Changing Attitudes Toward Homeless People

A Curriculum Evaluation

David Buchanan, MD, Louis Rohr, MD, Laura Kehoe, MD, MPH, Susan B. Glick, MD, Sharad Jain, MD

We assessed the impact of a 2-week required rotation in homeless health care on primary care residents' attitudes toward homeless people. Attitudes were assessed before and after the course using the Attitudes Toward Homelessness Inventory (ATHI), an instrument previously validated among undergraduate students. Attitude scores on the ATHI improved from 46 to 52 (range of possible scores 11 to 66; *P* = .001). The ATHI subscales showed, after the course, that residents had a greater belief that homelessness had societal causes and felt more comfortable affiliating with homeless people. After the course, residents also reported an increased interest in volunteering with homeless populations on an anonymous survey.

KEY WORDS: **homeless persons; attitude of health personnel; medical education; curriculum; social medicine.**
J GEN INTERN MED 2004;19:566–568.

Positive attitudes are necessary to provide appropriate care for impoverished patients. They can also act as important first steps in fostering future careers in the care of homeless and other underserved populations. A previous study documented that medical students who possess positive attitudes toward homeless patients are more likely to volunteer in a shelter-based clinic.[1] Although it is important to understand how attitudes correlate with volunteerism, it is also important to know whether and how these attitudes can be changed. However, we are unaware of any intervention targeted toward physicians in training that has documented an improvement in attitudes toward homeless people. Homeless people often account for over one-quarter of inpatients in Veterans Affairs and public hospitals.[2, 3] As the number of homeless people in the United States rises, it has become relevant for physicians to be knowledgeable about homelessness and to possess positive attitudes toward caring for homeless patients. However, despite the unique features of this growing population, physicians rarely receive formal training in this area.

Received from the Department of Medicine (DB, LR, LK, SBG), John Stroger Hospital of Cook County/Rush University, Chicago, Ill; and Department of Medicine (SJ), San Francisco VA/University of California, San Francisco, Calif.

Information contained in this paper was presented in preliminary form at the 2002 National Society of General Internal Medicine Meeting in a precourse entitled "Teaching and Learning About Vulnerable Populations," by Susan Glick, Rich Abrams, David Buchanan, et al., Atlanta, Ga, May 2002.

Address correspondence and requests for reprints to Dr. Buchanan: Division of General Medicine, 1900 W Polk Street, Room 969, Chicago, IL 60612 (e-mail: David_Buchanan@rush.edu).

To address this educational need, we designed a 2-week required rotation in homeless health care for second- and third-year primary care residents at an urban public hospital. This paper describes the rotation and evaluates its effectiveness in changing resident attitudes toward the homeless and in engendering interest in volunteer activity with this population.

PROGRAM DESCRIPTION

The course was based on an existing 2-week clinical elective for third- and fourth-year medical students at another institution.[4] In academic year 2000–2001, the curriculum was introduced as a required 2-week rotation for 6 third-year primary care internal medicine residents at an urban public hospital training program. Subsequent resident classes had 4 residents per year. In academic year 2001–2002, as a result of resident feedback, the course was transitioned into the second year of the residency and all second- and third-year residents completed the course. In academic year 2002–2003, it was again offered to second-year residents. In the future, we plan to offer it every other year to both second- and third-year residents to reduce the total administrative burden needed to support the course.

The homeless curriculum has 4 main components: 1) a series of 8 lectures (e.g., demographics of homelessness, chronic disease management, health outcomes, effective interventions); 2) 9 clinic sessions in 6 to 8 distinct sites commonly accessed by homeless patients (e.g., shelters, street outreach); 3) tours of community programs serving homeless people (e.g., respite care centers, shelters, day programs); and 4) journaling, case discussions, and hearing personal narratives of homeless individuals. In the process of the curriculum, residents met role models who provide care for homeless populations and advocate for improvements in health policy. Residents learned about the demographics and origins of homelessness, morbidity, mortality and common medical conditions seen in homeless people, and barriers to health care specific to homeless populations. An emphasis was also placed on teaching residents to better understand the everyday life of people who are homeless. Finally, we hoped to instruct them in the unique features of providing effective care to this population. Table 1 shows a sample course schedule.

Two to three faculty physician codirectors have shared the responsibility for developing and maintaining the curriculum. During each 2-week block, the rotation has included 12 hours of lectures, discussions, and tours led by one of the codirectors. Most clinical work was supervised by volunteer physicians and nurse practitioners who provide clinical services to homeless people year round. The

Table 1. Sample Schedule for the Homeless Health Care Course

Monday	Tuesday	Wednesday	Thursday	Friday
Demographics Service system description Common diseases Housing market description Respite care center tour Homeless guest speaker Journaling	Resident continuity clinic* Clinic: precept at student homeless shelter clinic	Clinic: homeless shelter for men in recovery from drug addiction Clinic: women and children's shelter	Clinic: alcohol treatment shelter Clinic: Chicago's largest homeless shelter for men	Journaling Street outreach lecture Clinical cases Health outcomes Clinic: large shelter focused on job skills
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
Tours of: Chicago's largest shelter Job skills-focused shelter Women's shelter Homeless guest speakers Journaling	Clinic: shelter for men released from prison Resident continuity clinic*	Clinic: women and children's shelter Clinic: suburban shelter	Clinic: small shelter with substance user focus Clinic: street outreach	Video interviews of homeless people Journaling Evaluations

* *Not part of the curriculum.*

remaining two to three clinical sessions were supervised by one of the course directors. Before the course was offered for the first time, the community practitioners were contacted to request their participation. None of the community practitioners were known to the codirectors prior to the course and all of those contacted agreed to participate without compensation. Two to three homeless speakers participated during each rotation and were recruited from the clinical sites. Each was given a $100 honorarium for his or her contribution to the course.

EVALUATION

Evaluation Methods

We chose to assess changes in attitude with the Attitudes Toward Homelessness Inventory (ATHI), an 11-item Likert scale questionnaire. This instrument was developed through a series of 4 studies among college students that were published in one article.[5] The initial instrument was subjected to factor and reliability analyses yielding the current version of the survey. Construct validity has been demonstrated for the ATHI by showing that its 4 subscales correlate with one another, and change in predicted ways with demographics, psychological constructs, and a history of prior homelessness. One of the studies documented that the ATHI is also responsive to change after an educational intervention. The instrument has 4 subscales that measure the belief that homelessness has societal causes, the belief that homelessness is a solvable problem, the willingness to affiliate with homeless people, and the belief that homelessness is caused by personal characteristics. The personal characteristics subscale is inversely correlated with positive attitudes toward homeless people. The possible scores on the ATHI range from 11 to 66. The range of possible scores on the ATHI subscales is from 3 to 18 except for the "willingness to affiliate" subscale, which has a range of 2 to 12. This study is the first to report the use of the ATHI for physicians in training.

The ATHI was administered to all residents on the first and last day of the course without the presence of the course instructors. Responses before and after the course were matched by the final 4 digits of the residents' Social Security numbers. The residents recorded no other identifiers. A mean change of 0.5 points per item (5.5 point change on the 11-item ATHI total score) was chosen to signify a meaningful change in residents' attitudes as a result of the 2-week rotation. A change of this magnitude, for example, would indicate that a resident changed half of the items on the survey from "agree" to "strongly agree," or from "unsure but probably agree" to "agree." The Wilcoxon signed ranks test was used to compare the pre- and post-course ATHI scores.

An anonymous qualitative survey was given with the ATHI on the last day of the rotation, which primarily provided feedback to the codirectors about the success of the course's components. One additional question on the survey asked the resident whether his or her interest in volunteering had changed as a result of the course.

Evaluation Results

A total of 18 residents have completed the rotation. During 2000–2001, the 6 third-year residents were split into 2 groups, with the groups completing the course in subsequent blocks. Thereafter, each residency class has completed the course in its own block for a total of 5 separate 2-week rotations during the 3-year period. All 18 residents completed the ATHI before and after the course. The 18 residents' total scores on the ATHI improved from 45 to 52 ($P = .001$). The ATHI subscales showed that after the course, residents had a greater belief that homelessness had societal causes and they felt more comfortable affiliating with homeless people. The subscales measuring the belief that homelessness has personal causes and that the problem of homelessness is solvable did not change after the course. Table 2 summarizes the results from the ATHI.

Table 2. Results of the Attitudes Toward Homelessness Inventory

ATHI Subscale	Mean Score Prior to Course ($N = 18$)	Mean Score After the Course ($N = 18$)	P Value
Belief that homelessness has societal causes*	12.1	15.1	.001
Willingness to affiliate with homeless people†	7.9	9.8	.004
Belief homelessness is caused by personal characteristics‡	11.7	12.6	.15
Belief that homelessness is a solvable problem§	13.7	14.3	.32
ATHI total score	45.4	51.7	.001

* *This subscale consisted of 3 items: "Recent government cutbacks in housing assistance for the poor may have made the homeless problem in this country worse" (R), "The low minimum wage in this country virtually guarantees a large homeless population" (R), "Recent government cutbacks in welfare have contributed substantially to the homeless problem in this country" (R).*
† *This subscale consisted of 2 items: "I would feel comfortable eating a meal with a homeless person" (R) and "I feel uneasy when I meet homeless people."*
‡ *This subscale consisted of 3 items: "Homeless people had parents who took little interest in them as children," "Most circumstances of homelessness in adults can be traced to their emotional experiences in childhood," and "Most homeless persons are substance abusers." A high score on this subscale indicates that the respondent believes personal characteristics are less likely to be an important cause of homelessness.*
§ *This subscale consisted of 3 items: "Rehabilitation programs for the homeless are too expensive to operate," "There is little that can be done for people in homeless shelters except to see that they are comfortable and well fed," and "A homeless person cannot really be expected to adopt a normal lifestyle."*
All items were rated 1 to 6 in terms of agreement with 1 = strongly agree, 2 = agree, 3 = unsure but probably agree, 4 = unsure but probably disagree, 5 = disagree, and 6 = strongly disagree.
(R), scoring reversed for that item.

On the anonymous qualitative survey given on the course's last day, 17 of 18 residents reported the course had increased their interest in volunteering.

DISCUSSION

We successfully developed and sustained a curriculum teaching primary care residents about health care for homeless patients. The curriculum helps meet two of the Accreditation Council for Graduate Medical Education general competencies in the categories of professionalism ("…sensitivity to a diverse patient population") and systems-based practice ("…awareness of and responsiveness to the larger context and system of health care").[6] Our evaluation of the course is the first to demonstrate an improvement in residents' attitudes toward homeless people as a result of an educational intervention. We have also demonstrated that the Attitudes Toward Homelessness Inventory (ATHI) is responsive to change when given before and after an educational intervention with medicine residents. The changes in attitude seen on the ATHI reflect an average change of greater than 0.5 points on each item of the scale, and moved residents' scores one-third of the way from their baseline score to the maximum score possible on the instrument.

Our curriculum evaluation has a number of important limitations. First, because the residency class size is small, only 18 residents have been exposed to the curriculum. Additionally, there was no measurement of residents' interest in volunteering before the course and no control group. Our outcomes are short term and from a single institution. This evaluation assessed attitudes and interest in volunteering but did not assess the course's impact on residents' clinical care of patients experiencing homelessness. The course has now been initiated and sustained at two institutions but is resource intensive and requires community support, which may limit its generalizability. Future curriculum evaluation should focus on determining the impact of homeless health care curricula on residents' clinical performance caring for homeless patients and on their choice of future employment and volunteer activity.

The authors would like to thank Dr. Arthur Evans for his assistance in preparing the statistics for this manuscript.

REFERENCES

1. O'Toole TP, Hanusa BH, Gibbon JL, Boyles SH. Experiences and attitudes of residents and students influence voluntary service with homeless populations. J Gen Intern Med. 1999;14:211–6.
2. Rosenheck R, Kizer KW. Hospitalizations and the homeless. N Engl J Med. 1998;339:1166–7.
3. O'Connell JJ. Utilization and Costs of Medical Services by Homeless Persons. Publication of the National Health Care for the Homeless Council; 1999.
4. Buchanan D, Jain S. Teaching students about healthcare of the homeless. Acad Med. 2001;76:524–5.
5. Kingree JB, Daves WF. Preliminary validation of the attitudes toward homelessness inventory. J Community Psychol. 1997;25:265–88.
6. ACGME Outcome Project. Accreditation Council for Graduate Medical Education. Available at: http://www.acgme.org/Outcome/. Accessed October 28, 2003.