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Latino Caregiver Psychosocial Factors and Health Care Services for Children Involved in the Child Welfare System

Caitlin Smith^a, Andrea Brinkmann^b, and Janet U. Schneiderman^b

^aDepartment of Psychology, University of Southern California, 3620 South McClintock Ave./SGM 501, Los Angeles, CA 90089

^bSchool of Social Work, University of Southern California, 669 West 34th Street, Los Angeles, CA 90089

Abstract

Children in the child welfare system have a high prevalence of health problems, making pediatric health service use critical. Latino children represent a growing proportion of the child welfare system, and are at increased risk for health problems. Many have argued that Latino caregivers can provide Latino children with the least disruptive out-of-home placement, but little is known about how caregiver factors might relate to health services utilization or child health status within this population. This study assessed relationships between caregiver psychosocial factors, health care service utilization, and health status for children in the child welfare system. This sample featured 48 Latino caregivers involved in child welfare. Logistic regression models were used to test for relationships between caregiver psychosocial factors and appointment adherence and child health status. Problem-focused coping was positively related to well-child status. No psychosocial factors were related to medical appointment adherence. Case workers may help improve child health outcomes by promoting problem-focused coping skills among Latino caregivers.

Keywords

coping behavior; appointments; healthcare; life stress; social support

1. Introduction

Children in foster care consistently have been found to have high levels of health problems, including chronic health conditions that can have significant consequences for development and quality of life (Chernoff, Combs-Orme, Risley-Curtiss, & Heisler, 1994; Hansen, Mawjee, Barton, Metcalf, & Joye, 2004; Jee et al., 2006; Steele & Buchi, 2008). Child-

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Corresponding author: Caitlin Smith, Department of Psychology, University of Southern California, 3620 McClintock Ave./SGM 501, Los Angeles, CA 90089; Tel: 805-509-8421; Fax: 213-740-5505; caitlias@usc.edu; Secondary Author: juschnei@usc.edu & abrinkma@usc.edu.

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welfare-involved children who remain at home with their biological parents have similar health problems to children in foster care (Ringeisen, Casanueva, Urato, & Cross, 2008; Schneiderman, Leslie, Arnold-Clark, McDaniel, & Xie, 2011). In response, concerned agency leaders have called for increased efforts to ensure that children involved in the child welfare system receive timely, appropriate medical care (Schneiderman, Brooks, Facher, & Amis, 2007; Task Force on Health Care for Children in Foster Care, 2005). To deliver effective health care in the child welfare system, it is important that children attend scheduled medical appointments. Missed appointments can prevent children from obtaining preventive care, such as receiving immunization vaccines on schedule, and appropriate diagnosis and treatment for medical conditions. Furthermore, missed appointments affect the efficiency of health care delivery to all patients in a given clinic (Moore, Wilson-Witherspoon, & Probst, 2001). There are several barriers to accessing health care for children in the child welfare system (Bass, Shields, & Behrman, 2004; Simms, Dubowitz, & Szilagyi, 2000), although the primary influence on pediatric health care use is the parent or caregiver. Caregivers are the gatekeepers to accessing health care for children in the child welfare system (Pasztor, Hollinger, Inkelas, & Halfon, 2006; Schneiderman, Smith, & Palinkas, 2012), thus caregivers' psychosocial characteristics may be important factors to consider in addressing the health care needs of children in foster care. This study described the Latino caregivers' psychosocial characteristics as well as examined how these characteristics were related to their child's health status and whether their child's outpatient return appointment was attended.

1.1. Caregiver psychosocial factors

There is limited research on caregiver factors related to medical adherence and health status within the child welfare population. One psychosocial factor that predicts low pediatric medical adherence for children with special health care conditions is high caregiver stress (Mellins, Brackis-Cott, Dolezal, & Abrams, 2004; Witherspoon & Drotar, 2006). This could be problematic for appointment-keeping in the child welfare system because foster caregivers often report high levels of stress and perceived burden (Fisher & Stoolmiller, 2008; Wilson, Sinclair, & Gibbs, 2000). For caregivers of children with medical problems, perceived burden could be even greater due to the complexity of these children's needs (Gray, Graef, Schuman, Janicke, & Hommel, 2013; Lauver, 2008). For children with diabetes, caregiver burden has been predictive of children's health problems and appears to have a proximal influence on low medical adherence (Cunningham, Vesco, Dolan, & Hood, 2010). Furthermore, regardless of the child's health status, the very task of bringing children to their medical appointments might be stressful for some adults, who might associate appointments with receiving bad news or undergoing uncomfortable procedures (Lacy, Paulman, Reuter, & Lovejoy, 2004). Therefore, overall caregiver perceived burden and stress related to attending medical appointments may interfere with keeping pediatric appointments and improving children's health. These findings from general pediatric health care literature may generalize to the child welfare population, but more research is needed.

On the other hand, some psychosocial factors may promote medical adherence. One example is problem-focused coping, or taking action to change the cause of stress (Folkman & Lazarus, 1985). Problem-focused coping includes individual coping strategies such as

devising a plan of action (Duangdao & Roesch, 2008) and it predicts improved medical adherence (Cohen, 2002) and physical health outcomes for adults (Lowe, Norman, & Bennett, 2000). However, the literature linking problem-focused coping and caregivers' adherence to their children's medical care is less clear. Based on the finding that problem-focused coping is associated with less perceived burden for caregivers of adults with dementia (Almberg, Grafström, & Winblad, 1997), it is possible that this coping style may also promote pediatric medical adherence through reducing caregiver stress for caregivers with children involved with the child welfare system.

Another caregiver psychosocial factor that may promote medical adherence is social support, which includes receiving emotional support from members of a social network and having opportunities to discuss difficult matters with trusted individuals. Social support has been found to promote medical adherence among adults (DiMatteo, 2004), but less is known about how caregivers' perceived social support might affect pediatric medical adherence. Social support seems to reduce burden for child welfare caregivers who report having a high need for assistance (Goodman, Potts, & Pasztor, 2007). Social support is also negatively related to stress for caregivers of children with health problems (Oh & Lee, 2009).

1.2. Latino caregivers and child health

Although Latino children are not disproportionately involved in the child welfare system on the national level, in California, over 50% of maltreated children are Latino (U.S. Department of Health and Human Services, 2013). A confluence of factors ranging from immigration trends to high poverty rates to ethnic biases may have resulted in a substantial number of Latinos now being under the supervision of child welfare systems in certain urban areas (Hill, 2006; Zambrana & Capello, 2003). Once Latino children have entered the child welfare system, they are more likely than White youth to be placed outside of the home and to spend longer times living in out-of-home placements (Church II, Gross, & Baldwin, 2005). Many have advocated for recruiting more Latino caregivers in order to reduce the stressful experience of out-of-home placement for Latino children (Capello, 2006; Garcia, Aisenberg, & Harachi, 2012), but research on Latino child welfare caregivers is sparse. Since Latino children are at increased risk for health problems (Vega, Rodriguez, & Gruskin, 2009), it is vital to understand what caregiver factors may promote health service utilization and improve child health status within the Latino child welfare caregiver population. However, no studies were found that examined potentially important factors such as caregiver burden, problem-focused coping, or social support among Latino child welfare caregivers.

Beyond caregiver psychosocial factors, linguistic and cultural barriers to accessing health services and promoting child health are also important to consider. Two relevant factors are caregiver language and medical provider ethnicity. The extant research suggests that Spanish-speaking Latinos have higher rates of health care use (Sanders, Thompson, & Wilkinson, 2007), but that language barriers between themselves and doctors can lead them to miss appointments (Garcia Popa-Lisseanu et al., 2005). Furthermore, the ability of the pediatric provider to speak Spanish as well as understand the culture of the Latino family affects health care utilization and adherence (Flores, 2000). It is important to take into

account relevant factors like these when investigating psychosocial and health factors within the Latino caregiver population.

1.3. Present study

This study aimed to (1) describe psychosocial factors (i.e., caregiver burden, problem-focused coping, and social support) among Latino child welfare caregivers; and (2) examine the relationships between these psychosocial factors and pediatric appointment-keeping and children's health status, adjusting for caregiver language and medical provider ethnicity. Specifically, we predicted that caregiver burden would be negatively related to appointment-keeping and well-child status (e.g., no medical diagnoses). We hypothesized that problem-focused coping and social support would be positively associated with well-child status and appointment-keeping.

2. Materials and Methods

2.1. Setting and sample

This study was conducted at the Community-Based Assessment and Treatment Center (CATC), a pediatric clinic directly linked to the Los Angeles County Department of Children and Family Services (DCFS). The CATC provides initial assessments and primary health care to children involved in the child welfare system, regardless of health insurance status. All children treated at CATC were receiving services from the child welfare system. Most CATC clients belong to ethnic minority groups, with the largest proportion identifying as Latino. The [blinded for review] Institutional Review Board, DCFS, and the County Juvenile Court granted approval for this research.

2.2. Procedures

Caregivers scheduled to bring a child for a follow-up appointment were invited to participate in the current study during medical appointments occurring between May 2012 and January 2013. Bilingual pediatricians and nurse practitioners obtained informed consent from any caregivers interested in participating in the study. More than 80% of study-eligible caregivers consented to participate. A research assistant abstracted data from the medical record about each child's health problems immediately after consent. After the scheduled follow-up appointment, a bilingual research assistant called the caregivers to administer self-report questionnaires measuring psychosocial factors and recorded whether scheduled appointments were attended based on the medical records. Sixty-six Latino caregivers who consented to participate still had their child living with them at the time of the scheduled follow-up appointment. Latino caregivers who completed the phone interview were included in the present study ($N = 48$, 72.3%) and represented the study sample. Caregivers were mailed \$10 gift certificates regardless of whether they completed the phone interview.

2.3. Measures

When caregivers consented to participate in the study, they self-reported age, gender, marital status, number of children in their care, average yearly family income, ethnicity, language, and type of relationship to the child (i.e., birth parent, kinship caregiver, or unrelated caregiver). Children were categorized as having a health problem if their medical records

indicated a diagnosis other than well-child status at the time of the initial appointment when the caregivers were consented. A missed appointment was defined as any appointment a child did not attend while living with the same caregiver from the initial appointment or a cancelled appointment that was not rescheduled and attended.

The three psychosocial factors were assessed using self-report questionnaires administered over the phone after the date of the scheduled follow-up appointment. Caregiver burden was measured using the Impact on Family Scale (IFS) (Stein & Jessop, 2003), an instrument with high internal consistency ($\alpha > .83$) and high correlations with other measures of parental distress or psychological adjustment. Mean scores on this 15-item questionnaire can range from 1 (i.e., strongly disagree) to 4 (i.e., strongly agree). An example of one item from the IFS is, "I don't have much time left over for other family members after caring for my child." Coping was measured using the problem-focused coping subscale from the Brief Coping Orientation to Problems Experienced instrument (Carver, 1997). This theory-based measure of dispositional coping style has demonstrated reliability ($\alpha = .84$) and correlates with other measures of coping and adaptive outcomes (Carver, 1997; Lowe et al., 2000). Mean problem-focused coping scores can range from 1 (i.e., I usually don't do this at all) to 4 (i.e., I usually do this a lot). One example item includes, "I try to come up with a strategy about what to do." Social support was measured using the Duke-UNC Functional Social Support Questionnaire (Broadhead, Gehlbach, & Kaplan, 1989). This measure also has high internal consistency ($\alpha = .83$) and is associated with other measures of social support (Broadhead et al., 1989; Isaacs & Hall, 2011). Mean scores on this 8-item measure can range from 1 (i.e., much less than I would like) to 5 (i.e., as much as I would like). An example item from this scale is, "I have chances to talk to someone I trust about my personal and family problems." All mean scores were calculated by summing the values for each item, and dividing the sum by the number of items.

2.4. Analysis

We began our analysis by calculating means and frequencies to describe the demographic characteristics of the total sample. We also calculated means of psychosocial variables and compared the means between monolingual Spanish-speaking caregivers and caregivers who could speak English or who were bilingual. To test whether psychosocial factors were associated with appointment-keeping or well-child health status, we created multivariate logistic regression models which included caregiver language and medical provider ethnicity as covariates.

3. Results

Information about caregiver and child characteristics is presented in Table 1. Most caregivers were female and not biological parents to the children in their care. The average age of caregivers was 46.00 years old ($SD = 10.38$). About half of the caregivers were married and a majority of study participants reported caring for at least two children.

Means and standard deviations for psychosocial variables are presented in Table 2. Psychosocial factors were not significantly related to one another. Both social support, $t(46) = 2.73$, $p < .01$, and problem-focused coping, $t(46) = 2.17$, $p = .04$, were significantly higher

among monolingual Spanish-speaking Latino caregivers. However, monolingual Spanish-speaking caregivers were no more likely than English-speaking caregivers to keep their appointments (65.4% vs. 68.2%, respectively), $\chi^2(1, 48) = 0.04$, $p = .84$, or to be currently caring for children with well-child status (26.9% vs. 22.7%, respectively), $\chi^2(1, 48) = 0.11$, $p = .74$.

The multivariate logistic regression model estimated the association between appointment-keeping and caregiver psychosocial factors, caregiver language, and medical provider ethnicity did not identify any significant predictor variables. In addition, the logistic regression model did not describe a large amount of variance in appointment-keeping (Cox and Snell $R^2 = .06$). The multivariate logistic regression model estimating the association between well-child status (e.g., zero versus one or more diagnoses) and caregiver psychosocial factors, caregiver language, and medical provider ethnicity, indicated that caregivers who reported more problem-focused coping were significantly more likely to be caring for children with no health problems. The amount of variance in well-child status explained in this model was larger (Cox and Snell $R^2 = .18$). The results of both multivariate logistic regression models are included in Table 3.

4. Discussion

In this sample of Latino caregivers in the child welfare system, caregivers of children who had no medical diagnoses reported significantly more problem-focused coping. Both social support and problem-focused coping were significantly higher among monolingual Spanish-speaking caregivers. However, none of the measured psychosocial factors were related to appointment-keeping.

Caregivers' problem-focused coping was related to well-child status, but the child's health status was measured before the caregivers' coping was measured. Thus it could be that caregivers looking after healthier children, were more able to use problem-focused coping. Also, caregivers who focus on solving problems may choose to foster children with fewer health care needs. If this is true, it could mean that caregivers with the most psychosocial resources are selecting children who least need their active problem-solving skills. Alternatively, participants were already caring for the child when their health status was assessed, so another potential explanation is that caregivers had used problem-focused coping earlier and addressed the root causes of health problems (Lazarus, 1991). Caregivers who use more problem-focused coping strategies could thereby improve the health of children in their care. For example, if caregivers observe negative side effects of a particular medication in their child, a problem-focused coping strategy such as making an appointment to consult with a doctor about alternative treatment options could result in improved child health.

Although problem-focused coping was related to children's health status, burden, coping, and social support did not explain why caregivers might have difficulty attending pediatric medical return appointments. Structural factors such as transportation and busy schedules (Gower et al., 2013), lack of reminders about scheduled appointments (Guy et al., 2012), or other factors (Lacy et al., 2004) may have had more influence on appointment-keeping.

Psychosocial factors such as problem-focused coping or social support may influence other aspects of caregiving in the child welfare system, but do not appear to be associated with appointment-keeping.

Although monolingual Spanish-speaking caregivers reported more social support and problem-focused coping than English-speaking caregivers, this did not translate to better appointment-keeping or fewer child health problems. In contrast with our results, existing research found that monolingual Spanish speakers in the United States report equal or less social support than individuals who are proficient in English or bilingual in English and Spanish (Mulvaney-Day, Alegria, & Sribney, 2007; Watt, Martinez-Ramos, & Majumdar, 2012). In the census tracts immediately surrounding the CATC clinic where this study took place, Latino residents comprise more than 90% of the population (U.S. Census Bureau, 2010). Monolingual Spanish-speaking caregivers who enrolled in our study may belong to ethnic enclaves in which bilingualism or English proficiency were not necessary for accessing social support (Viruell-Fuentes, Morenoff, Williams, & House, 2013). In addition, caregivers involved in child welfare may have different strengths and stressors compared with the general population, which could explain why relationships between psychosocial factors and health variables identified in among types of caregivers did not occur in this study's sample. Our finding that problem-focused coping was higher among Spanish speakers involved in child welfare is novel. To our knowledge there have been no comparisons of coping styles between monolingual Spanish speakers and English-speaking or bilingual Latinos, whether in studies of the general population or within child welfare system caregivers. Existing research has presented a complicated narrative about whether Spanish-speaking caregivers are more or less likely to access health care services for their children (Sanders et al., 2007; Uwemedimo, Findley, Andres, Irigoyen, & Stockwell, 2012; Yin et al., 2012). Complex contextual factors that promote or inhibit appointment-keeping by Spanish speakers may have more influence on children's health care in the child welfare system than the psychosocial factors examined in this study.

4.1. Limitations

Several limitations reduced the generalizability of this study and warrant caution. First, the sample size was small, limiting statistical power. Second, caregiver burden, problem-focused coping, and social support were self-reported, not objective measures of problem-solving behavior, social support, or actual caregiving stress. Third, the findings of the study are correlational and causality cannot be determined. Since a large proportion of caregivers did not bring children back to their follow-up appointments, it was impossible to assess whether caregiver psychological factors were precursors to the child's health status or changes in health status. Therefore, it could be that caregivers with stronger problem-focused coping may have accepted children into their care who were in already in better health than others. Finally, the results obtained with this urban, Latino sample may be less relevant for caregivers in other geographic locations or of different racial and ethnic backgrounds.

4.2. Summary

The current study examined caregiver psychosocial characteristics and children's health in the context of the child welfare system. Problem-focused coping was related to children's health status, and monolingual Spanish-speaking caregivers reported higher levels of psychosocial factors generally considered adaptive. Unfortunately, none of the psychosocial factors were related to medical appointment-keeping. Future research could illuminate the nature of the relationships among coping and health by examining intraindividual longitudinal dynamics (i.e., whether increases in problem-focused coping precede improvements in child health or whether improved child health precedes increases in problem-focused coping) and by testing whether interventions to improve problem-focused coping have an impact on child welfare caregivers' pediatric health service use or children's health problems. In a study of children with disabilities, a family competence intervention that included help with handling everyday problems as well as information about their child's specific health problem improved the active coping ability of parents (Dellve, Samuelsson, Tallborn, Fasth, & Hallberg, 2006). All of the children in this study were receiving child welfare services, including home visitation and case management, thus it is possible for child welfare caseworkers to employ some of these techniques during their home visits to help caregivers better cope with the stress of caring for sick children. It would also be helpful to explore how to help monolingual Spanish-speaking caregivers utilize their strong coping skills and social support to improve their ability to meet the medical needs of their children. Regardless, the experiences of caregivers, especially related to pediatric health care and medical adherence, should be further investigated.

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References

- Almberg B, Grafström M, Winblad B. Major strain and coping strategies as reported by family members who care for aged demented relatives. *Journal of Advanced Nursing*. 1997; 26(4):683–691.10.1046/j.1365-2648.1997.00392.x [PubMed: 9354978]
- Bass S, Shields MK, Behrman RE. Children, families, and foster care: Analysis and recommendations. *The Future of Children*. 2004;5–29.10.2307/1602752
- Broadhead W, Gehlbach SH, Kaplan BH. Functional versus structural social support and health care utilization in a family medicine outpatient practice. *Medical Care*. 1989; 27(3):221–233. [PubMed: 2784523]
- Capello DC. Recruiting Hispanic foster parents: Issues of culture, language, and social policy. *Families in Society: The Journal of Contemporary Social Services*. 2006; 87(4):529–535.10.1606/1044-3894.3568
- Carver CS. You want to measure coping but your protocol's too long: Consider the brief cope. *International Journal of Behavioral Medicine*. 1997; 4(1):92–100.10.1207/s15327558ijbm0401_6 [PubMed: 16250744]
- Chernoff R, Combs-Orme T, Risley-Curtiss C, Heisler A. Assessing the health status of children entering foster care. *Pediatrics*. 1994; 93(4):594–601. [PubMed: 8134214]

- Church WT II, Gross ER, Baldwin J. Maybe ignorance is not always bliss: The disparate treatment of Hispanics within the child welfare system. *Children and Youth Services Review*. 2005; 27(12): 1279–1292.10.1016/j.childyouth.2005.01.003
- Cohen M. First-degree relatives of breast-cancer patients: cognitive perceptions, coping, and adherence to breast self-examination. *Behavioral Medicine*. 2002; 28(1):15–22. [PubMed: 12244641]
- Cunningham NR, Vesco AT, Dolan LM, Hood KK. From caregiver psychological distress to adolescent glycemic control: the mediating role of perceived burden around diabetes management. *Journal of Pediatric Psychology*. 2010;jsq071.10.1093/jpepsy/jsq071
- Dellve L, Samuelsson L, Tallborn A, Fasth A, Hallberg LRM. Stress and well-being among parents of children with rare diseases: a prospective intervention study. *Journal of Advanced Nursing*. 2006; 53(4):392–402.10.1111/j.1365-2648.2006.03736.x [PubMed: 16448482]
- DiMatteo MR. Social support and patient adherence to medical treatment: a meta-analysis. *Health Psychology*. 2004; 23(2):207.10.1037/0278-6133.23.2.207 [PubMed: 15008666]
- Duangdao KM, Roesch SC. Coping with diabetes in adulthood: a meta-analysis. *Journal of Behavioral Medicine*. 2008; 31(4):291–300. doi:07/s10865-008-9155-6. [PubMed: 18493847]
- Fisher PA, Stoolmiller M. Intervention effects on foster parent stress: Associations with child cortisol levels. *Development and psychopathology*. 2008; 20(03):1003–1021.10.1017/S0954579408000473 [PubMed: 18606041]
- Flores G. Culture and the patient-physician relationship: achieving cultural competency in health care. *The Journal of Pediatrics*. 2000; 136(1):14–23. [PubMed: 10636968]
- Folkman S, Lazarus RS. If it changes it must be a process: study of emotion and coping during three stages of a college examination. *Journal of Personality and Social Psychology*. 1985; 48(1): 150.10.1037/0022-3514.48.1.150 [PubMed: 2980281]
- Garcia A, Aisenberg E, Harachi T. Pathways to service inequalities among Latinos in the child welfare system. *Children and Youth Services Review*. 2012; 34(5):1060–1071.10.1016/j.childyouth.2012.02.011
- Garcia Popa-Lisseanu MG, Greisinger A, Richardson M, O'Malley KJ, Janssen NM, Marcus DM, Suarez-Almazor ME. Determinants of treatment adherence in ethnically diverse, economically disadvantaged patients with rheumatic disease. *The Journal of Rheumatology*. 2005; 32(5):913–919. [PubMed: 15868630]
- Goodman CC, Potts MK, Pasztor EM. Caregiving grandmothers with vs. without child welfare system involvement: Effects of expressed need, formal services, and informal social support on caregiver burden. *Children and Youth Services Review*. 2007; 29(4):428–441.10.1016/j.childyouth.2006.10.002
- Gower EW, Silverman E, Cassard SD, Williams SK, Baldonado K, Friedman DS. Barriers to Attending an Eye Examination after Vision Screening Referral within a Vulnerable Population. *Journal of Health Care for the Poor and Underserved*. 2013; 24(3):1042–1052.10.1353/hpu.2013.0134 [PubMed: 23974379]
- Gray WN, Graef DM, Schuman SS, Janicke DM, Hommel KA. Parenting stress in pediatric IBD: relations with child psychopathology, family functioning, and disease severity. *Journal of Developmental and Behavioral Pediatrics: JDBP*. 2013; 34(4):237.10.1097/DBP.0b013e318290568a [PubMed: 23669870]
- Guy R, Hocking J, Wand H, Stott S, Ali H, Kaldor J. How effective are short message service reminders at increasing clinic attendance? A meta-analysis and systematic review. *Health Services Research*. 2012; 47(2):614–632.10.1111/j.1475-6773.2011.01342.x [PubMed: 22091980]
- Hansen RL, Mawjee FL, Barton K, Metcalf MB, Joye NR. Comparing the health status of low-income children in and out of foster care. *Child Welfare*. 2004; 83(4):367. [PubMed: 15310062]
- Hill, RB. Synthesis of Research on Disproportionality in Child Welfare: An Update. 2006. Retrieved August 24, 2014, from <http://www.cssp.org/reform/child-welfare/other-resources/synthesis-of-research-on-disproportionality-robert-hill.pdf>
- Isaacs KB, Hall LA. A psychometric analysis of the functional social support questionnaire in low-income pregnant women. *Issues in Mental Health Nursing*. 2011; 32(12):766–773.10.3109/01612840.2011.610561 [PubMed: 22077749]

- Jee SH, Barth RP, Szilagyi MA, Szilagyi PG, Aida M, Davis MM. Factors associated with chronic conditions among children in foster care. *Journal of Health Care for the Poor and Underserved*. 2006; 17(2):328–341.10.1353/hpu.2006.0062 [PubMed: 16702718]
- Lacy NL, Paulman A, Reuter MD, Lovejoy B. Why we don't come: patient perceptions on no-shows. *The Annals of Family Medicine*. 2004; 2(6):541–545.10.1370/afm.123
- Lauver LS. Parenting foster children with chronic illness and complex medical needs. *Journal of Family Nursing*. 2008; 14(1):74–96.10.1177/1074840707313337 [PubMed: 18281644]
- Lazarus, RS. *Emotion and adaptation*. New York, NY: Oxford University Press; 1991.
- Lowe R, Norman P, Bennett P. Coping, emotion and perceived health following myocardial infarction: Concurrent and predictive associations. *British Journal of Health Psychology*. 2000; 5(4):337–350.10.1348/135910700168964
- Mellins CA, Brackis-Cott E, Dolezal C, Abrams EJ. The role of psychosocial and family factors in adherence to antiretroviral treatment in human immunodeficiency virus-infected children. *The Pediatric Infectious Disease Journal*. 2004; 23(11):1035–1041.10.1097/01.inf.0000143646.15240.ac [PubMed: 15545859]
- Moore CG, Wilson-Witherspoon P, Probst JC. Time and money: effects of no-shows at a family practice residency clinic. *Family Medicine*. 2001; 33(7):522–527. [PubMed: 11456244]
- Mulvaney-Day NE, Alegria M, Sribney W. Social cohesion, social support, and health among Latinos in the United States. *Social Science & Medicine*. 2007; 64(2):477–495.10.1016/j.socscimed.2006.08.030 [PubMed: 17049701]
- Oh H, Lee EKO. Caregiver burden and social support among mothers raising children with developmental disabilities in South Korea. *International Journal of Disability, Development and Education*. 2009; 56(2):149–167.10.1080/10349120902868624
- Pasztor EM, Hollinger DS, Inkelas M, Halfon N. Health and mental health services for children in foster care: The central role of foster parents. *CHILD WELFARE-NEW YORK*. 2006; 85(1):33.
- Ringeisen H, Casanueva C, Urato M, Cross T. Special health care needs among children in the child welfare system. *Pediatrics*. 2008; 122(1):e232–e241.10.1542/peds.2007-3778 [PubMed: 18595968]
- Sanders LM, Thompson VT, Wilkinson JD. Caregiver health literacy and the use of child health services. *Pediatrics*. 2007; 119(1):e86–e92.10.1542/peds.2005-1738 [PubMed: 17200263]
- Schneiderman JU, Brooks D, Facher B, Amis J. Improving health services for foster youth: Multidisciplinary and multistakeholder perspectives and recommendations. *Children and Youth Services Review*. 2007; 29(3):313–328.10.1016/j.childyouth.2006.08.005
- Schneiderman JU, Leslie LK, Arnold-Clark JS, McDaniel D, Xie B. Pediatric health assessments of young children in child welfare by placement type. *Child Abuse & Neglect*. 2011; 35(1):29–39.10.1016/j.chiabu.2010.06.007 [PubMed: 21316106]
- Schneiderman JU, Smith C, Palinkas LA. The caregiver as gatekeeper for accessing health care for children in foster care: A qualitative study of kinship and unrelated caregivers. *Children and Youth Services Review*. 2012; 34(10):2123–2130.10.1016/j.childyouth.2012.07.009 [PubMed: 23139436]
- Simms MD, Dubowitz H, Szilagyi MA. Health care needs of children in the foster care system. *Pediatrics*. 2000; 106(Supplement 3):909–918. [PubMed: 11044143]
- Steele JS, Buchi KF. Medical and Mental Health of Children Entering the Utah Foster Care System. *Pediatrics*. 2008; 122(3):e703–e709.10.1542/peds.2008-0360 [PubMed: 18762506]
- Stein RE, Jessop DJ. The impact on family scale revisited: further psychometric data. *Journal of Developmental & Behavioral Pediatrics*. 2003; 24(1):9–16. [PubMed: 12584480]
- Task Force on Health Care for Children in Foster Care. *Fostering health: Health care for children and adolescents in foster care*. 2. New York, NY: American Academy of Pediatrics; 2005.
- U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. *Child Maltreatment 2012*. 2013. Retrieved from <http://www.acf.hhs.gov/sites/default/files/cb/cm2012.pdf>
- U.S. Census Bureau. *US Census 2010 Interactive Population Map*. 2010. Retrieved from <http://www.census.gov/2010census/popmap/>

- Uwemedimo OT, Findley SE, Andres R, Irigoyen M, Stockwell MS. Determinants of influenza vaccination among young children in an inner-city community. *Journal of Community Health*. 2012; 37(3):663–672.10.1007/s10900-011-9497-9 [PubMed: 22045471]
- Vega WA, Rodriguez MA, Gruskin E. Health disparities in the Latino population. *Epidemiologic Reviews*. 2009; 31(1):99–112.10.1093/epirev/mxp008 [PubMed: 19713270]
- Viruell-Fuentes EA, Morenoff JD, Williams DR, House JS. Contextualizing nativity status, Latino social ties, and ethnic enclaves: an examination of the ‘immigrant social ties hypothesis’. *Ethnicity & Health*. 2013; 18(6):586–609.10.1080/13557858.2013.814763 [PubMed: 23947776]
- Watt TT, Martinez-Ramos G, Majumdar D. Race/ethnicity, acculturation, and sex differences in the relationship between parental social support and children’s overweight and obesity. *Journal of Health Care for the Poor and Underserved*. 2012; 23(4):1793–1805.10.1353/hpu.2012.0147 [PubMed: 23698690]
- Wilson K, Sinclair I, Gibbs I. The trouble with foster care: The impact of stressful events’ on foster carers. *British Journal of Social Work*. 2000; 30(2):193–209.10.1093/bjsw/30.2.193
- Witherspoon D, Drotar D. Correlates of adherence to prophylactic penicillin therapy in children with sickle cell disease. *Children’s Health Care*. 2006; 35(4):281–296.10.1207/s15326888chc3504_1
- Yin HS, Sanders LM, Rothman RL, Mendelsohn AL, Dreyer BP, White RO, Perrin EM. Assessment of health literacy and numeracy among Spanish-Speaking parents of young children: validation of the Spanish parental health literacy activities test (PHLAT Spanish). *Academic Pediatrics*. 2012; 12(1):68–74.10.1016/j.acap.2011.08.008 [PubMed: 22056223]
- Zambrana RE, Capello D. Promoting Latino child and family welfare: Strategies for strengthening the child welfare system. *Children and Youth Services Review*. 2003; 25(10):755–780.10.1016/S0190-7409(03)00078-1

Highlights

- We examined the relationships of caregiver psychosocial factors with pediatric medical appointment-keeping and well-child status within a Latino child welfare caregiver sample.
- Monolingual Spanish-speaking Latino caregivers reported significantly higher social support and problem-focused coping than English-speaking Latino caregivers.
- Problem-focused coping was positively related to well-child status.
- No psychosocial factors were related to medical appointment adherence.

Table 1

Caregiver, health services, and child characteristics

Characteristics	Missing	<i>n</i> (%)
Female	0	41 (85.4)
Monolingual Spanish-speaking	0	26 (45.8)
Married	1	27 (56.3)
Relationship to child	0	
Birth parent		5 (10.4)
Kinship caregiver		19 (39.6)
Unrelated caregiver		24 (50.0)
Average family yearly income	7	
Less than \$15,000		6 (12.5)
\$15,000–\$29,999		14 (29.2)
\$30,000–\$44,999		10 (20.8)
\$45,000–\$59,999		1 (2.1)
More than \$60,000		10 (20.8)
Number of children in home	6	
One		15 (31.3)
Two		9 (18.8)
Three or more		18 (37.5)
Caring for a Latino child	0	43 (89.6)
Kept the scheduled appointment	0	32 (66.7)
Latino medical provider	0	29 (60.4)
Health problems of children in home	0	
Well child (no diagnoses)		12 (25.0)
One diagnosis		16 (33.3)
Two or more diagnoses		20 (41.7)

Table 2

Caregiver psychosocial variables

	Total Sample (<i>n</i> = 48)	Monolingual Spanish (<i>n</i> = 26)	English or Bilingual (<i>n</i> = 22)
Social Support, <i>M</i> (<i>SD</i>) *	2.08 (1.25)	2.50 (1.39)	1.58 (.83)
Problem-Focused Coping, <i>M</i> (<i>SD</i>) *	3.11 (.88)	3.36 (.75)	2.83 (.95)
Caregiver Burden, <i>M</i> (<i>SD</i>)	2.01 (.56)	1.99 (.72)	2.03 (.31)

*
 $p < .05$

Table 3

Logistic regression models

Variables	β	SE β	Wald's χ^2	d.f.	p	OR (95% CI)
Appointment-Keeping Model						
Social Support	-.17	.28	.36	1	.55	.84 (.49–1.47)
Problem-Focused Coping	-.52	.46	1.27	1	.26	.59 (.24–1.47)
Caregiver Burden	-.82	.59	1.92	1	.17	.44 (.14–1.41)
Monolingual Spanish	-.29	.75	.15	1	.70	.75 (.17–3.23)
Latino Medical Provider	.20	.66	.09	1	.76	1.22 (.34–4.41)
Well-Child Health Status Model						
Social Support	-.16	.33	.24	1	.62	.85 (.44–1.63)
Problem-Focused Coping*	1.57	.77	4.17	1	.04	4.81 (1.07–21.68)
Caregiver Burden	-.07	.85	.01	1	.93	.93 (.18–4.92)
Monolingual Spanish	.21	.85	.06	1	.85	1.24 (.24–6.51)
Latino Medical Provider	–1.09	.81	1.81	1	.18	.34 (.07–1.65)

* $p < .05$