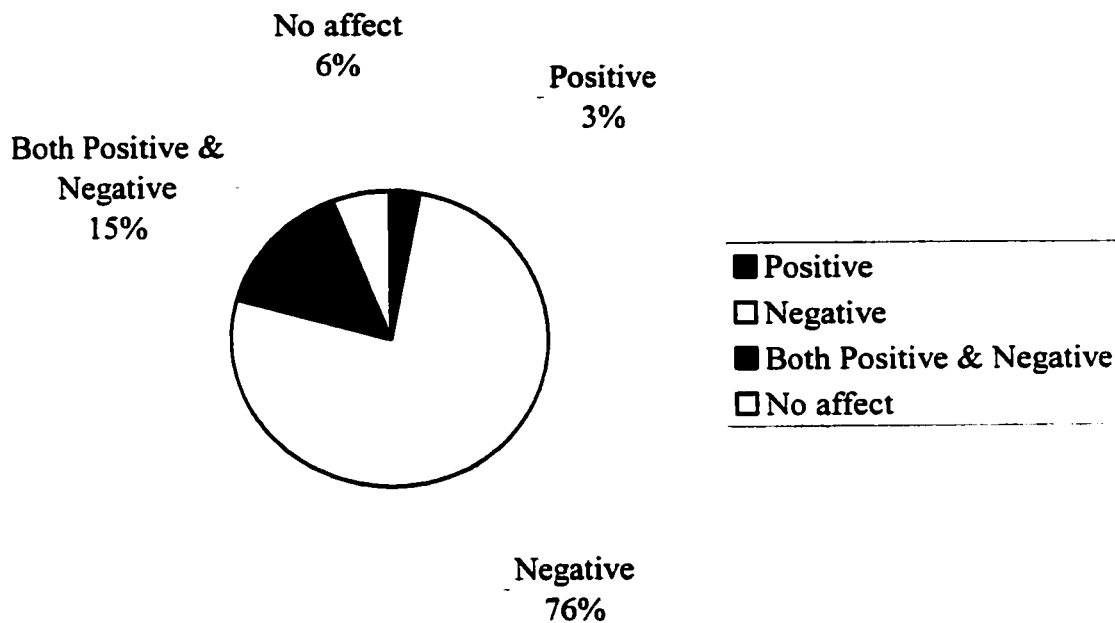


Figure 3. Parents' perceptions of the impact of shelter living on child health.

Parents who stated that the shelter had at least some positive impact on their children's health attributed this impact to the safety, stability, and opportunities for play, recreation, and socialisation offered their children through the shelter. Negative health impacts were most frequently attributed to the perception that their children were learning poor behaviour from other children at the shelter and the impact of the living conditions at the shelter on their physical health and psychosocial well being.

Most of the 34 parents (61.8%) reported that there were places where their children could play at the shelter. However, numerous concerns were raised about the safety and adequacy of these play spaces and equipment. Of the 33 parents who responded to the question about living arrangements at the shelter, 28 (84.8%) described them as unsatisfactory. The most frequently

cited reasons provided for these opinions were overcrowding, lack of privacy, the poor condition of the beds, and room conditions such as the temperature, dust, mould, and humidity.

Most of the 34 parents in this study reported an awareness of the following shelter-based or shelter-organised activities: Boys and Girls Club drop-in (61.8%), Child and Youth Programs (52.9%), and the Homework Club (20.6%). However, seven parents (20.6%) were not aware of any activities available to their children through the shelters. Thirty-four of the 61 children (55.7%) were not involved in any shelter-associated activity. Parents reported that 24.6% of the 61 study children participated in the Child and Youth Programs, (26.2%) in the Boys and Girls Club, and (11.5%) in the Homework Club. However, ten parents (29.4%) provided reasons for their children's lack of participation in certain shelter activities despite their knowledge of them. These reasons included their perception of inadequate supervision at the Boys and Girls Club and the inappropriateness of certain activities for specific age groups, particularly young teens. Others reported that their children preferred not to attend such activities. *"He does not like to go because he's not like the other children and they treat him bad."* Another parent commented that there was a lack of family-focused activities at the shelter and she preferred to have her child participate in activities that involved both child and parent.

Health and Community Services

Health services. Twenty of the 34 parents (58.8%) reported having a regular health care provider. Nineteen of these parents stated that this professional was their family physician. Of these 19 parents, four also reported having a paediatrician (14.7%) whom they consulted regarding their children's health. Additionally, one other parent stated that she visits a paediatrician for such care but does not have a family physician. As well, 15 parents (44.1%) reported accessing a nurse practitioner (NP) at the shelter for a health concern regarding their

children, eight of whom reported having a regular physician. None of the 34 parents had consulted a NP for issues related to their children prior to the shelter visit. Parents reported other sources of health care for children that included walk-in clinics (38.2%), community health or other community-based resource centres (23.5%), various mental health professionals (14.2%), public health nurses (2.9%), and other specialists (2.9%). Four parents (11.8%) did not name any source of health care for their children and two other parents (5.9%) named only the NP at the shelter.

Of the 61 children in the study, 35 (57.4%) had never been to the emergency room (ER) for health care. The parents of 22 of the 26 children who had been treated in the ER were able to approximate the date of their last ER visit. Of these 22 children, 11 had been in the ER within 6 months of the interview. One other child had visited the ER between six months and one year ago. Thirteen children (21.3%) were reported to have been previously admitted to the hospital, two between one and two years ago and nine greater than five years ago. Two children (3.3%) were reported to have been admitted to hospital within the past year.

While 40 children (65.6%) were reported to be covered by dental insurance and the parents of two (3.2%) were unsure of their dental insurance status, only nine (14.8%) children were reported to have a regular dentist. Twelve children (19.7%) had seen a dentist within the past six months and 15 (24.6%) had seen a dentist between six months and one year ago. For 17 children (27.9%), it had been over a year since they had last seen a dentist. Another 15 children (24.6%) had never seen a dentist.

Over two thirds (67.6%) of the 34 parents surveyed reported that their children were in need of services that they were not getting. The most frequently reported services that parents perceived that at least one of their children needed were academic support (38.2%) and mental

health services (38.2%). Other needed services included health services such as dental, speech and language, and vision (23.5%), recreational and other child and youth focused activities (14.7%), and peer supports (8.8%).

Community services. Of the 34 parents, 67.6% indicated that the services of financial or housing social workers were used for their children. Parents also reported that food banks (41.2%), the Children's Aid Society (17.6%), and other community service organisations (17.6%) such as the Salvation Army were among community services used by or for their children.

The vast majority of the 61 children in the study (85.2%) did not participate in after school care, instead coming directly back to the shelter at the end of the school day. Of the nine children (14.8%) who were in an after school program, three were in the care of an extended family member, two attended a licensed facility, and one was involved in a homework club at school. The only parent who provided a rationale for the lack of such involvement stated that the cost of such programs precluded her children's participation.

Parents reported that over three-quarters (80.3%) of the 61 children were not involved in any extra curricular activities outside of the shelter system. Of the 12 children (19.7%) who participated in such activities, eight were involved in organised sport and other social groups such as Girl Guides, four took part in other activities at local community centres, and two had joined school-based homework clubs. One parent commented on the lack of shelter support for her child's continued involvement in such activities upon entry to the shelter stating,

There is no support here for extra-curricular activities. We're treated as though it is wrong to use our money on such luxuries. She had been involved in (several activities and programs) but she had to give them up when we came here. There's no support. No

bus tickets. No support to continue her classes. She took it as a message that what she was doing before wasn't important.

Facilitators of access and use of services. Of the 33 parents who commented on facilitators of access and use of health and community services, 22 parents (66.7%) reported that other supportive adults provided them with the most assistance. These adults included parents, *“Other parents bringing the kids to sports”*, and professionals, *“Someone to advocate for me. The PHN was very helpful.”* Of one worker perceived to be of great support, a parent stated, *“She’s never too busy. I’m never on hold. There’s no appointment necessary.”*

Seventeen of these parents (51.6%) reported that having information on existing services and how to access them was helpful. For example, one parent indicated the helpfulness of *“Information, word of mouth from the people who live here.”* Other facilitators of access and use of health and other community services included: transportation (39.4%), access to a phone (21.2%), money (18.2%), and self-advocacy (12.1%).

Barriers to access and use of services. The 33 responding parents most frequently identified staff attitudes and behaviour (54.5%) as barriers to access and use of health and community services while they were living at the shelter. Parents said, *“Uncaring staff judge us for being here”*. The following example illustrates this barrier, *“Attitudes of workers, I need help but I get treated like I don’t deserve help. Being treated like I am begging for everything.”* The lack of information on services and resources available to families with children was cited as a barrier by 16 parents (48.5%). *“We’re not notified of all the services available. Staff should be giving more information to people.”*

Other perceived barriers included the lack of transportation or proximity to services (36.4%) and the lack of access to a phone combined with the difficulty experienced in receiving

messages left at the shelter (27.3%), *“A phone - people can leave messages (with staff) but (we) don't always get it from staff. Some things are important and they can't leave a message. Appointments have been missed. Housing appointments lost.”* Of the timing of appointments, reported as a barrier by seven respondents (21.2%), one parent said, *“It's their school schedule, one in the morning and one in the afternoon, how do I go anywhere for services. Makes arranging appointments difficult. They occasionally miss school because I am busy with other things.”*

A lack of money (15.2%) and restrictive shelter rules (3.0%) were also reported to be barriers. *“She has to be in her room by a certain time here so that limits some of her activities.”* Another parent stated,

The rules are prohibitive. You can't leave the children unattended but you can't bring them to go grocery shopping when it is arranged by the shelter. But then you have to leave them with an adult (another resident). I don't trust the adults here. I don't know them.

Two parents (6.1%) reported that they had not experienced any barrier to their access to or use of health and other community services.

Child Strengths

When parents were asked to identify the strengths of the 61 children, personality characteristics were the most frequently identified. The personality characteristics that included sociability and an easy-going temperament were identified as a strength for 36 children (59.0%). Cognitive ability was identified as a strength for 24 children (39.3%). For 22 children (36.0%), parents considered the children's helpfulness to their parents and others as among their strengths. The children's use of certain activities such as sports, drama, and music as outlets for their

emotions was cited as a strength of 16 children (26.2%) by parents. A clean and attractive appearance was cited as a strength for four children (6.6%). Unfortunately, for seven children (11.5%), parents were unable to identify any strength. *"I can't find their strengths now because of everything that happened to them ...and how they are behaving and feeling now."* *"Right now I am feeling so low that I can't even see the good points about my own children."*

Parent Concerns

Of the 34 responding parents, 16 (47.1%) most commonly identified the environment as a main source of concern they had for their children. Environmental conditions cited included negative peer (foul language, violence, aggression) and family (drug use, prostitution) influences, conditions at the shelter (safety, noise, lack of appropriate activities), and a lack of housing stability. Fourteen parents (41.2%) reported health concerns among their major concerns regarding their children. Of those indicating such health concerns nine cited emotional concerns most frequently. One woman stated,

They need to get out of this place, this nightmare. They need a stable home. They feel responsible for me and our situation. It's not good for them, emotionally, to be here. I am concerned about not getting back to a normal home life. The impact of instability on their mental health and development. The lack of positives in their life.

Seven parents (20.6%) also indicated their concerns about their children's future as productive citizens. To exemplify, one woman stated, *"I am afraid they won't be productive. I feel that they will not be allowed to become all that they can be."* Another stated that she feared her children *"getting involved in criminal activities"*. One parent (2.9%) reported that she had no concerns regarding her children.

When asked what they could do about their concerns, 15 parents (44.1%) reported that they could take some control over the situation for themselves and their children through self-advocacy, speaking out, and seeking outside help. *“Speak out. Be a strong advocate for my children. Role model them speaking out for themselves.”*

We can keep hope. We are a close family. We will keep supporting each other. We will never lose hope. We accept more that this will take time. We can accept a good space without waiting for the perfect space. We have chosen to stay away from the negative influences. We will not stay pitying ourselves.

Twelve parents (35.3%) felt that they needed to leave the shelter in order to relieve their concerns. Three parents (8.8%) felt that a change in their parenting strategies could affect the concerns they had for their children. However, 12 parents (35.3%) stated that they did not know what they could do and/or felt powerless. One parent stated, *“Nothing really because I’m in turmoil too. I am trying not to be so self absorbed but it takes so much energy.”* Another parent reported, *“I don’t know what to do. I work so hard. I get no help. I am so tired.”*

Parents’ Goals for Their Children

The 34 parents were asked for their top three goals for their children. Each parent reported at least one such goal, and 19 (55.9%) cited their children’s academic success, 18 (52.9%) reported housing stability, and 17 (50.0%) stated that health and happiness were among their top three goals for their children. Other goals for their children included a career (20.6%), independence (17.6%), and becoming good citizens (11.8%).

Additional Parent Comments

At the end of the interviews, parents were asked if there was anything else that they would like to add in order that the researcher understand more fully their children's health and factors that influence it (Table 7).

Table 7

Additional Parent Comments (N=32)

Additional comments	Frequency	Percent (%)
Hopelessness/helplessness	22	68.8
Parental mental health	21	65.6
Impact on parenting	12	37.5
Family disruptions	11	34.4
Loss of belongings	8	25.0
Blame	6	18.8
Positive outlook	4	12.5

The comments of 68.8% of responding parents related to a sense of hopelessness and helplessness.

I feel like there's nothing I can do...I am afraid it will be so much longer before I can find us a house. No one cares about (our) health problems...No one around here cares about me. We are on our own. I am afraid this will never end.

As well, 65.6% of respondents reported on their own mental health status. Comments such as the following referred to depression, *"Things have not been stable for a year. I am so depressed. I've lost weight."* and *"Since moving here my doctor has increased my medicine, antidepressants, twice. I still feel depressed. I am not able to sleep well. The doctor has prescribed medicine for that."* The stress of shelter living and its impact on the family were also cited. *"My stress is affecting my children badly. I have been very sick since coming here. Then I can't look after them properly. I am on antidepressants since coming here."*

Several parents (37.5%) commented on the impact that their experiences were having on their parenting abilities.

Some days the kids don't feel loved because I'm so stressed. What kind of children will we produce under these circumstances? It'll have an effect for generations. It's difficult to be the kind of parent I know I should be.

I know I shouldn't take my problems and stress out on them. Sometimes I can't help it. I get no support here. I am afraid how my stress will affect him. I don't have no hope anymore. I can't see a way out. It's all affecting how I am with them.

I am not allowed to go anywhere without them. I get mad and grumpy at them. But I know it's not their fault. I am just feeling so stressed. I need a break from them but I just can't get one.

Loss of belongings was reported by one quarter of respondents. *"We had to get rid of (the dog) when we moved to the motel (before coming to the shelter). Everything is in storage. He doesn't have any of his belongings."* *"All our belongings – everything we own is in (another city). The kids' comfort things, computer games, books – all still there. Don't know if we can get it back. We left quickly."*

The comments of four (12.5%) parents indicated a positive outlook and attempts to make a difference for their children as the following example illustrates,

We would be lost if we lost hope. We will make do on our own. It has been a big adjustment coming to Canada. A whole new world. A different way of life and raising children. We left the war. We really had to get over that. We are still getting over that. It's been healing... We are better off though. We lived on the streets over there for three months and then in a refugee camp. This place is so much better.

Chapter Five

Discussion

This final chapter examines the results presented in the previous chapter. It provides a discussion of the findings, study limitations, and the implications for practice and further research.

To the author's knowledge this is the first descriptive study in Canada that explores the population of children living in shelters, their health, and factors that may influence it. Child and family characteristics, child health status, and risk and protective factors at individual, family, and community levels have been identified and together create a profile of these children. This information adds to the body of knowledge about children living in shelters and a resilience framework on which future practice, policy, and research regarding this population can be based.

Demographic Characteristics

Based on comparisons with various published statistics related to families in Ottawa and/or Canada, the families of the children in this study are: a) living with approximately twice as many children (Federal, Provincial, and Territorial Advisory Committee on Population Health [ACPH], 1999); b) six times more likely to be headed by a single female parent (ACPH, 1999); c) headed by a parent who is less likely to have completed grade nine, high school, or post secondary education (Ottawa-Carleton Health Department, 1997); d) headed by a parent who is two to three times more likely to be unemployed (ACPH, 1999; Ottawa-Carleton Health Department, 1997); e) four times as likely to have an income below \$30,000 (Health Canada, 1999); f) ten times more likely to be receiving social assistance as their main source of income (ACPH, 1999); and g) up to three times more likely to speak languages other than English or French at home (Health Canada, 1999; Ottawa-Carleton Health Department, 1997). While just

over half of these parents were born in Canada, immigrants to Canada are over represented among the parents of these children in comparison to the parents of children in Canada (Health Canada, 1999). When findings from this study are compared with results reported by the Canadian Council on Social Development [CCSD] (1999), the parents of these children are six times more likely than the general population and twice as likely as other low income parents to report experiencing depression, severe stress, and other mental health concerns.

Over half this sample of school-aged (5-14 year old) children was male, similar to that of the school-aged population in Canada (CCSD, 2001). In general, these children have lived in two to three other places in the past year. The majority of children in this study had been living at the shelter between one and six months. These family and child demographic characteristics are consistent with those cited in the literature related to children living in shelters (Amery et al., 1995; Bassuk & Rubin, 1987; Bassuk et al., 1986; Buckner & Bassuk, 1997; Masten et al., 1993; Vostanis et al., 1997).

Health Status

Most of the children in this study are reported by their parents to be in excellent to good health. This rating is generally higher than that suggested in other studies of homeless children (Miller & Lin, 1988; Riley-Eddins, 1995; Roth & Fox, 1990; Weinreb, Goldberg, Bassuk, & Perloff, 1998; Wood et al., 1990). However, their health status was reported to have declined since entering the shelter and they were more likely to have certain health conditions. For example, they were twice as likely to have asthma as the general child population (Ministry of Health and Long-Term Care, 2000). Higher rates of such conditions for this population in comparison to the general population have been reported in the literature (Alperstein et al., 1988; Bass et al., 1990; Berti et al., 2001; Efron et al., 1996; Parker et al., 1991).

Parental concerns about the diet of almost half of the children in this study and the reasons provided for such concerns are consistent with reports of poor nutrition for this population (Acker et al., 1987; Drake, 1992; Kelly, 2001; Wood et al., 1990). The proximity of two of the shelters to fast food outlets and the relative distance to grocery stores or fresh food markets may have increased the use of these less healthy food sources for families with limited transportation and child care options. Parents also expressed concerns with a decrease in appetite for over half of the children for whom they had dietary concerns. This finding may be, in part, related to the emotional impact of shelter living on these children, especially in light of reported parental concerns for their children's mental health.

Consistent with the literature on this population (Bassuk & Rosenberg, 1990; Bassuk et al., 1986; Bassuk & Rubin, 1987; Davey, 1998; Efron et al., 1996; Fox et al., 1990; Liff, 1991; Masten et al., 1993; Vostanis et al., 1996; Zima et al., 1999), this study found a higher proportion of children whose parents reported emotional and behavioral concerns than the incidence of those concerns among the general population of children in Canada (ACPH, 1999; CCSD, 2001). Only a very small proportion of children whose parents reported concerns about their emotional or behavioral health and development had been seen by a professional for these concerns and over two thirds of parents stated that their children were in need of services that they were not getting. These findings suggest a high level of unmet need that is consistent with findings from other studies (Vostanis et al., 1996; Vostanis et al., 1997).

According to statistics from the Health Information Partnership – Eastern Ontario [HIP] (2002), 93% of children in Ottawa have a regular health care provider. Only 58.8% of parents in this study however, reported that their children had a regular health care provider. This reduced likelihood of having a regular source of health care is consistent with some studies with this

population (Hu et al., 1989; Roth & Fox, 1990) but higher than others (Miller & Lin, 1988; Wood & Valdez, 1991). Having a regular health care provider has been associated with better health outcomes in homeless children (Hu et al., 1989).

As noted by previous researchers regarding this population (Alperstein et al., 1988; Bassuk et al., 1997; Weinreb, Goldberg, Bassuk, & Perloff, 1998; Weinreb, Goldberg, & Perloff, 1998), the use of emergency room services and hospitalization rates among study children were higher than those reported by HIP (2002) for children in Ottawa. This finding may be reflective of the lack of a regular health care provider and a lower likelihood to use preventative health services noted in this study. As well, these families may find themselves unable to attend to health concerns until they reach emergent levels as they are focused on the daily survival associated with shelter living. The timing of appointments, a barrier to service use indicated in this study, may require that families use the emergency room. Regular health care provider visits require appointments and are often available at times that these families may not find convenient or even possible.

Low usage rates of preventative health services such as immunizations (Alperstein et al., 1988; Riley-Eddins, 1995) and dental health care (Menke & Wagner, 1997) are reported for homeless children from the US. However, immunizations were up to date for the vast majority of children in this study. Up to date immunization status is required for school entry in Ontario (Government of Ontario, 1991) and given that the children of this study were all of school age, this high immunization rate is likely attributable to that policy. While dental insurance coverage rates in this study compares with those reported for other children in Ottawa (Child and Youth Health Network of Eastern Ontario [CYHNEO], 2000), less than half the study children had seen a dentist in the past year. According to statistics reported by the CYHNEO (2000), this figure

compares with rates cited for other low-income children in Ottawa but is considerably lower than that of children from higher income groups.

School attendance, school leaving rates, and the frequency of school changes found in this study are consistent with those reported in the literature (Rubin et al., 1996; Vostanis et al., 1997). Three times as many children were not attending school at the time of the interview compared to the rate reported by CICH (1991). While the vast majority of children were reported to have never repeated a grade, the grade retention rate reported by parents (16.4%) was considerably higher than reported for the general school aged population (3-7%) (CICH, 2000). Studies from the US have reported much higher grade-retention rates for homeless children (Wood et al., 1990). Further, the inability of some parents to name what their child was best at in school may relate to a lack of parental involvement in school or a preoccupation with other priority issues. Such a lack of involvement has been associated with poorer academic outcomes in homeless children (Miliotis et al., 1999). The frequency of school changes may have an adverse impact on the emotional health, scholastic achievement, social development, and self-esteem of these homeless children (Anglin, 1998; Rescorla et al., 1991; Sullivan, 1997).

The high frequency of special assistance in school is consistent with the literature on this population (Bass et al., 1990; Bassuk et al., 1986; Rescorla et al., 1991; Rubin et al., 1996; Zima et al., 1997). However, given reports of the low rates of receipt of such services even when there is a documented need (Zima et al., 1994; Zima et al., 1997), further research should be undertaken to accurately ascertain the extent of such need in this population of children and the associated barriers.

Risk Factors

According to the study framework, risk factors are variables within the individual,

family, and community that increase the likelihood of the onset, maintenance, or worsening of adverse health outcomes. Many of the individual, family, and health related factors found in this study are identified through the resilience framework as placing these children at risk for poorer health outcomes. Based on the findings of this study, individual risk factors present in this population of children include child health concerns. A large family size, poverty, exposure to violence, and parental mental health issues are among the family level risk factors. At the community level, noted risk factors include: a) frequent school and housing moves, b) small adult and peer social support networks, c) the lack of involvement in extra-curricular activities, d) living conditions at the shelter, e) restrictive or punitive shelter rules, f) the lack of a regular health care provider, g) negative service provider attitudes, and h) other barriers to service use and access.

Individual and family level risk factors. While male gender was identified in the resilience framework as a risk factor for children, no study of homeless children was found in which this was reported. Several children were noted to have chronic health conditions, a risk factor according to the resilience framework. Larger family size has been shown to be a risk factor in a family's ability to secure housing post-shelter (Rocha, Johnson, McChesney, & Butterfield, 1996), thus children from larger families may end up staying at the shelter and experiencing the associated stressors for a longer time period.

The reasons families cited for their housing situation in this study are similar to those found in the literature (Farrell et al., 2000; Liff, 1991) and included: an inability to afford housing, eviction, domestic violence, dangerous living situations, and the inability to continue to live with family and friends. The poverty, abuse, and housing and neighborhood conditions which contribute to the family's housing crisis, together with the number of previous housing

moves indicate potential sources of stress for homeless children (Huang, 1995; Huang & Menke, 2001). For example, children from families who were fleeing abuse may have been exposed to the violence and conflict that precipitated their housing crisis. Exposure to violence has been associated with poorer behavioral outcomes in homeless children (Zima et al., 1999). Further, the frequency of moves may have contributed to poor scholastic performance and also decreased possibilities for these children to develop close peer relationships.

A higher incidence of parental mental health concerns, another risk factor, compared with the general population was noted in this study. This finding is supported by the literature with this population (Banyard & Graham-Bermann, 1998; Bogard et al., 1999; Liff, 1991; Phillips et al., 1988; Vostanis et al., 1996; Vostanis et al., 1997; Waldron et al., 2001; Wood et al., 1990). Research has found that mothers' emotional distress is associated with emotional and behavioral problems in homeless children (Bassuk et al., 1997; Buckner et al., 1997; Graham-Bermann et al., 1996; Zima et al., 1996) and negative parenting behavior (Torquati & Gamble, 2001). Homeless children who were exposed to lower levels of parental and family stress exhibited better cognitive, academic, and behavioural outcomes (Danescu & Holden, 1998).

The high proportion of children who were reported to go to their parents with concerns or worries at least some of the time is consistent with findings of the CCSD (2001) for school aged children in the general population. Parents reported that they were among the important adults in the lives of their children. This finding is congruent with results from researchers who have found that parents are valuable buffers against stressors experienced by homeless children (Huang, 1995; Miliotis et al., 1999; Torquati & Gamble, 2001). However, the literature about homeless children often suggests that parents are focussed on issues of survival and meeting basic needs. In this study, for example, a primary mandate of parents living in the shelters is to

secure housing. This attention to survival, together with parents' own levels of stress and their lack of extensive social networks, also noted in this study, could result in an inability to provide the necessary attention to their children's needs (Hausman & Hammen, 1994). It is imperative that parents be supported in their role.

Community level risk factors. For many of the children in this study, parents were the only source of adult support. Studies of homeless children have suggested that a relationship with a non-familial supportive adult from the school, neighbourhood, or community is an important protective factor (Voegler, 2000). Talking to another adult was found by Huang (1995) to be a successful coping strategy for homeless children. The lack of important adults for the children may also be indicative of a small social network for the parents. Parents who feel stressed or unsupported in their current environment may not be able to offer the social support needed by their children. The value of extended networks of supportive adults should not be underestimated and efforts to promote such social support should be undertaken.

In comparison with statistics on other Canadian children (CCSD, 2001), children in this study are reported by their parents to have fewer close friends. The disruption to peer relationships that can result from frequent moves and the associated school changes may explain this smaller peer network. It is important to note, however, that in previous studies, parents regarded their homeless children as having more supportive adults and fewer supportive friends than did the children themselves (Landow & Glenwick, 1999). Future research could assess these variables from the child's perspective. The lack of peers, missing old friends, together with the negative influence of some of the friends, all noted in this study, may pose risk factors for these children (Huang, 1995; Huang & Menke, 2001). Involvement in extra curricular activities at the

shelter, in school, and in the community could also serve to expand and strengthen the peer-based social network for homeless children.

The findings suggested that children in this study are less likely to be involved in sports; music, dance, or arts classes; social groups such as the Girl Guides; or after school care when compared to other Canadian children (CCSD, 1997). Boredom in the shelter environment, which can be alleviated through such participation, has been identified as a stressor for homeless children (Huang, 1995; Huang & Menke, 2001). Further, this lack of involvement in extra curricular activities and after school care minimises their opportunities for relationships with other supportive adults and peers. The cost of participation in these activities may be a barrier. In Ontario, over 80% of recreation departments charge user fees for school-aged arts and aquatics programs. Policies to reduce or eliminate financial and other barriers to participation are warranted.

The unsanitary shelter conditions, noise, lack of privacy, restrictive rules, and exposure to violence cited by parents in this study have been noted in previous research (Bassuk & Rubin, 1987; Deforge et al., 2001; Gewirtzman & Fodor, 1987; Huang & Menke, 2001). Such conditions have been shown to be a source of stress to homeless children (Huang, 1995; Huang & Menke, 2001) and associated with poorer physical (Roth & Fox, 1990) and psychosocial outcomes (Liff, 1991; Voegler, 2000). Shelter rules, such as not allowing older siblings to babysit, can undermine the school-aged child's development of independence, decision-making ability, and self-esteem (Percy, 1995). Such punitive and restrictive shelter rules further limit parental control and authority and contribute to feelings of a lack of control, hopelessness, and helplessness reported by parents. The loss of belongings that occurs upon shelter entry as children have to leave possessions behind has been cited as a stressor by homeless children

(Huang, 1995; Huang & Menke, 2001). At the shelter, perceived inadequacy of staff, negative staff attitudes, and barriers to access to services were reported to contribute to parental stress and to negatively impact parenting abilities. These findings are consistent with those from the literature related to shelter living (Torquati & Gamble, 2001). Parents' lack of trust in certain members of the shelter staff and other service providers may contribute further to their social isolation and reduced access to services.

Over one third of children were considered by their parents to be in need of services that they were not getting. Parents named facilitators to their access and use of health and community services many of which were reported as being absent from the shelter environment, for example access to a phone, information regarding shelter and community services, and the presence of supportive adults. The absence of these resources and a lack of money and transportation are consistent with barriers to services and care cited in the literature (Adkins & Fields, 1992; Berne et al., 1990; Efron et al., 1996; Riemer et al., 1995; Wood & Valdez, 1991). These barriers to service use noted by families points to the importance of informing families of community resources and of having services available and easily accessible in the shelters.

Protective Factors

In a population characterized by such risk factors, however, it also important to note the individual, family, and community factors with the potential to promote positive health outcomes for these children. Individual protective factors noted in children in this study include certain personality characteristics, cognitive and coping abilities, connections with the primary care giver, and a positive health status. Parental advocacy, family hopefulness, and parents who have positive expectations and goals for their children constitute family level protective factors. Community level protective factors include positive school experiences, safety and security in

the shelter, and shelter opportunities for peer and adult social support.

Individual level protective factors. At the individual level, several of the children's strengths identified by parents in this study are noted in the resilience framework to be protective factors. These include cognitive ability, helpfulness, social competence, and the use of self-help coping strategies, such as sports or other activities, as outlets for their stress. The cognitive abilities of children in the study were also evidenced by passing grades and awards received in school. Parents in this study expressed concerns for the negative changes in children's emotions and behavior. While this is a negative outcome of the shelter experience, behaviors such as aggression, shyness, and withdrawal may, in fact, also be coping behaviors, as previous studies of homeless children have suggested (Bassuk & Gallagher, 1990; Huang, 1995). The overall excellent to good rating of children's health status, while at risk, may be a protective factor according to the resilience framework.

Family level protective factors. Several familial protective factors were noted in this study. The finding that many of the children were perceived by their parents as coming to them to discuss concerns or worries may indicate a good relationship with at least one parent. Such close parent-child relationships have been noted in other studies of homeless children and are considered essential to children's coping (Liff, 1991). Approximately one quarter of parents had advocated through the school for their child to remain in the original school, recognizing this as among the child's needs. Good parenting and high levels of parental involvement with their children's school have been associated with healthy child outcomes such as school success (Miliotis et al., 1999). Policies to alleviate the hardship experienced by families in keeping their children in the same school are warranted and could include financial support through the provision of bus passes.

Parents reported strategies, including self-advocacy and assisting their children to maintain hope, which have been associated with resilience in homeless children (Liff, 1991). In suggesting that their concerns for their children could be alleviated upon leaving the shelter, parents may be indicating optimism and hope for the future. Parents' concerns and goals noted in this study are consistent with those of other parents of homeless children (Dail, 1990).

Community level protective factors. Many of these children exhibit protective factors at the community level. Positive school experiences as evidenced by good grades and occasional awards have been associated with resilience in the study framework. Parents reported that the shelter provided a source of social support to their children through other supportive adults. Social support, through family, peers, and others, is a frequently used coping behavior for homeless children (Huang, 1995; Huang & Menke, 2001). The opportunities for peer interaction available to children at the shelter may enhance positive social interaction and social competence, noted in the resilience framework to be associated with resilience in children. Over one fifth of parents reported that the shelter provided safety and security and the presence of other care providing adults for their children. Almost ten percent of the children had received awards in school, this combined with passing grades for the majority of children may be indicative of positive school experiences also noted in the framework to be protective factors for children.

Implications for Nursing

The results of this study provide guidance for nursing practice and the role of Advanced Practice Nurses (APNs), including public health nurses and Nurse Practitioners (NPs). Nurses at the general and advanced practice levels need to consider both risk and protective factors at each of the individual, family and community levels in their assessments related to children living in

shelters and their families. Nurses must recognise the complexity and multifaceted nature of these factors and their potential impact on the health of children living in shelters. Interventions must be designed that minimise the identified risks and build, strengthen, and maintain protective factors.

Public health nurses in shelters, schools, and other community settings are in excellent positions to identify these children and assess their risk and protective factors. With their knowledge of community resources, public health nurses can make appropriate referrals to community agencies in order to enhance protection and minimise risk. General practice public health nurses can work in collaboration with advanced practice nurses (APNs) and other community service providers to develop interventions, programs, and services to optimise the potential healthy development of children living in shelters. The complexity of the issues facing these children and their families requires that nurses participate in the development and implementation of programs that ensure multidisciplinary, multisectoral, comprehensive care that begins upon initial shelter entry or upon identification of a family's risk for homelessness and continues post shelter stay. The programs could provide services in the shelter and throughout the community.

The role of APNs combines the dimensions of expert care provider, care co-ordinator, educator, collaborator, researcher, and advocate (Hickey, 2000). The scant body of literature regarding the APN role with this population provides some direction in each of these role dimensions (Berne et al., 1990; Wagner & Menke, 1991; Wagner & Menke, 1992).

APNs, with their holistic view of health, knowledge and skill in complex and vulnerable client care, and knowledge of the determinants of health and family and child nursing, are well positioned as care co-ordinators within shelter and community-based programs (Wagner &

Menke, 1992). As such, the APN ensures co-ordination of many essential community services such as education, social services within and outside of the shelter setting, other health care providers, and such community based services as recreation and peer support programs.

Wagner and Menke (1992) suggest that the APN role in care co-ordination with this population involve direct care and advocacy dimensions. Thus, the APN is better able to develop a trusting collaborative relationship with the family and is in a position to effectively advocate for individual service needs. Participants in this study valued the presence of a supportive care provider. At the individual and family levels, an assessment of the child and family should be conducted upon entry to the shelter. This assessment would address such areas as child and family health status, reasons for homelessness, social support networks, and use and knowledge of community services. An individual plan of care would be developed by the family and the APN. Interventions that aim to enhance the social network of the child and family and educate the family as to shelter and community services should be undertaken. Parents need support to identify and build upon their children's strengths. Referrals could be made to health care providers and community agencies to assist families in their advocacy efforts aimed, for example, at securing housing or enrolling their children in school and other activities.

Advocacy at the community level could address an existing gap in service delivery. Currently, public health nurses are working in the shelters with children aged birth to six years through the Healthy Babies Healthy Children Program. Extending similar services to the school-aged population could help address some of the needs identified for this population through this study. Based on the findings of this study, changes are needed within the shelter system. The APN could assume a leadership role in the review and development of shelter policies to address such issues as the perceived inadequacy of staff, the lack of cleanliness and other living

conditions, and negative interpersonal relationships. The aim of the policies would be to minimise the risk factors and maximise the protective factors associated with shelter living to promote the optimal health of children living there. Together with shelter staff and management, the rules for shelter residents and guidelines for staff could be reviewed and analysed, to determine their value and impact on children and families.

Given the dearth of data related to this population, the APN could advocate for the revision of the current Homeless Individuals and Families Information System (HIFIS) database to include health and resilience related information. HIFIS is an electronic data management system that allows users to collect information on the homeless population in Canada (Government of Canada, 2002). Such a revision could facilitate the collection of valuable data about this population at local, regional, and national levels that could further inform health and resilience-promoting program and policy development as well as the identification of emerging issues.

However, the APN's service delivery and advocacy efforts aimed at the individual or family, either alone or in collaboration, will not be sufficient to address the needs of this population and build upon their strengths. This requires advocacy at the level of healthy public policy (HPP). HPP is a process of policy development and implementation, grounded in principles of public participation and intersectoral collaboration, that is intended to promote the health of populations (Glass & Hicks, 2000). The results of this study suggest several areas for policy development. These areas include: transportation services to enable students to remain in their own school and participate in after school activities, reducing the economic and other barriers to participation in community recreation and other social organisations, and enhancing the focus within the shelter on other issues facing children and their families rather than solely

the search for housing. As interventions and policies are developed to address the health needs, issues, and gaps in service delivery associated with homelessness, APNs must ensure that school-aged children, who comprise a unique, vulnerable, and often invisible subgroup of the homeless population, are not overlooked.

Additionally, nurses must also advocate for primary prevention efforts and policies that address the underlying issues of safe affordable housing, child and family poverty, family violence, unemployment, and literacy which contribute to the incidence of child and family homelessness and potentially exacerbate the issues facing this population. To this end, the APN must be knowledgeable of the policies impacting this population within multiple sectors. The nurse must understand such policies and work within the political systems to make changes where necessary. Efforts in this area would include lobbying politicians, participating on coalitions involving homeless families and their community service partners, educating the public and decision makers on the population and their issues in order to foster public support, and work with the media (Canadian Nurses Association, 2000).

Education efforts by the APN should also be aimed at other service providers as to the needs, issues, and strengths of this population and the importance of a non-judgmental respectful approach to client care and service delivery. Cultural and economic sensitivity training for these service providers could enhance their supportive role with these families. These service providers can be educated as to the importance of their role in fostering resilience and the healthy development of these children. For example, teachers, recreation specialists, and youth workers can be advised as to the significance of their role as an adult mentor. The education of various volunteer organisations as to the issues facing this population and the role of protective factors could result in financial and practical support from the community for efforts aimed at

minimising risk factors, promoting protective factors, and improving health outcomes for children living in shelters and their families. The APN can also participate in the education of other nurses as to the importance of the nursing role in working with this population. The complex nature of this population makes working with children living in shelters and their families an ideal practicum placement for nursing and medical students (DiMarco, 2000).

The APN could collaborate with schools and school boards to ensure services such as tutoring and extra curricular activities are provided by qualified personnel either on site at the shelter or in the schools through participation in a “School as the Hub of the Community” program. This project is a local community initiative being supported by the Ottawa Carleton District School Board [OCDSB], the City of Ottawa, and many local community organisations in which schools, health, recreation, and other sectors would be integral partners in the services provided to at risk children and their families (OCDSB, 2001).

Finally, in order to improve the health of children and their families who live in shelters, APNs must address gaps in knowledge and service delivery through research efforts. Several areas for future research have been identified during the course of this study and will be addressed later in this thesis.

Limitations of the Study

There were several limitations of this study that affect the generalisability and interpretation of the findings. The main limitation relates to the relatively small sample size. While the sampling of families occurred from three different sites, it was difficult to access families with children from the age of five to 14 for reasons that included the language limitations placed on the sample, the issues of trust and concerns for confidentiality expressed by

parents who declined participation, and the difficulty leaving and receiving messages at the two largest sites.

Participation in the study was voluntary. Parents who chose to participate may have been more motivated and concerned about the health of their children or conditions at the shelter than other families living at the shelter. As informed consent was not provided by parents who chose not to participate in the study, there was no way of determining the characteristics of this group to then compare with the study population. Thus, the extent to which they differed from those who were interviewed cannot be determined.

Measurement bias may have been introduced, as parents, many of whom reported high levels of stress or depression, may have been inaccurate in their perceptions regarding the levels of distress experienced by their children. Further, some inaccuracy may have been introduced as a result of variations in the lengths of stay, ability to recall, lack of knowledge of certain aspects of their children's health, or discomfort with the disclosure of certain information. Some parents may have misrepresented some of their responses to provide socially acceptable answers that could have impacted the study results. Such social response bias is more common with the use of interviews as data collection tools than with self-administered questionnaires (Woodward & Chambers, 1999). The use of no other information sources means that the data provided by the parents could not be verified. The lack of standardised instruments to assess health and educational status with this population may affect the accuracy of the findings.

Data were collected in different settings depending on the shelter and on the preference of the respondents. At one shelter, a quiet private area was set aside, although some participants preferred to be interviewed in their rooms or in the kitchen. In other shelters, the interviews were conducted in the family's room, often in the presence of the children and with frequent

interruptions. The timing of the study, which spanned the September 11, 2001 tragic events in the United States and their aftermath, may have impacted recruitment and the degree to which participants reported child and parent stress levels and racial issues. As well, this timing may have impacted recruitment during the first few weeks following the attacks. The limited time frame may have introduced some bias, as there may be seasonal variations in shelter use.

The length of shelter stay reported in this study is lower than average shelter stays reported in the literature, however this is attributable in part because it represents the length of stay at one point in time and not the entire length of shelter stay. This discrepancy poses some difficulty in comparing these results with those from previous studies.

Although comparisons were made with other published data, the lack of a comparison group means that the extent to which other variables such as poverty are associated with the findings cannot be determined. The dynamic nature of resilience and thus the complex interplay between the risk and protective factors that can change over time and with developmental stages will not be addressed through this one-time survey design. This study identified the presence of risk and protective factors commonly associated with resilient outcomes in children. However, the extent to which any of these factors is associated with health outcomes in this population of children was not able to be determined through this study.

Recommendations for Future Research

Findings from this descriptive study suggest several directions for future research. Nurses need to continue to conduct research on homeless children and their families in order to expand the body of nursing knowledge related to this population, to further develop a resilience framework for children living in shelters, and add to the body of knowledge regarding the role of APNs with this population of children and families.

In order for the findings to be more generalisable to the target population, the research should be expanded to include other children and their parents from the shelters such as those who speak languages other than English. The use of linguistic and cultural interpretation should be considered. Further research on the health status of the broader population of sheltered homeless children and their families could help to better inform program planners to target sub-groups for needed services.

A case control study, using a matched sample of low-income housed children and families, should be conducted to determine if the findings specifically related to homelessness rather than another factor such as poverty. Future research ought to assess previous episodes of homelessness. A single homeless episode may differ from chronic homelessness in its impact on child health. Longitudinal studies should be conducted to determine the long-term impacts on health and well being, allow for follow up after the shelter, follow changes in risk and protective factors over time, and determine processes involved in childhood resilience.

Studies using standardised tools to more accurately determine the physical, developmental, psychosocial, behavioural, and academic health status of these children should be undertaken. This would provide a more comprehensive assessment of the health of children living in shelters. Standardised tools could also be used to assess such variables as the social network of the child and family, parenting abilities, stress, coping skills, and parental mental health. This standardised testing could be supplemented by qualitative research as the findings derived from the open-ended questions provided valuable insights into the lives of these children and their parents.

Discrepancies have been noted by other researchers in the data obtained from parents and that from children on such factors as child mental health, stressors, and social networks (Voegler,

2000). Research efforts should be directed at the extent to which the findings, based on data collected from parents of homeless children, reflect the experiences of homeless children themselves. In fact, it is imperative to conduct research in which the children are the sources of the data collected. Creative means such as videotaping, the use of storytelling, or having the children document their experiences through art or photography may be explored in addition to or in place of the more traditional interviews and standardised testing. Further, the use of other data sources such as medical and academic records and teacher report can provide different information and perspectives. Behavioural observations of the children at the shelter and at school can also aid in the depth and validity of the data collected.

Future research could be conducted to explore the objectives of this study in other populations of homeless children such as those living in motels or hotels, those living with family or friends, and those who are on the verge becoming homeless. Research should be undertaken involving specific age groups of children living in shelters. In particular, adolescents living with their families in shelters are a sub-population that has received little attention in the literature. The focus on homeless youth has been primarily on those who are living independent of their families. Children of different ages have been noted in studies to respond differently to the homeless experience (Liff, 1999). It would be valuable to document these developmental differences more closely, especially in light of the dynamic nature of resilience which changes over time and with developmental stages (Stewart et al., 1997).

A larger sample size might allow for the deeper exploration of the correlations between variables and health outcomes not just the existence of them. Subsequently, the processes by which the variables impact resilience could be explored through multivariate analysis.

Collaboration between multiple additional agencies may be required to conduct a study with a

large enough sample size. Future research efforts could result in the development of a resilience framework specific to homeless children and their families that can then be tested empirically.

Conclusion

In summary, the findings from this study provide critical information about this population of children regarding their risk factors but also those factors with the potential to optimise their potential health and development. Consistent with resilience frameworks, even children with many serious risk factors have resources that may protect them from poorer health outcomes often deemed to be forgone conclusions for children in these circumstances. The results of this study have provided a balanced profile of children living in shelters that can be a first step in the development of effective programs and policies aimed at the optimization of health of homeless children and serve to inform future research related to this population.

References

- Acker, P., Fierman, A. H., & Dreyer, B. P., (1987). An assessment of parameters of health and nutrition in homeless children. American Journal of Diseases of Children, 141 (4), 388.
- Adkins, C. B., & Fields, J. (1992). Health care values of homeless women and their children. Family and Community Health, 15 (3), 20-29.
- Alperstein, G., Rappaport, C., & Flanigan, J. M. (1988). Health problems of homeless children in New York City. American Journal of Public Health, 78 (9), 1232-1233.
- Amery, J., Tomkins, A., & Victor, C. (1995). The prevalence of behavioural problems amongst homeless primary school children in an outer London borough: A feasibility study. Public Health, 109, 421-424.
- Anglin, B. F. (1998). What are the effects of homelessness on children socially, educationally, and emotionally? (Doctoral dissertation, The Union Institute, 1998).
- Bass, J. L., Brennan, P., Mehta, K. A., & Kodzis, S. (1990). Pediatric problems in a suburban shelter for homeless families. Pediatrics, 85 (1), 33-38.
- Bassuk, E. L., & Gallagher, E. M. (1990). The impact of homelessness on children. Child and Youth Services, 14 (1), 19-33.
- Bassuk, E. L., & Rosenberg, L. (1988). Why does family homelessness occur? A case control study. American Journal of Public Health, 78 (7), 783-788.
- Bassuk, E. L., & Rosenberg, L. (1990). Psychosocial characteristics of homeless children and children with homes. Pediatrics, 85 (3), 257-261.
- Bassuk, E., & Rubin, L. (1987). Homeless children: A neglected population. American Journal of Orthopsychiatry, 57 (2), 279-286.

Bassuk, E. L., Rubin, L., & Lauriat, A. S. (1986). Characteristics of sheltered homeless families. American Journal of Public Health, 76 (9), 1097-1100.

Bassuk, E. L., Weinreb, L. F., Dawson, R., Perloff, J. N., & Buckner, J. C. (1997). Determinants of behaviour in homeless and low-income housed preschool children. Pediatrics, 100 (1), 92-100.

Berne, A., Dato, C., Mason, D., & Rafferty, M. (1990). A nursing model for addressing the health needs of homeless families. Image, 22 (1), 8-13.

Berti, L. C., Zylbert, S., & Rolnitzky, L. (2001). Comparison of health status of children using a school-based health centre for comprehensive care. Journal of Pediatric Health Care, 15 (5), 244-250.

Bogard, C. J., McConnell, J. J., Gerstel, N., & Schwartz, M. (1999). Homeless mothers and depression: Misdirected policy. Journal of Health and Social Behaviour, 40, 46-62.

Buckner, J. C., & Bassuk, E. L. (1997). Mental disorders and service utilization among youths from homeless and low-income housed families. Journal of the American Academy of Child and Adolescent Psychiatry, 36 (7), 890-900.

Burns, N., & Grove, S. K. (1999). Understanding nursing research (2nd ed.). Toronto: W.B. Saunders.

Canada Mortgage and Housing Corporation [CMHC]. (2001). Children and youth in homeless families: Shelter spaces and services. Ottawa: Author.

Canadian Council on Social Development [CCSD]. (1999). The progress of Canada's children. Ottawa: Author.

Canadian Council on Social Development [CCSD]. (2001). The progress of Canada's children. Ottawa: Author.

Canadian Institute of Child Health [CICH]. (1991). The health of Canada's children: A CICH profile (2nd ed.). Ottawa: Author.

Canadian Institute of Child Health [CICH]. (2000). The health of Canada's children: A CICH profile (3rd ed.). Ottawa: Author.

Canadian Nurses Association. (2000). Nursing is a political act: The bigger picture. Nursing Now, May (8), [On-line]. Available: http://www.can-nurses.ca/pages/issuestrends/nrgnow/nrsg_is_a_political_act.htm

Child and Youth Health Network of Eastern Ontario. (2000). Challenges our children face: A report card on child poverty in Ottawa-Carleton. Ottawa: Author.

City of Toronto. (2000). The Toronto report card on homelessness 2000 [On-line]. Available: <http://www.city.toronto.on.ca/homelessness>

Cumella, S., Grattan, E., & Vostanis, P. (1998). The mental health of children in homeless families and their contact with health, education, and social services. Health and Social Care in the Community, 6 (5), 331-342.

Dail, P. W. (1990). The psychosocial context of homeless mothers with young children: Program and policy implications. Child Welfare League of America, 59 (4), 291-308.

Danesco, E. R., & Holden, E. W. (1998). Are there different types of homeless families? A typology of homeless families based on cluster analysis. Family Relations, 47 (2), 159-165.

Davey, T. L. (1998). Homeless children and stress: An empirical study. Journal of Social Distress and the Homeless, 7 (1), 29-40.

DeForge, V., Zehnder, S., Minick, P., & Carmon, M. (2001). Children's perceptions of homelessness. Pediatric Nursing, 27 (4), 377-383.

DiMarco, M. A. (2000). Faculty practice at a homeless shelter for women and children.

Holistic Nursing Practice, 14 (2), 29-37.

Drake, M. A. (1992). The nutritional status and dietary adequacy of single homeless women and their children in shelters. Public Health Reports, 107 (3), 312-319.

Edmonton Homelessness Count Committee. (2000). Homeless in Edmonton: A count of homeless persons in Edmonton [On-line]. Available:

http://www.gov.edmonton.ab.ca/comm_services/city_wide_services/housing

Efron, D., Sewell, J. R., Horn, M., & Jewell, F. (1996). Children in homeless families in Melbourne: Health status and use of health services. Medical Journal of Australia, 165 (2), 630-633.

Farrell, S., Aubry, T., Klodawsky, F., & Petty, D. (2000). Describing the homeless population in Ottawa-Carleton [On-line]. Available:

<http://www.uottawa.ca/academic/socsci/crcs/homeless>

Federal, Provincial and Territorial Advisory Committee on Population Health [ACPH]. (1999). Statistical report on the health of Canadians [On-line]. Available: http://www.hc-sc.gc.ca/hppb/phdd/report/stat/pdf/english/all_english.pdf

Fierman, A. H., Dreyer, B.P., Quinn, L., Shulman, S., Courtlandt, C. D., & Guzzo, R. (1991). Growth delay in homeless children. Pediatrics, 88 (5), 918-925.

Fox, S. J., Barnett, J., Davies, M., & Bird, H. R. (1990). Psychopathology and developmental delay in homeless children: A pilot study. Journal of the American Academy of Child and Adolescent Psychiatry, 29 (5), 732-735.

Gewirtzman, R., & Fodor, I. (1987). The homeless child at school: From welfare hotel to classroom. Child Welfare, 66 (3), 237-245.

Glass, H., & Hicks, S. (2000). Healthy public policy in health system reform. In M. J. Stewart (Ed.), Community nursing: Promoting Canadian's health (2nd ed., pp. 156-171). Toronto: W. B. Saunders.

Government of Canada. (2002). Homeless Individuals and Families Information System (HIFIS) Fact Sheet [On-line]. Available: http://www21.hrdc-drhc.gc.ca/hifis/index_e.html

Government of Ontario. (1991). Immunization of School Pupils Act [On-line]. Available: http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/90i01_e.htm

Graham-Bermann, S. A., Coupet, S., Egler, L., Mattis, J., & Banyard, V. (1996). Interpersonal relationships and adjustment of children in homeless and economically distressed families. Journal of Clinical Child Psychology, 25 (3), 250-261.

Hausman, B., & Hammen, C. (1993). Parenting in homeless families: The double crisis. American Journal of Orthopsychiatry, 63 (3), 358-369.

Health Canada. (1999). Healthy development of children and youth [On-line]. Available: <http://www.hc-sc.gc.ca/hppb/childhood-youth/spsc/pdf/child&vo.pdf>

Health Information Partnership – Eastern Ontario Region [HIP]. (2002). The health status of children and youth in Eastern Ontario [On-line]. Available: <http://www.hip.on.ca>

Herth, K. (1998). Hope as seen through the eyes of homeless children. Journal of Advances Nursing, 28 (5), 1053-1062.

Hickey, J. V. (2000). Advanced practice nursing at the dawn of the 21st century: Practice, education, and research. In J. V. Hickey, R. M. Ouimette, & S. L. Vengoni (Eds.), Advanced practice nursing: Changing roles and clinical applications (2nd ed., pp. 3-33). New York: Lippincott, Williams, & Wilkins.

Hodnicki, D. R., & Horner, S. D. (1993). Homeless mothers' caring for children in a

shelter. Issues in Mental Health Nursing, 14, 349-356.

Hu, D. J., Covell, R. M., Morgan, J., & Arcia, J. (1989). Health care needs for children of the recently homeless. Journal of Community Health, 14 (1), 1-8.

Huang, C. (1995). School-aged homeless sheltered children's stressors and coping behaviors: A thesis. (Masters thesis, Ohio State University, 1995).

Huang, C., & Menke, E. M. (2001). School-aged homeless sheltered children's stressors and coping behaviors. Journal of Pediatric Nursing, 16 (2), 102-109.

Kauppi, C., & Bélanger, J. (2001). Report on homelessness in Sudbury: Comparison of findings July, 2000 and January, 2002 [On-line]. Available:

<http://www.city.greatersudbury.on.ca/English/HealthSocial/HSSHomeless/hsshomeless.html>

Kelly, E. (2001). Assessment of dietary intake of preschool children living in a homeless shelter. Applied Nursing Research, 14 (3), 146-154.

Kirby, L. D., & Fraser, M. W. (1997). Risk and resilience in childhood. In M. W. Fraser (Ed.), Risk and resilience in childhood: An ecological perspective (pp. 10-33). Washington, DC: National Association of Social Workers.

Landow, R. W., & Glenwick, D. S. (1999). Stress and coping in homeless children. Journal of Social Distress and the Homeless, 8 (2), 79-93.

Leticq, B. L., Anderson, E. A., & Koblinsky, S. A. (1996). Social support of homeless and permanently housed low-income mothers with young children. Family Relations, 45, 265-272.

Leticq, B. L., Anderson, E. A., & Koblinsky, S. A. (1998). Social support of homeless and housed mothers: A comparison of temporary and permanent housing arrangements. Family Relations, 47 (4), 415-421.

Liff, S. R. (1991). Homeless: Perceptions and coping strategies of mothers and children living in one temporary urban shelter. (Doctoral dissertation, New York University, 1990).

LoBiondo-Wood, G., & Haber, J. (1998). Nursing research: Methods, critical appraisal, and utilization, 4th ed. Toronto: Mosby.

Masten, A. S., Miliotis, D., Graham-Bermann, S. A., Ramirez, M., & Neeman, J. (1993). Children in homeless families: Risk to mental health and development. Journal of Consulting and Clinical Psychology, 61 (2), 335-343.

Mayer, R. R., & Greenwood, E. (1980). The nature of policy research. In The design of social policy research (pp. 41- 66). New Jersey: Prentice-Hall.

Mayor's Homelessness Action Task Force [MHATF]. (1999). Taking responsibility for homelessness: An action plan for Toronto. Toronto: City of Toronto.

Menke, E. M., & Wagner, J. D. (1997). A comparative study of homeless, previously homeless, and never homeless school-aged children's health. Issues in Comprehensive Pediatric Nursing, 20, 153-173.

Miles, M. B., & Huberman, A. M. (1994). An expanded sourcebook: Qualitative data analysis (2nd ed.). Thousand Oaks: Sage.

Miliotis, D., Sesma, A., & Masten, A. S. (1999). Parenting as a protective process for school success in children from homeless families. Early Education and Development, 10 (2), 111-133.

Miller, D. S., & Lin, E. H. B. (1988). Children in sheltered homeless families: Reported health status and use of health services. Pediatrics, 81 (5), 668-673.

Ministry of Health and Long-Term Care. (2000). Taking action on asthma: Report of the Chief Medical Officer of Health [On-line]. Available:

http://www.gov.on.ca/health/english/pub/pubhealth/asthma/cmoh_asthma.html

Ottawa-Carleton District School Board [OCDSB]. (2001). The school as the hub of the community [On-line]. Available:

http://www.ocdsb.edu.on.ca/Board/Community_Development/Resources/Resource2.htm

Ottawa-Carleton Health Department. (1997). Child and family health status report.

Ottawa: Author.

Parker, R. M., Rescorla, L. A., Finkelstein, J. A., Barnes, N., Holmes, J. H., & Stolley, P. D. (1991). A survey of the health of homeless children in Philadelphia shelters. American Journal of Diseases in Childhood, 145, 520-526.

Percy, M. S. (1995). Children from homeless families describe what is special in their lives. Holistic Nursing Practice, 9 (4), 24-33.

Peterson, R. A. (2000). Constructing effective questionnaires. Thousand Oaks, CA: Sage.

Phillips, M. N., DeChillo, N., Kronenfeld, D., & Middleton-Jeterr, V. (1989). Homeless families: Services make a difference. Social Casework: The Journal of Contemporary Social Work, 69(1), 48-53.

Polit, D. F., & Hungler, B. P. (1999). Nursing research: Principles and methods, 6th ed. Philadelphia: Lippincott.

Rafferty, Y. (1991). Developmental and educational consequences of homelessness on children and youth. In Homeless Children and Youth: A new American dilemma. J. H. Kryder-Coe, L. M. Salamon, & J. M. Molnar (eds). New Brunswick: Transaction Publishers.

Region of Ottawa-Carleton [ROC]. (1999). Homelessness in Ottawa-Carleton. Ottawa, ON: Author.

Rescorla, L., Parker, R., & Stolley, P. (1991). Ability, achievement, and adjustment in

homeless children. American Journal of Orthopsychiatry, 61 (2), 210-220.

Rew, L., Taylor-Seehafer, M., Thomas, N. Y., & Yockey, R. D. (2001). Correlates of resilience in homeless adolescents. Journal of Nursing Scholarship, 33 (1), 33-40.

Riemer, J. G., Van Cleve, L., & Galbraith, M. (1995). Barriers to well child care for homeless children under age 13. Public Health Nursing, 12 (1), 61-66.

Riley-Eddins, E. A. (1995). Health status of sheltered homeless families: An ethnic-cultural assessment. Journal of Multicultural Nursing and Health, 1 (4), 16-22.

Roberts, G. A., & Burke, S. O. (1989). Nursing research: A quantitative and qualitative approach. Boston: Jones and Bartlett.

Rocha, C., Johnson, A. K., McChesney, K. Y., & Butterfield, W. H. (1996). Families in Society: The Journal of Contemporary Human Services, 77 (1), 50-57.

Roth, L., & Fox, E. R. (1990). Children of homeless families: Health status and access to health care. Journal of Community Health, 15 (4), 275-284.

Rubin, D. H., Erickson, C. J., Agustin, M. S., Cleary, S. D., Allen, J. K., & Cohen, P. (1996). Cognitive and academic functioning of homeless children compared with housed children. Pediatrics, 97 (3), 289-294.

Shinn, M., & Weitzman, B. C. (1996). Homeless families are different. In J. Baumohl (Ed.), Homeless in America (pp. 109-122). Phoenix, AR: Oryx.

Social Planning Council of Ottawa–Carleton [SPCOC]. (2000). Homelessness mapping project. Ottawa: Author.

Social Planning Council of Winnipeg. (2001). A community plan on homelessness and housing in Winnipeg [On-line]. Available: http://www.spcw.mb.ca/reference/doc_complan.pdf

Stewart, M., Reid, G., & Mangham, C. (1997). Fostering resilience in children. Journal of

Pediatric Nursing, 12 (1), 21-31.

Sullivan, L. (1997). The Impact of Homelessness on Children. New York: Garland.

The City of Calgary. (1998). Homeless count, 1998 [On-line]. Available:

<http://www.gov.calgary.ab.ca/community/publications/hcensus98/index.html>

Timberlake, E. M., & Sabatino, C. A. (1994). Homeless children: Impact of school attendance on self-esteem and loneliness. Social Work in Education, 16 (1), 9-20.

Torquati, J. C., & Gamble, W. C. (2001). Social resources and psychosocial adaptation of homeless school aged children. Journal of Social Distress and the Homeless, 10 (4), 305-321.

Voegler, M. E. (2000). Risk and protective factors associated with social resilience in homeless youth. (PhD thesis, University of North Carolina, Chapel Hill, 2000).

Vostanis, P., Cumella, S., Briscoe, J., & Oyebode, F. (1996). A survey of psychosocial characteristics of homeless families. European Journal of Psychiatry, 10 (2), 108-117.

Vostanis, P., Grattan, E., & Cumella, S. (1998). Mental health problems of homeless children and families: Longitudinal study. British Medical Journal, 316, 899-902.

Vostanis, P., Grattan, E., Cumella, S., & Winchester, C. (1997). Psychosocial functioning of homeless children. Journal of the American Academy of Child and Adolescent Psychiatry, 36 (7), 881-889.

Wagner, J., & Menke, E. (1991). The depression of homeless children: A focus for nursing intervention. Issues in Comprehensive Pediatric Nursing, 14, 17-29.

Waldron, A., Tobin, G., & McQuaid, P. (2001). Mental health status of homeless children and their families. Irish Journal of Psychological Medicine, 18 (1), 11-15.

Weinreb, L., Goldberg, R., Bassuk, E., & Perloff, J. (1998). Determinants of health and service use patterns in homeless and low-income housed children. Pediatrics, 102, 554-562.

Weinreb, L., Goldberg, R., & Perloff, J. (1998). Health characteristics and medical service use patterns of sheltered homeless and low-income mothers. Journal of General Internal Medicine, *13*, 389-397.

Whitman, B. Y., Accardo, P., Boyert, M., & Kendagor, R. (1990). Homelessness and cognitive performance in children: A Possible link. Social Work, *35* (6), 516-519.

Wiley, D. C., & Ballard, D. J. (1993). How can schools help children of homeless families? Journal of Pediatric Health Care, *3*, 194-199.

Wood, D., & Valdez, B. (1991). Barriers to medical care for homeless families compared with housed poor families. American Journal of Diseases in Childhood, *145*, 1109-1115.

Wood, D., Valdez, B., Hayashi, T., & Shen, A. (1990). Health of Homeless Children and Housed, Poor Children. Pediatrics, *86* (6), 858-866.

Woodward, C. A., & Chambers, L. W. (1999). Guide to questionnaire construction and question writing. Ottawa: Canadian Public Health Association.

Zima, B. T., Bussing, R., Bystritsky, M., Widawski, M. H., Belin, T. R., & Benjamin, B. (1999). Psychosocial stressors among sheltered homeless children: Relationship to behaviour problems and depressive symptoms. American Journal of Orthopsychiatry, *69* (1), 127-133.

Zima, B. T., Bussing, R., Forness, S. R., & Benjamin, B. (1997). Sheltered homeless children: Their special eligibility and unmet need for special education evaluations. American Journal of Public Health, *87* (2), 236-240.

Zima, B. T., Wells, K. B., Benjamin, B., & Duan, N. (1996). Mental health problems among homeless mothers: Relationship to service use and child mental health problems. Archives of General Psychiatry, *53*, 332-338.

Zima, B. T., Wells, K. B., & Freeman, H. E. (1994). Emotional and behavioural problems and severe academic delays among sheltered homeless children in Los Angeles. American Journal of Public Health, 84 (2), 260-264.

Appendix A

Description of Three Family-Serving Shelters in Ottawa

Appendix A: Description of Three Family-Serving Shelters in Ottawa

Family Shelter	Description
Carling Family Shelter	<ul style="list-style-type: none"> • Run by the City of Ottawa • Provides temporary housing for homeless families. • Former 1970's hotel • Maximum of 208 beds available. <ul style="list-style-type: none"> ○ 36-44 units that can house 150+ people ○ 14 units (one floor) devoted to women fleeing abuse with their children ○ shared kitchens ○ bathroom in each family bedroom • Services include emergency assistance, counseling, referrals, and advocacy. • Served 250 families consisting of 291 adults with 555 children (1998) • Funded by City of Ottawa, Government of Ontario, and donations
Forward Family Shelter	<ul style="list-style-type: none"> • Run by the City of Ottawa • Provides secure temporary shelter in a supportive environment to homeless families • Former school (former classrooms divided into three family bedrooms) • No maximum bed number <ul style="list-style-type: none"> ○ 21 units which can house 100+ people ○ shared kitchen and bathrooms • Services provided at the shelter include assistance in obtaining appropriate housing • Served 125 families consisting of 163 adults with 317 children (1998) • Funded by City of Ottawa
YMCA/YWCA of Ottawa Carleton	<ul style="list-style-type: none"> • Run by YMCA/YWCA • Primary clientele of this shelter is single homeless adults and youth, but provides emergency shelter overflow for families • Hostel-style <ul style="list-style-type: none"> ○ 27 rooms (2 of which are available for families) ○ shared bathrooms ○ no kitchen ○ cafeteria on first floor • Funded by the City of Ottawa, per diem rates, Children's Aid Society, CSC, the United Way, and rental income

Adapted from: Region of Ottawa-Carleton. (2000). The Community Action Plan to Prevent and End Homelessness in Ottawa-Carleton: Update 2000. Ottawa: Region of Ottawa-Carleton.

Appendix B
Letter of Invitation



Université d'Ottawa • University of Ottawa

Faculté des sciences de la santé
Ecole des sciences infirmières

Faculty of Health Sciences
School of Nursing

Dear Parent or Guardian,

I am a graduate student in nursing at the University of Ottawa. I would like to understand more about the health of children living in shelters and the things that affect it.

I invite you to participate in this study because your experience is important. If you agree to be part of this study, your interview with me will take about 45-60 minutes. The interview will be scheduled at a time that is convenient to you and at your shelter or another time and place that are good for you.

No names will be used to identify the information collected during this study. The results will be reported so that no one individual can be identified. The information collected will be kept in a locked place and will be viewed only by myself, and my supervisor, Dr. Denise Alcock. Identifying information will not be used in any written or verbal report or at conferences and will not be released unless required by law, as is required in the case of abuse. Identifying information will be destroyed, by shredding, after the study is complete and my thesis defended and published. After the study is done, I would be pleased to share a summary of the results with you.

This study may not directly benefit you or your children but it is hoped that the report based on this study will provide decision-makers with information about the health of children living in shelters and thus help other children and families in similar situations in the future.

If you have any questions or concerns, please contact me or my supervisor. I can be reached at 613 841-7665 and Dr Alcock is available at 613 562-5432. Thank you for considering participation in this study. You may withdraw at any time, if you change your mind, or refuse to answer a particular question.

If you are willing to participate, please fill out the attached form and leave it in the envelope provided at the information desk.

Yours truly,

Paula Robeson RN, BN

451, ch. Smyth
Ottawa (Ontario) K1H 8M5 Canada

451 Smyth Rd.
Ottawa, Ontario K1H 8M5 Canada

(613) 562-5473 • Téléc./Fax (613) 562-5443

Appendix C
Consent Form



Université d'Ottawa • University of Ottawa

Faculté des sciences de la santé
École des sciences infirmières

Faculty of Health Sciences
School of Nursing

I, _____, am willing to participate in the research conducted by Paula Robeson, a graduate student in the Faculty of Health Sciences, School of Nursing, University of Ottawa. The project is under the supervision of Dr. Denise Alcock. The purpose of the research is to learn about the health and health needs of children living in shelters. I understand that I will be interviewed and asked questions about my child's/children's health, factors that influence their health, and where and from whom we receive health and community services. My participation involves a face-to-face 45 to 60 minute interview with Paula Robeson. The session has been scheduled for _____.

I understand that the information I give will be used only for this study and that my confidentiality will be respected. This information will always be locked in a secure place, and only the researcher and her supervisor will have access to it. No information that would identify me or my child(ren) such as our names and locations will be mentioned in any written, verbal, or published report of this research. No information that could identify me or my child(ren) will be disclosed except where required by law such as in the case of a disclosure of abuse. The information will be destroyed by shredding after the study is completed and the thesis defended and published. After the study is done, I can receive a summary of the results.

I understand that my participation is voluntary, that I am free to withdraw from the project at any time, before or during an interview and I can skip any question that I do not want to answer or that makes me uncomfortable. Withdrawal from the research project or not answering a question will in no way affect the services that my child(ren) or I now receive. I understand that there may be no direct benefits to my child(ren) or myself, but that the information I provide may be helpful to decision-makers and thus help other children and families in similar situations in the future.

This project has been approved by the Human Research Ethics Committee at the University of Ottawa and by the City of Ottawa and the YMCA. Any information, requests, or complaints about the ethical conduct of the project may be addressed to the relevant Research Ethics Boards or by calling the Protocol Officer for Ethics in Research, Lise Frigault at (613) 562-5800, extension 1787.

There are two copies of the consent form, one of which I may keep. If I have any questions about the conduct of the research project, I may contact the researcher or her supervisor at the numbers indicated below.

Researcher's signature:

Name:

Date:

Research Subject's signature:

Name:

Date:

- I wish to receive a summary of the findings of this research which will be available about June 15, 2002 by contacting Paula Robeson at 613 841-7665 or Dr. Denise Alcock at 613 562-5432.

451, ch. Smyth
Ottawa (Ontario) K1H 8M5 Canada

451 Smyth Rd.
Ottawa, Ontario K1H 8M5 Canada

(613) 562-5473 • Téléc./Fax (613) 562-5443

Appendix D
Questionnaire

Appendix G: Questionnaire

Date: _____

Participant's Study # _____

A Profile of Children Living in Shelters: Parents' perspectives on their children's health and the factors that influence it

CHILD(REN)

I am going to ask you questions about your child/children's health, school performance, and your access to basic resources.

1. How many children do you have?
2. How many live with you?
3. Tell me their names, ages, and whether they are a boy or a girl.

	Child 1	Child 2	Child 3	Child 4	Child 5
Child's name					
Age					
Gender					

For the remainder of the interview, we will be focusing on your children who are 5-14 years of age and currently living with you.

4. How would you describe your child(ren)'s health?

Child	Child 1	Child 2	Child 3	Child 4	Child 5
Excellent to very good					
Good					
Fair to Poor					

5. Has(have) your child(ren) had any of the following:

Child	Child 1	Child 2	Child 3	Child 4	Child 5
Ear infections					
Muscle problems					
Stomach pain					
Diarrhea					
Skin rashes					
Headaches					
Other infections (e.g., lung, urinary tract)					
Asthma					
Allergies					
Other					

6. Is(Are) your child(ren) on any medications? What are they? What for?

Child	Child 1	Child 2	Child 3	Child 4	Child 5
Medications					
For?					

7. Has(have) your child(ren)'s health changed since have been living in a shelter?

Child	Child 1	Child 2	Child 3	Child 4	Child 5
Change in status (Y/N)					
In what way?					

8. How long have you and your child(ren) lived in this shelter?

- Less than one week ago
- 8-14 days
- 15-30 days
- 1-3 months
- 4-6 months
- 7-12 months
- 13 months-2 years
- over 2 years

9. Has(Have) your child(ren)'s sleep patterns changed since coming to the shelter?

Child	Child 1	Child 2	Child 3	Child 4	Child 5
Sleep changed (Y/N)					
How?					
Usual amount of sleep?					

The next few questions relate to your child/children's diet.

10. Do you have any concerns about your child(ren)'s diet? What are those concerns?

Child	Child 1	Child 2	Child 3	Child 4	Child 5
Dietary concerns (Y/N)					
Concerns					

11. Please rate the cooking facilities here at the shelter.

Excellent to very good	
Good	
Fair to Poor	

Comments:

12. What did your child(ren) have to eat in the past day?

I will now ask you a few questions about your child's development.

13. Do you have concerns about your child(ren)'s ability to learn and do the things that other children his/her(their) age do? (probe for language, reading, social development, cognitive development)

Has(have) your child(ren)'s ever seen a professional because of concerns about development?

Child	Child 1	Child 2	Child 3	Child 4	Child 5
Concerns re development (Y/N)					
Nature of Concerns					
Assessed (Y/N)					
By whom?					
When (approximate date)					
Results					

I am interested in your child(ren)'s emotional health?

14. Do you have any concerns about your child(ren)'s emotional health and behaviour?
 Probe for worries, happy/sad, self-injury, activity level, anger, aggressiveness, fears.

Has your child seen a professional for these?

Child	Child 1	Child 2	Child 3	Child 4	Child 5
Emotional concerns (Y/N)					
Seen anyone? (Y/N)					
Behavioural Concerns (Y/N)					
Seen anyone? (Y/N)					

The next few questions are about your child's school experiences.

15. Did your child(ren) attend nursery school or preschool?

Child	Child 1	Child 2	Child 3	Child 4	Child 5
Nursery/pre school Y/N					

16. Does (do) your child(ren) attend school?

If no, School leaving age/grade?

Child	Child 1	Child 2	Child 3	Child 4	Child 5
Attends school (Y/N)					
School leaving age/grade					

17. What grade is(are) your child(ren) in?

Child	Child 1	Child 2	Child 3	Child 4	Child 5
Grade					

18. Has (have) your child(ren) repeated any grades?

Which one(s)?

Child	Child 1	Child 2	Child 3	Child 4	Child 5
Repeated grade (Y/N)					
Grade(s) repeated					

19. Has(have) your child(ren) skipped any grades?

Which ones?

Child	Child 1	Child 2	Child 3	Child 4	Child 5
Skipped grades (Y/N)					
Grade(s) skipped					

20. What is (are) your child(ren) best at in school?

Child	Child 1	Child 2	Child 3	Child 4	Child 5
Best at					

21. What kind of grades does(do) he/she(they) get?

Has your housing situation affected his/her(their) grades? If so, how?

Child	Child 1	Child 2	Child 3	Child 4	Child 5
As					
Bs					
Cs					
Ds					
Other					
Grades affected (Y/N)					
How?					

22. Is(are) he/she(they) receiving help in school?

Child	Child 1	Child 2	Child 3	Child 4	Child 5
Received help					
For what?					

23. How does(do) your child(ren) get to school?

24. Where is(are) the school(s) located?

- In old neighbourhood?
- In shelter neighbourhood?
- Other? _____

25. Number of schools attended by each child(ren) in past 12 months?

Child	Child 1	Child 2	Child 3	Child 4	Child 5
Number of schools					

The next few questions will be about your child(ren)'s support system.

26. Does(do) your child(ren) come to you with his/her(their) feelings, problems, or worries?

Child	Child 1	Child 2	Child 3	Child 4	Child 5
Discusses problems or worries with parent (Y/N)					

27. Does(do) your child(ren) have close friends?

Child	Child 1	Child 2	Child 3	Child 4	Child 5
Close friends (Y/N)					
# Close friends					
Length of time since last contact					

28. Do you approve of these friends?

Child	Child 1	Child 2	Child 3	Child 4	Child 5
Approval of friends (Y/N)					
Why? or Why not?					

29. Has(have) your child(ren) made friends while being at the shelter?

Child	Child 1	Child 2	Child 3	Child 4	Child 5
New friends at shelter (Y/N)					

30. Do you approve of these friends?

Child	Child 1	Child 2	Child 3	Child 4	Child 5
Approval of friends (Y/N)					
Why? or Why not?					

31. Who are the adults who are most important to your child(ren)?

Child	Child 1	Child 2	Child 3	Child 4	Child 5
Important adults					
Nature of relationship					

The next few questions relate to life here at the shelter.

32. List three things that you like most about the shelter for your children.

- 1.
- 2.
- 3.

33. List three things that you like least about the shelter for your children.

- 1.
- 2.
- 3.

34. Do you think that living in the shelter has affected your child(ren)?

Yes, positively Explain

Yes, negatively Explain

No Explain

35. Is there a place that your child(ren) can do homework in the shelter?

Yes

No

36. Is it appropriate?

Yes

No

37. Are your living arrangements here at the shelter satisfactory?

Yes

No

Comments

38. Are there places where your child(ren) can play at the shelter or in the shelter neighbourhood?

Yes Describe

No

The next few questions relate to health and community services.

39. Who provides health care for your children?

Do you have a Family doctor?

A nurse?

Or someone else who you see for their health?

40. What other community services do your children use? (probe for health, social worker, food bank, other community services)

Which ones are available to you here?

Where would you go if these were not available to you here?

41. Has(have) you child(ren) ever visited the emergency room?

For what?

When was the last visit?

Child	Child 1	Child 2	Child 3	Child 4	Child 5
Emergency visit (Y/N)					
Reason					
Approximate dates					

42. Has(have) your child(ren) ever been admitted to hospital?

Child	Child 1	Child 2	Child 3	Child 4	Child 5
Admitted (Y/N)					
Approximate dates					
Reasons for admission					

43. When were his/her(their) immunisations last received and from whom?

Child	Child 1	Child 2	Child 3	Child 4	Child 5
From whom Immunisations last received					
Approximate dates					

44. When did your child(ren) last see a dentist or dental hygienist?

Child	Child 1	Child 2	Child 3	Child 4	Child 5
Dental insurance (Y/N)					
Last dental visit					
Have a dentist? (Y/N)					

45. Are there any services that you feel your child(ren) need(s) that he/she(they) is(are) not getting?

- Yes For what? Why not?
 No

46. Name three things you find most helpful to you in accessing and using services?

- 1.
- 2.
- 3.

47. Name the top three things that are barriers to your access to and use of services?

- 1.
- 2.
- 3.

48. Is(are) your child(ren) involved in after school child care? Who takes care of him/her(them) after school?

Child	Child 1	Child 2	Child 3	Child 4	Child 5
After school care (Y/N)					
By whom					

49. Is(are) your child(ren) involved in any extra curricular activities? (e.g., sports, arts, Boys and Girls Club, YMCA/YWCA, cubs or brownies, etc)

Child	Child 1	Child 2	Child 3	Child 4	Child 5
Extra curricular activities					
Which ones					

50. What programs/activities are available to your child(ren) at the shelter?

51. Which ones does he/she(they) take part in?

Child	Child 1	Child 2	Child 3	Child 4	Child 5
Shelter activities available					
Shelter activities taken part in					

52. Name three of your child(ren)'s strengths?

53. What are your major concerns about your child(ren)?

54. What can you or your child(ren) do about these concerns?

55. List your top three goals for your child(ren).

1.

2.

3.

The next few questions are about you and the rest of your family.

56. Gender

Female

Male

57. Age _____

58. Relationship to the Child(ren) _____

59. Marital Status

Single

Common law

Married

Divorced

Separated

Widowed

60. Who else lives with you and your child(ren)? (probe for relationships to respondent and child(ren))

61. Highest grade level of education completed

- Grade _____ School leaving age?
- Post secondary
- College
- Vocational school Vocation
- University
- Completed a degree
- Completed a graduate degree

62. How much money does your family receive in a month, year? (Probe for source)

63. Employment status

- | | |
|--|--|
| <input type="checkbox"/> Working full time
At what? | <input type="checkbox"/> Unemployed
Reasons? |
| <input type="checkbox"/> Working part time
At what? | <input type="checkbox"/> Looking after family |
| <input type="checkbox"/> Unemployed but seeking work | <input type="checkbox"/> Full time education or training
To become? |

64. Country of Origin

65. Language most frequently spoken at home

- English
- French
- Other: _____

66. Length of time in Canada

67. How many places have you and your child(ren) lived in the 12 months before coming to this shelter? Where were they?

68. What were your reasons for coming to the shelter?

69. What would you like to add to make sure that I understand your child(ren)'s circumstances?

Thank you very much for participating. It was a pleasure to have met you and your family!

Appendix E

Research Ethics Board Letter of Ethical Approval



Université d'Ottawa • University of Ottawa

UNIVERSITÉ D'OTTAWA / UNIVERSITY OF OTTAWA

HEALTH SCIENCES AND SCIENCE RESEARCH ETHICS BOARD

CERTIFICATION OF ETHICAL APPROVAL

This is to certify that the University of Ottawa Health Sciences and Science Research Ethics Board (REB) has examined the Application for Ethical Approval for the research project *Developing a profile of children living in shelters: Parents' perspectives on their children's health and factors that influence it (File H06-01-07)* submitted by Paula M. Robeson, and supervised by Denise Alcock of the School of Nursing at the University of Ottawa. The REB found that this project met appropriate ethical standards as outlined in the Tri-Council Policy Statement and in the Procedures of the University of Ottawa Research Ethics Boards and accordingly gave it a Category 1a (Approval). This certification is valid for one year from the date indicated below.

Lise Frigault

Protocol officer for ethics in research,
for the Chair of the Health Sciences and Science REB
Julian Roberts

July 5, 2001

Date

FILE NUMBER: H06-01-07

Appendix F

Letter of Approval from the City of Ottawa

July 25, 2001

Paula M. Robeson
123 Wendler Terrace
Orleans, Ontario
K1E 3R2

Re: Your research project: Developing a profile of children living in shelters: Parents' perspectives on their children's health and factors that influence it.

Dear Ms. Robeson:

Thank you for forwarding the Certification of Ethical Approval for your research project from the University of Ottawa Health Sciences and Science Research Ethics Board.

We are pleased that you are ready to proceed with your study. To this end, we offer permission for you to invite parents in each of our two shelters, Forward and Carling, to participate in your study. As well, we are offering the support of the supervisors of these shelters to access families.

Please contact Andrea McCoy-Naperstkow at Carling or Monique Cook at Forward to make suitable arrangements.

We know that there is a scarcity of data on the population of the emergency shelters. Therefore, we are appreciative of your project, which will eventually help with meaningful strategic planning of shelter services.

Yours truly



Constance Woloschuk
Manager, Residential Services
Housing Branch, People Services

Cc: Andrea McCoy-Naperstkow
Monique Cook

Shaping our future together
Ensemble, formons notre avenir

City of Ottawa
www.city.ottawa.on.ca

Ville d'Ottawa
www.ville.ottawa.on.ca



Appendix G

Letter of Approval from the YMCA/YWCA



- Midtown Central Y Centre
Centre Y Midtown central
180 Argyle, R2P 1B7
Tel: 788-5000 Fax/ téléc. : 788-5052
- Barrhaven Y Centre
Centre Y de Barrhaven
99 Barr - B100, K1P 6M9
Tel: 237-9331 Fax/ téléc. : 237-2230
- Statenheim Y Residence
Résidence Statenheim de Y
Short/long-term and emergency housing
Hébergement de courte/longue durée et d'urgence
180 Argyle, R2P 1B7
Tel: 237-1320 Fax/ téléc. : 788-5095
- Carletonplace Y Centre
Centre Y de Carletonplace
200 Locant. R2A 4C4
Tel: 729-7131 Fax/ téléc. : 788-5073
- Y Child Care Centre
Centre de garderie de Y
Tel: 788-5095/788-5004 Fax/ téléc. : 788-5095
- Y Community Centre
Centre d'activités de Y
Tel: 788-5001 Fax/ téléc. : 788-5051
- Volunteer Leadership Development Program
Programme de formation à l'intention
des conseils d'administration
BoardWALK/C.A. MARCHÉ
Tel: 237-1320 ext: 4024 Fax/ téléc. : 788-5051
- Bilingual Programs
Programmes bilingues
Playcare
Amusements
Day Cares
Camps de jour
Y Enterprise Centre
Centre d'entreprises de Y
Volunteer Leadership Development Program
Programme de formation à l'intention
des conseils d'administration
BoardWALK/C.A. MARCHÉ
Family Violence Counselling
Counselling sur la violence familiale
English as a Second Language
Anglais langue seconde
Regional Health and Wellness Centre
Centre régional de santé et bien-être
Volunteer Opportunities
Bénévoles
Sponsorship - Financial Assistance
Commanditaires - Aide financière
Youth Job Bank
Banque d'emplois pour les jeunes
Community Youth Programs
Programmes communautaires pour les jeunes
Youth Emergency Housing
Hébergement d'urgence pour les jeunes
Youth Drop-in
Centre d'activités pour les jeunes
Youth Employment
Emploi pour les jeunes
Y Child Care Centre
Centre de garderie de Y
Child Youth and Family Development
Développement de l'enfant, des jeunes
et de la famille
International Education
Éducation internationale
Leadership Training
Formation en leadership
Community Programs
Programmes communautaires
Camping and Outdoor Education
Camping et éducation en plein air
Short/Long-Term and Emergency Housing
Hébergement de courte/longue durée
Youth Activity Centre
Centre d'activités pour les jeunes
The Men's Project
Le projet des hommes
Housing Support
Soutien au niveau de l'hébergement
Annual Giving Program
Programme annuel de financement

August 16 2001

Ms. Paula Robeson
University of Ottawa

Ms. Robeson:

The National Capital Region YMCA-YWCA wishes to indicate its support for your Masters of Science in Nursing thesis related to the health of children living in shelters "Developing a profile of children living in shelters: Parents' perspectives on their children's health and factors that influence it".

The number of families with children living in poverty and accessing emergency shelters is disturbingly high. Developing an understanding of the effects of this reality on the children's well being could have a significant impact on both service delivery, political lobbying and public education.

We look forward to working with you in achieving the outcomes of this research project.

Respectfully,

Rob Boyd, Manager
Housing and Support Services
The National Capital Region YMCA-YWCA

We Build Strong Kids... Strong Families... Strong Communities.
Dévoué au mieux-être des enfants... des familles... des communautés.

The Y is a charity... Your donations and bequests to support our ongoing activities are greatly appreciated. Call 237-1320 ext. 5035.
Le Y est un organisme de charité. Vos dons et legs à l'appui de nos activités sont très appréciés. Appelez 237-1320 poste 5035.

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Agence membre Carlaide/United Way Ottawa-Carleton.