Translation, Adaptation, and Validation of the Health Professionals' Attitudes Towards the Homeless Inventory (HPATHI) to Spanish for Puerto Rican Health Professionals

Traducción, Adaptación y Validación al Español del Inventario de Actitudes de Profesionales de la Salud Hacia Personas Sin Hogar para Profesionales de la Salud Puertorriqueños

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ABSTRACT

The purpose of this study was to translate, adapt, and initially validate the Health Professional's Attitude Toward the Homeless Inventory (HPATHI) for Puerto Rican health professionals in Puerto Rico. The original HPATHI was translated by a bilingual certified in translation who translated the original instrument to the target language. The translated version was analyzed and modified for cultural adaptation purposes by the consensus of a committee of graduate psychology students and licensed psychologists. Afterwards the culturally adapted version was back translated and compared to the original instrument. The sample was innovative given that it included mental health professionals. The final sample size consisted of N = 86 Puerto Rican participants born and currently residing on the island between the ages of 23 and 74 years (*M*=34.62, SD=12.45) of which 63 were women (73.3%) and 23 were men (26.7%). Cronbach's alpha internal consistency measure produced an α = .84 coefficient for the whole 14-item HPATHI-Spanish instrument. Factor 1, labeled *Cynicism*, produced a Cronbach's alpha coefficient of α = .77, Factor 2, labeled *Personal Advocacy*, produced a Cronbach's alpha coefficient of α = .80, and Factor 3, labeled *Social Advocacy*, produced a Cronbach's alpha coefficient of α = .60. This study provides initial evidence of the HPATHI-Spanish's usefulness in identifying health professionals' negative

attitudes toward homeless individuals, and with further research could potentially be used to measure attitude change.

Keywords: Homeless, Health Professionals, Attitudes, Inventory, Scale, Puerto Rico

RESUMEN

El propósito de esta investigación fue traducir, adaptar y validar el Inventario de Actitudes de Profesionales de la Salud Hacia Personas Sin Hogar (HPATHI por sus siglas en inglés) para Profesionales de la Salud en Puerto Rico. El HPATHI original fue traducido al español por un traductor bilingüe certificado. La versión traducida se analizó y modificó por razones de adaptación cultural por consenso de un comité estudiantes graduados de psicología y un psicólogo licenciado. Luego, la versión culturalmente adaptada se tradujo al inglés nuevamente y se comparó con el instrumento original en inglés. El muestreo fue innovador dado a que incluyó profesionales de la salud mental. La muestra final consistió de N = 86 participante puertorriqueños nacidos y actualmente residiendo en la isla entre las edades de 23 y 74 años (*M*=34.62, DE=12.45) de los que 63 fueron mujeres (73.3%) y 23 fueron hombres (26.7%). La medida de consistencia interna del alpha de Cronbach produjo un coeficiente α = .84 para el instrumento 14-item HPATHI-Spanish. El Factor 1, llamado *Cynicismo*, produjo un coeficiente de alfa de Cronbach de α = .77, el Factor 2, llamado *Abogacía Personal*, produjo un coeficiente de alfa de de α = .80 y el Factor 3, llamado *Abogacía Social*, produjo un coeficiente de alfa de Cronbach de α = .60. Este estudio provee evidencia inicial de la utilidad HPATHI-Spanish en identificar actitudes negativas de profesionales de la salud hacia personas sin hogar y con mayor investigación potencialmente podría utilizarse para medir cambios en actitudes.

Palabras Claves: Sin Hogar, Profesionales de la Salud, Actitudes, Inventario, Escala, Puerto Rico

LITERATURE REVIEW

In Puerto Rico, 4,309 homeless people were identified during the year 2007. During the year 2009, the count dropped to 3,687 homeless individuals. During 2011, the trend followed with 3,445 homeless people identified during that year. During 2013, the trend reversed with a homeless population estimated to have been of 4,128 people. During 2015, the numbers continued to rise with 4,518 homeless people identified during the year. During the 2017 homeless count, a decrease in numbers was seen once again with 3,501 individuals identified as homeless during the year (Departamento de la Familia, 2017). On the years 2007, 2015, and 2017 more detailed information can be found on the identified homeless population for each respective year.

In the Conteo de Personas Sin Hogar (2017), 3,501 homeless people were identified. Of those identified, 76% were men, 24% women, <1% were Trans (FAM), and <1% were Trans (MAF). Moreover, 40% were 50 years or older, 72.8% were unsheltered, 31% were chronically homeless by HUD's definition of the term, 34% reported having a mental health diagnosis, 27% a chronic health condition, and 18% a physical disability. Main reasons provided for being homeless included: substance abuse (30.6%), family problems (23%), financial or economic problems (15%), and alcohol abuse (6.4%) (Departamento de la Familia, 2017).

In a secondary analysis of existing data of quantitative descriptive design, researchers Torres, Garcia-Carrasquillo and Nogueras (2010) explored sociodemographic variables, childhood characteristics, and family risk factors for homelessness in the Puerto Rican homeless population of the Caguas municipality. A homeless sample from Caguas (N = 113) was compared to a primary care patient group, from Cidra, Humacao, and Yabucoa, (N = 102). The homeless sample ranged from 19 to 79 years of age and the primary care group sample ranged from 21 to 80 years of age. According to the study:

> The results indicated that the homeless sample was significantly more likely to endorse living in foster care, $\chi 2(1, N = 207) = 7.057$, $p = .008$; being abandoned by their family, $\chi 2(1, N = 192) = 32.522$, $p < .001$; experiencing the death of both parents, $\chi 2(1, N = 191) = 9.0$, $p < .05$; and having no family support, $\chi 2(1, N = 194) = 6.094$, $p = .014$, than the primary care population (p. 538).

Gender differences in both comparison groups was brought up by the authors as a possibly significant factor that played a role in how risk factors appeared to have affected both samples. Through Discriminant function analysis, childhood and family risk factors were found to correctly classify 84% of the sample. The death of both parents, the death of a close family member, and being abandoned by their family were observed to be the best sample discriminators in the present study.

According to the U.S. Department of Housing and Urban Development (2018) as stated in the 2018 "Annual Homelessness Assessment Report (AHAR) to Congress":

> Chronically Homeless Individual refers to a homeless individual with a disability who has been continuously homeless for one year or more or has experienced at least four episodes of homelessness in the last three years where the combined length of time homeless in those occasions is at least 12 months (p. 2).

Additionally, "Homeless describes a person who lacks a fixed, regular, and adequate nighttime residence." (HUD, 2018, p. 2). According to the U.S. Department of Housing and Urban Development (2018), on a single night approximately 553,000 people were homeless in the U.S.

According to Warnes, Crane, and Coward (2013), the current framework for understanding exits from homelessness are "structural societal factors (particularly the labor and housing markets and the welfare system), variations in local services, social capital and individual vulnerabilities" (Warnes et al., 2013, p. 784). Based on a study by Phelan, Link, Moore, & Stueve (1997), homeless people are more stigmatized than housed poor individuals and are comparably blamed for their financial situation. Additionally, the authors concluded that the stigma associated with being homeless has been compared to the stigma related to mental health hospitalizations.

In the United States *Housing First* serves as a model to specific housing programs for the homeless that has demonstrated high tenancy retention rates. According to McNaughton, Nicholls, and Atherton (2011), the variations in the implementation of U.S. *Housing First* programs make the model undefinable in a single way. As McNaughton, Nicholls, & Atherton (2011) point out, Pearson, Locke, Montgomery, and Buron (2007) have outlined the common features of *Housing First* projects. According to these authors, *Housing First* programs share: (1) a commitment to permanently house the targeted homeless, (2) offer supportive services without housing as a prerequisite, and (3) participate in outreach efforts to house mentally ill homeless people who would not otherwise seek treatment (Pearson et al., 2007, p. xv).

Promising outcomes were observed in a 2-year study of a *Housing First* program that began in 2007 in Washington, DC (Tsemberis et al., 2012). According to this study, retention rates in the housing program for homeless individuals who were identified as alcohol dependent and had been homeless for at least five years (N = 36) was 97% for the first year and 84% for the second. The authors measured client psychological distress by administering the self-reported Brief Symptom Inventory at two points in time (Tsemberis et al., 2012, p.15). After the first year of housing and voluntary psychiatric services, significant reductions in psychological distress were observed (Tsemberis et al., 2012).

In another study focused on health risk factors in a homeless population in Dallas, Texas, Taylor et al. (2016), found that 76% of the sampled homeless people (N = 394) reported smoking. On the other hand, this study is among the first to demonstrate that homeless adults show interest in addressing many modifiable health risk factors. Most smokers, in the sample expressed a desire to quit smoking. More than half of those who were overweight/obese, had insufficient fruit and vegetable intake, and/or a deficiency in physical activity expressed a desire to modify these health risk factors. Moreover, 31% of "at-risk drinkers" reported a desire to reduce their drinking (Taylor et al., 2016, p. 458). The study's findings support the prevalence of modifiable health risk factors and a desire to change them among homeless individuals, even before receiving housing.

Experiences Receiving Health-Care

In a phenomenological study by Rae and Rees (2015) in the United Kingdom that sought to study homeless people's perspectives on their healthcare encounters and how these have influenced their health-seeking behavior, homeless participants (N = 14) consistently described

their priorities as survival (i.e. shelter, food, and stability) and escaping reality through alcohol and drug use. Additionally, "participants in this study felt discouraged from seeking health care when they had been given inappropriate or impractical advice" (p. 2104). For those sampled in this study, positive healthcare experiences had been with clinicians who listened and showed interest and concern while not making assumptions about the participants. Moreover, the study reported that follow-up care is valued by this population. According to the authors, treating homeless people as worthless supports low confidence and social isolation. Finally, the study suggested inadequate discharge planning among homeless service providers and that feelings of marginalization, inadequately addressed problems and/or difficulties accessing healthcare can negatively influence "health-seeking behavior and engagement" (p. 2104).

Wen, Hudak, and Hwang (2007) investigated homeless people's perceptions of welcomeness and unwelcomeness in healthcare encounters. The study was of qualitative design and interpretative content analysis was done by means of iterative stages of inductive coding with 17 in-depth interviews. Participants consisted of 17 homeless people between 29 and 62 years of age who resided in five shelters in Toronto, Canada. According to the study's results, most of the participants perceived their experiences of unwelcomeness as discriminatory acts. The most common perceived reasons for being treated in a discriminatory way were: being homeless and belonging to low social classes. Many participants reported strong emotional reactions to the experience of unwelcomeness, which in turn negatively affected their future desire to receive health services. The descriptions participants offered regarding experiences of unwelcomeness were related with participants feeling dehumanized, not listened to or being treated as if they were unimportant. On the other hand, participants reported feeling valued as people, listened to, and empowered during experiences in which they felt welcomed.

Another qualitative study by Derbyshire et al. (2006) described and discussed the perspectives and experiences receiving health and social services of a group of 10 homeless youth with mental health problems within the ages of 16 and 24. The study took place in Adelaide, Australia where in-depth interviews were conducted with the study's participants. In general, participants' evaluations of the services they received in emergency care were negative. They described feeling stigmatized and unwelcome. Being labeled was perceived negatively as reducing participants to a group of symptoms and behaviors; it was perceived as a shortcut to actually listen and understand participants' problems. Furthermore, participants reported feeling vulnerable and fearful which was augmented by a lack explanation in terms of decisions being made that related to their treatment and person. The authors concluded that, above all, participants valued being "respected and treated by professionals as fellow human beings who matter" (p. 561).

Instruments Regarding Attitudes Toward Homeless People

Various instruments have been developed in an attempt to measure attitudes towards homeless individuals. In the United States of America, Kingree and Daves (1997) developed the 11-item Attitudes Toward Homelessness Inventory (ATHI). They conducted four studies which they argue collectively provide initial validation for their instrument. The authors argue that

information regarding attitudes toward homeless people can help "guide policymakers who are seeking public support for initiatives that affect homeless people" (p. 266).

In their initial ATHI study, 27 potential items were subjected to Exploratory Factor Analysis (Principal Component Analysis with Varimax Rotation) and reliability analyses which produced the final 11-item inventory with four subscales. Through convenience sampling, 383 students (149 males and 234 females) at Georgia State University volunteered during their introductory psychology classes to participate in the study. The mean participant age was 22 years, and their racial composition was: 71% white, 22% African American, 4% Asian, and 3% Hispanic. The ATHI obtained an acceptable internal consistency Cronbach alpha coefficient of 0.71 (Kingree & Daves, 1997).

In the United Kingdom, Lester and Pattison (2000) developed the 20-item Attitudes Towards the Homeless Questionnaire (ATHQ). The instrument was developed specifically to assess medical students' attitudes towards homeless individuals. It was developed using the views of 370 medical students in regards to providing medical care to homeless people. The questionnaire produced a Cronbach's alpha coefficient r = 0.74, and a test-retest reliability alpha of 0.80. The authors concluded that the ATHQ could potentially be a valid and reliable questionnaire in assessing the effectiveness of educational interventions. "The item pool included value judgements about the personal and societal causation of homelessness, motivations for applying to medical school and willingness to affiliate with the homeless" (p. 267).

Buck et al. (2005) developed the Health Professionals' Attitudes Toward the Homeless Inventory (HPATHI). The instrument was developed "to assess the attitudes of health-care professionals toward homeless patients and to demonstrate how those attitudes might impact optimal care" (Buck et al., 2005, para. 1). Authors were interested in gaining information that could influence the "design and implementation of educational activities that foster more compassionate homeless health care" and consequently measure the impact of such interventions using the HPATHI (Buck et al., 2005, para. 1). The 19-item HPATHI proved to have good internal consistency, Cronbach's alpha coefficient of r = 0.88, and a test-retest reliability of 0.69. The authors argue that the instrument showed good concurrent validity given that "respondents with more than one year of experience with homeless patients scored significantly higher than did those with less experience" (Buck et al., 2005, para. 3). According to the authors, the three subscales present in the instrument seem to represent: *personal advocacy*, *social advocacy*, and *cynicism*. The three-factor structure explained 39% of the data variance.

In the first phase of the instrument's development, content validity was assessed using the Delphi technique, "which seeks consensus on instrument items among a panel of experts" (Buck et al., 2005, para. 11). Experts in homeless health-care were recruited through snowball sampling. During the second phase of the HPATHI's development, the first draft of the inventory was administered to a convenience sample of 72 third-year medical students enrolled at Baylor College of Medicine (BCM) in Houston, Texas. About half of the participants (N = 34) later completed the instrument a second time, providing data for the calculation of test-retest reliability. Afterwards, the authors "conducted an item analysis of redundant items or those with poor item-to-scale

correlations" (Buck et al., 2005, para. 13). During the third and final phase of the HPATHI's development, the authors developed web-based versions of the HPATHI and the ATHI. They recruited 160 participants for this third phase through convenience sampling focused on health-care professionals, which consisted of physicians who served as faculty, family practice residents, general internal medicine residents, and medical students at BCM. In this final phase, the HPATHI was shortened to 19 items. The instrument as a whole and its three factors, respectively, achieved acceptable Cronbach alpha coefficients. The HPATHI's concurrent validity was argued on the basis of Pearson's correlation coefficient of 0.68 between the HPATHI's total scale and the ATHI.

Justification

In 2013, the U.S. Secretary of Housing and Urban Development and the U.S. Secretary of Veterans Affairs described homelessness as a "public health crisis" and emphasized the importance of an intervention that is "data driven, is research informed, and prioritizes more immediate access to permanent housing" (Donovan & Shinseki, 2013). The American Psychological Association in their *Health and Homelessness* fact sheet states that psychologists must increase their efforts to end homelessness (APA, 2019).

This study aimed to contribute to the scientific literature of the public issue of homelessness by providing a Spanish inventory that would facilitate the assessment of Puerto Rican health professionals' attitudes toward the homeless population in Puerto Rico. As Buck et al. (2005) argue, the information attainable from such an inventory could influence the "design and implementation of educational activities that foster more compassionate homeless health care" (Buck et al., 2005, para. 1).

Objective

To translate, adapt, and initially validate the Health Professional's Attitude Toward the Homeless Inventory (HPATHI) for Puerto Rican health professionals in Puerto Rico. The sample was innovative given that it included mental health professionals. The instrument's original authors (Buck et al., 2005) had written about their interest in expanding their sample to include health professionals that were not only medical professionals or medical doctors in training. This study aimed to contribute to a growing body of research directed towards homeless individuals receiving more empathic and individualized treatment by health care professionals from both the mental and medical health perspective both in and out of the primary care environment.

METHOD

Instrumentation

The HPATHI's authors were contacted by e-mail to request permission to translate, adapt, and validate the instrument for Spanish speaking Puerto Rican health professionals residing on the island. After permission was acquired, the *Toolkit on Translating and Adapting Instruments* commissioned by the Evaluation Center@HSRI and authored by Chávez and Canino (2005) was used as a guide for translating and culturally adapting the instrument. The project itself was led by an indigenous researcher, which Erkut et al. (1999) argue protects against the "unexamined exportation of ideas and methods."

In line with Step 2 in the *Toolkit on Translating and Adapting Instruments* commissioned by the Evaluation Center@HSRI (Chávez & Canino, 2005), the original HPATHI was translated by a bilingual certified in translation who translated the original instrument to the target language. In keeping with the authors' recommendations, the professional translator had the same first language as the target language for the instrument's translation. As part of Step 3 of the toolkit, a bilingual committee of experienced researchers, evaluators or professionals familiar with the field being studied and fluent in both the source and target language of the instrument evaluated the target language translation of the inventory. This step consisted of having the instruments' items evaluated to identify possible difficulties in comprehension or in an unsatisfactory communication of its intent. The bilingual committee consisted of the PI, three third year graduate students who were currently enrolled in the Ph.D. Clinical Psychology program at Carlos Albizu University's San Juan Campus, and a licensed Clinical Psychologist in order to critically analyze the HPATHI's target language translation. Translated items were only modified when there was a majority consensus regarding a lack of conceptual equivalence between the original instrument in English and the translated target version in Spanish. If items were identified as conceptually inequivalent translations, the group discussed possible rewordings until a majority consensus was reached regarding a conceptually equivalent and locally relevant translated item. Afterwards, in accordance with step 7 of the *Toolkit on Translating and Adapting Instruments,* the adapted instrument was back-translated by an independent translator that was not involved in the first translation. Equivalency was compared between the source instrument and the back-translated instrument by a bilingual committee of experienced researchers, evaluators or professionals familiar with the field being studied and fluent in both the source and target language of the instrument. In theory, significant discrepancies in meaning between the source instrument and the back-translated instrument could suggest problems in the target language translated version.

Sample Selection

Participant inclusion criteria consisted of: having at least 21 years of age, being fluent in speaking and reading Spanish, being a resident of Puerto Rico, at the time either a graduate student or professional in one or more of the health and health-care professions, and being a student or professional with a desire or intent to participate in clinical work with patients at the time of participating in the study. Exclusion criteria consisted of: having less than 21 years of age, not being fluent in Spanish, not being a resident of Puerto Rico, not either a graduate student or professional in one or more of the health and health-care professions at the time of participating, and being a student or professional of the health and health-care professions with no current desire or intent to participate in clinical work with patients. Sampling was non-probabilistic expert sampling. Expert, or judgmental, sampling tries to sample individuals who embody certain traits or characteristics of interest (Hernandez Sampieri et al., 2014). In this study, experts were graduate level medical and psychology students, as well as medical and psychology practicing professionals. The sample was also be open to other health professionals and graduate students such as those in nursing and social work. Sampling was done through online promotion of the instrument.

Procedures

To promote the instrument among graduate students in the health professions, a letter of intent was sent to a Graduate University in the Metropolitan Area of Puerto Rico with a variety of health-related programs. The letter communicated the purpose and procedures of the study and requested that a promotional e-mail be sent to all the students from their respective academic programs. To promote the instrument among health professionals, a letter of intent communicating the purpose of the study, its procedures, and requesting a promotional e-mail be sent to all the professionals from their respective association was sent to the Asociación de Psicología de Puerto Rico (Psychology Association of Puerto Rico) and to the Asociación Médica de Puerto Rico (Medical Association of Puerto Rico), which is recognized as a constituent of the American Medical Association. Identified individuals from the associations were sent a web-based link to participate in the study by completing an informed consent form, a sociodemographic form, and the translated and adapted HPATHI (Appendix A) through the use of the Survey Monkey online platform. To help prevent sample contamination, Survey Monkey was set to automatically lock anyone out of completing the instrument who did not comply with both inclusion and exclusion criteria for the study.

The consent form was uploaded to Survey Monkey to provide participants with the purpose and procedures of the study, the inclusion and exclusion criteria for participating, the approximate duration. It clearly stated that participating was completely voluntary and that they would not be penalized if they choose not to participate in the study or if they decided to abandon the inventory after having begun to complete it. Participants were informed of the possible risk of feeling emotional or psychological discomfort after reading the questions in the instrument. In the event a participant felt the need of receiving psychological services they were provided with the contact information to Carlos Albizu University's community mental health clinic located at Old San Juan. Additionally, participants were informed of the study's adverse event protocol. Participants were also informed of their possible contribution to the advancement of research aimed at promoting optimal care for the underserved population of homeless people if they chose to partake in the study. Additionally, information was provided regarding how participants' anonymity would be protected; no identifying participant information was collected during the study and Survey Monkey did not collect the I.P. addresses of the computers from which the inventory was accessed and completed in order to reduce any effect of social desirability on participants' approach to answering the inventory. The anonymity of the participants hopefully dissuaded health-care graduate students and professionals from trying to exhibit socially desirable answers on such a delicate subject matter such as attitudes toward an underserved minority group. Finally, participants were provided with the contact information of both the PI Álvaro M. Longo Saladrigas, alvaromlongo@gmail.com, and his direct research supervisor Dr. José Martínez, Ph.D, jmartinez@albizu.edu, in the event they wished to ask questions.

The study was of cross-sectional, descriptive, non-experimental design and statistically consisted of an exploratory factor analysis structural equation model (EFA) to analyze the translated instrument's factor structure. As previously mentioned, sampling was non-probabilistic

expert sampling. The recommended sample size for factorial analyses is at least 300 participants, although a sample of 200 participants could be considered "fair," and each factor should have at least from 5 to 10 observations (Comrey & Lee, 1992). Descriptive analyses were conducted with sociodemographic variables and included analyses of central tendency, frequency computations, and standard deviations. Missing data analysis were not necessary given that eligible participants who completed the survey did so in its entirety. Once the data was collected, it was entered into the computer statistics program IBM-SPSS-26 where the exploratory factor analysis and correlational analyses were carried out including the computation of Cronbach's alpha coefficient of internal validity (Cronbach, 1951). As a rule of thumb, a Cronbach's alpha coefficient above .70 is acceptable in terms of internal consistency (Frisbie & Ebel, 1991). As part of the exploratory factor analysis, factor loadings were calculated and items that do not load higher than .30 in any factor were not considered in the final translated version of the instrument because this would be considered a low item-factor correlation (Price, 2016).

RESULTS

Sample Characteristics (Table 1)

The study's total sample size consisted of N = 167 participants; 81 cases were eliminated from the study due to incompatibility with the study's inclusion and exclusion criteria. The final sample size consisted of N = 86 Puerto Rican participants born and currently residing on the island between the ages of 23 and 74 years (*M*=34.62, *SD*=12.45) of which 63 were women (73.3%) and 23 were men (26.7%).

The sample consisted of post graduate level students in health-related professions or health professionals who had already completed their post graduate degrees. In the sample, 40 (46.51%) identified a career in Psychology, 37 (43%) identified Medicine, 7 (8.1%) identified their chosen career as Social Work, 1 (1.2%) identified Speech Pathology, and 1 (1.2%) identified Professional Counseling as their career of choice. Additional sample characteristics are available in Table 1.

Table 1

Sociodemographic Characteristics of Participants at Baseline

Baseline characteristic	Male n (%)	Female n (%)	Total n (%)
	23 (26.7)	63 (73.3)	86 (100)
Legal Relationship Status			
Single (never married)	13 (15.12)	35 (40.70)	48 (55.81)
Mutual Cohabitation with Partner(s)	2 (2.33)	3 (3.49)	5 (5.81)
Married	8 (9.30)	16 (18.60)	24 (27.91)
Separated	0 (0)	1 (1.16)	1 (1.16)
Divorced	0 (0)	8 (9.30)	8 (9.30)
Spiritual			
Yes	17 (19.77)	61 (70.93)	78 (90.70)
No	6 (6.98)	2 (2.33)	8 (9.30)

(Cont.)

Baseline characteristic	Male *n* (%) 23 (26.7)	Female *n* (%) 63 (73.3)	Total *n* (%) 86 (100)
Religious			
Yes	7 (8.14)	24 (27.91)	31 (36.05)
No	16 (18.60)	39 (45.35)	55 (63.95)
Religious Belief			
Atheist	2 (2.33)	2 (2.33)	4 (4.65)
Agnostic	5 (5.81)	7 (8.14)	12 (13.95)
Theist without religious affiliation	2 (2.33)	12 (13.95)	14 (16.28)
Catholic	6 (6.98)	24 (27.91)	30 (34.88)
Catholic Orthodox	2(2.33)	0 (0)	2 (2.33)
Protestant	4 (4.65)	15 (17.44)	19 (22.09)
Buddhist	0 (0)	2 (2.33)	2 (2.33)
Would rather not say	1 (1.16)	1 (1.16)	2 (2.33)
Experience with homeless people			
Yes	14 (16.28)	35 (40.70)	49 (56.98)
No	9 (10.47)	28 (32.56)	37 (43.02)
Experience with homeless people			
Less than a month	4 (4.65)	9 (10.47)	13 (15.12)
More than a month	2 (2.33)	4 (4.65)	6 (6.98)
Less than a year	3 (3.49)	10 (11.63)	13 (15.12)
More than a year	5 (5.81)	13 (15.12)	18 (20.93)
Experience with homeless people			
2 years	0 (0)	1 (1.16)	1 (1.16)
3 years	0 (0)	1 (1.16)	1 (1.16)
4 years	1 (1.16)	2 (2.33)	3 (3.49)
10 years	0 (0)	1 (1.16)	1 (1.16)
15 years	0 (0)	1 (1.16)	1 (1.16)
Career			
Clinical Psychology	7 (8.14)	28 (32.56)	35 (40.70)
Counseling Psychology	0 (0)	2 (2.33)	2 (2.33)
School Psychology	0 (0)	3 (3.49)	3 (3.49)
Medicine	14 (16.28)	23 (26.74)	37 (43.02)
Social Work	2 (2.33)	5 (5.81)	7 (8.14)
Speech Pathology	0 (0)	1 (1.16)	1 (1.16)
Professional Counseling	0 (0)	1 (1.16)	1 (1.16)
Years of clinical experience			
Less than one	6 (6.98)	14 (16.28)	20 (23.26)
More than one	17 (19.77)	48 (55.81)	65 (75.58)
Years of clinical experience			
2 years	3 (3.49)	2 (2.33)	5 (5.81)

(Cont.)

Baseline characteristic	Male n (%)	Female n (%)	Total n (%)
	23 (26.7)	63 (73.3)	86 (100)
3 years	3 (3.49)	0 (0)	3 (3.49)
4 years	2 (2.33)	8 (9.30)	10 (11.63)
5 years	2 (2.33)	6 (6.98)	8 (9.30)
6 years	0 (0)	6 (6.98)	6 (6.98)
8 years	0 (0)	2 (2.33)	2 (2.33)
10 years	0 (0)	1 (1.16)	1 (1.16)
14 years	0 (0)	1 (1.16)	1 (1.16)
15 years	0 (0)	2 (2.33)	2 (2.33)
16 years	0 (0)	1 (1.16)	1 (1.16)
20 years	1 (1.16)	4 (4.65)	5 (5.81)
30 years	1 (1.16)	1 (1.16)	2 (2.33)
32 years	1 (1.16)	0 (0)	1 (1.16)
35 years	0 (0)	1 (1.16)	1 (1.16)
40 years	1 (1.16)	0 (0)	1 (1.16)

Note. $N = 86$. Participants were on average 34.6 years old ($SD = 12.45$).

Exploratory Factor Analysis (Table 2, 3, 4, and 5)

An Exploratory Factor Analysis was conducted using the statistical program IBM SPSS 26 in order to investigate the 19-item HPATHI-Spanish's factor structure (Table 2). Initial statistical analyses where in line with those Buck et al. (2005) employed in the third phase of their original study. As such, Principal Component Analysis (PCA) with oblique rotation (Promax) was used to account for the expected relationship between components. The PCA with Promax rotation resulted in 52 (57%) nonredundant residuals with absolute values greater than 0.05 computed between observed and reproduced correlations. Field (2017) argues that more than 50% nonredundant residuals with absolute values greater than 0.05 are probably a cause for concern in terms of the adequacy of the proposed model. Thus, Principal Axis Factoring (PAF) was used instead as the preferred method of factor extraction, while maintaining the Promax rotation as part of the analysis. Additionally, PAF assumes that a latent variable is being measured, whereas PCA does not (Field, 2017). In this case the variable of interest to the researchers is Health Professional's attitudes towards the homeless, thus PAF seems adequate and in fact produced <50% nonredundant residuals with absolute values greater than 0.05 computed between observed and reproduced correlations.

The Kaiser-Meyer-Olkin measure verified the sampling adequacy for the analysis, $KMO =$ .746 (considerably above the .5 minimum established by Field, 2017). An initial analysis was run to obtain eigenvalues for each factor in the data. Seven factors had eigenvalues over Kaiser's criterion of 1 and in combination explained 68.63% of the variance in the data. The scree plot was

ambiguous and showed inflexions that would justify retaining either 3 or 7 factors. We retained 3 factors for the sake of the parsimony of the model because of the considerable drop off in explained variance from the 4th factor onwards. After the 3-factor extraction was calculated, the model explained 44.44% of the variance. Table 2 shows the factor loadings after rotation. The internal consistency of the 19-item HPATHI-Spanish showed an acceptable whole scale internal consistency Cronbach alpha coefficient of .81.

Table 2

Results from the Factor Analysis of the 19-item HPATHI-Spanish

HPATHI-Spanish Item	Factors		
	1	2	3
Factor 1: Cynicism			
4. Las personas sin hogar escogen vivir sin hogar. (R)	**-.604**	.206	.080
5. Las personas sin hogar son vagas. (R)	**-.841**	**.317**	.021
8. Me sentiría cómodo/a siendo parte de un equipo que provea servicios de salud a personas sin hogar.	**.477**	.279	.047
7. Me sentiría cómodo/a ofreciéndole servicios de salud a personas sin hogar que tienen un trastorno de salud mental grave.	**.546**	.016	.014
11. Entiendo que las prioridades de mis pacientes/clientes pueden ser más importantes que seguir mis recomendaciones de salud.	**.389**	-.209	.142
12. Los profesionales de la salud deben abordar los problemas físicos y sociales de las personas sin hogar.	**.346**	.126	.292
15. Disfrutaría abordar asuntos psicosociales con los pacientes/clientes.	**.560**	.085	-.004
16. Resentiría la cantidad de tiempo que me tomaría atender a pacientes/clientes sin hogar. (R)	**-.477**	-.087	-.056
17. Disfrutaría aprender de la vida de mis pacientes/clientes sin hogar.	**.615**	.117	.011
Factor 2: Personal Advocacy			
2. Las personas sin hogar tienen el derecho a cuidado de salud básico.	-.135	**.376**	.076
9. Me sentiría cómodo/a proveyéndole servicios de salud a diferentes grupos étnicos y minoritarios.	.149	**.625**	.141
10. Siento que me abrumaría la complejidad de los problemas que tienen las personas sin hogar. (R)	.138	**-.514**	.094
13. Ingresé a una profesión de la salud porque quiero ayudar a los que lo necesiten.	.163	**.459**	-.091

(Cont.)

HPATHI-Spanish Item	Factors		
	1	2	3
14. Me interesaría trabajar con personas desatendidas.	**.387**	**.524**	-.180
19. Creo que ofrecerle servicios de salud a las personas sin hogar no es económicamente viable para mi carrera. (R)	**.364**	**-.525**	-.234
Factor 3: Social Advocacy			
1. Las personas sin hogar son víctimas de las circunstancias.	-.067	.127	**.324**
3. El no tener hogar es un problema principal en nuestra sociedad.	-.032	.131	**.521**
6. El presupuesto para el cuidado de la salud debe destinarse a proveer servicios a personas pobres y sin hogar.	.109	-.264	**.761**
18. Creo que la justicia social es una parte importante del cuidado de salud.	.176	.187	**.336**

Note. $N = 86$. The extraction method was principal axis factoring with an oblique (Promax with Kaiser normalization) rotation. Factor loadings above .30 are in bold. Reverse scored items are denoted with (R).

Afterwards, an item redundancy analysis was conducted. Items that had loadings equal to or higher than .4 on more than one factor were eliminated, as well as items that did not load at least .3 in any factor. Additionally, items that had low (< .3) item-scale correlations were eliminated as well. This process resulted in the elimination of items 1, 2, 10, 11, and 19.

After the item redundancy analysis was conducted, the resulting 14-item HPATHI-Spanish was run again through the PCA extraction method with Promax rotation, but the significant residuals were still over 50% after the 3-factor extraction. We continued, again, with the PAF with Promax rotation. The produced Kaiser-Meyer-Olkin measure verified the sampling adequacy for the analysis, *KMO* = .798 (much closer to the "Meritorious", but technically in the "Middling" category according to Hutcheson & Sofroniou, 1999). An initial analysis with the 14-item HPATHI-Spanish was run to obtain eigenvalues for each factor in the data. Four factors had eigenvalues over Kaiser's criterion of 1 and in combination explained 62.86% of the variance in the data. The scree plot was ambiguous and showed inflexions that would justify retaining either 3 or 5 factors. Three factors for the sake of the parsimony of the model because of the considerable drop off in explained variance from the 4th factor onwards and the 5th factor did not reach Kaiser's criterion of 1. After the 3-factor extraction was calculated, the model explained 54.96% of the variance. Table 3 shows the factor loadings after rotation. Items from the Factor 1 (4, 5, 7, 15, 16, and 17; 34.88% of the model's explained variance) appear to reflect *Cynicism* similar to the third factor identified by Buck et al. (2005). Items from Factor 2 (8, 9, 12, 13, and 14; 10.27% of the model's explained variance) appear to reflect *Personal Advocacy* as previously identified by Buck et al. (2005) in their original HPATHI study as their first factor. Finally, items from the Factor 3 (3, 6, and 18; 9.80% of the model's explained variance) appeared to reflect *Social Advocacy* as previously identified by Buck et al. (2005) in their original study as their second factor.

Table 3

Results from a Factor Analysis of the 14-item HPATHI-Spanish

HPATHI-Spanish Item	Factors		
	1	2	3
Factor 1: Cynicism			
4. Las personas sin hogar escogen vivir sin hogar. (R)	**-.526**	.042	.100
5. Las personas sin hogar son vagas. (R)	**-.758**	.139	.043
7. Me sentiría cómodo/a ofreciéndole servicios de salud a personas sin hogar que tienen un trastorno de salud mental grave.	**.596**	.041	-.029
15. Disfrutaría abordar asuntos psicosociales con los pacientes/clientes.	**.483**	.168	.040
16. Resentiría la cantidad de tiempo que me tomaría atender a pacientes/clientes sin hogar. (R)	**-.649**	.061	-.025
17. Disfrutaría aprender de la vida de mis pacientes/clientes sin hogar.	**.578**	.129	.067
Factor 2: Personal Advocacy			
8. Me sentiría cómodo/a siendo parte de un equipo que provea servicios de salud a personas sin hogar.	.240	**.501**	.080
9. Me sentiría cómodo/a proveyéndole servicios de salud a diferentes grupos étnicos y minoritarios.	.005	**.672**	.156
12. Los profesionales de la salud deben abordar los problemas físicos y sociales de las personas sin hogar.	.090	**.332**	**.308**
13. Ingresé a una profesión de la salud porque quiero ayudar a los que lo necesiten.	-.185	**.759**	-.056
14. Me interesaría trabajar con personas desatendidas.	.130	**.774**	-.179
Factor 3: Social Advocacy			
3. El no tener hogar es un problema principal en nuestra sociedad.	-.124	.156	**.504**
6. El presupuesto para el cuidado de la salud debe destinarse a proveer servicios a personas pobres y sin hogar.	.061	**-.326**	**.853**
18. Creo que la justicia social es una parte importante del cuidado de salud.	-.087	**.314**	**.486**

Note. $N = 86$. The extraction method was principal axis factoring with an oblique (Promax with Kaiser normalization) rotation. Factor loadings above .30 are in bold. Reverse scored items are denoted with (R).

Cronbach's alpha internal consistency measure produced an $\alpha = .84$ coefficient for the whole 14-item HPATHI-Spanish instrument. Factor 1, labeled *Cynicism*, produced a Cronbach's alpha coefficient of $\alpha = .77$, Factor 2, labeled *Personal Advocacy*, produced a Cronbach's alpha coefficient of $\alpha = .80$, and Factor 3, labeled *Social Advocacy*, produced a Cronbach's alpha

coefficient of α = .60. All internal consistency coefficients are acceptable, although clearly Factor 3's is the least desirable given it falls short of the .70 cutoff point commonly used for ability tests identified by Kline (1999) (as cited in Field, 2017). Nonetheless, Kline (1999) argues that when working with psychological constructs, values below .7 can be expected due to the diversity of the constructs being measured (as cited in Filed, 2017).

Table 4

Scale and Subscale Alpha Coefficients

Scale	Alpha Coefficient
14-item HPATHI-Spanish instrument	α = .84
Factor 1: *Cynicism*	α = .77
Factor 2: *Personal Advocacy*	α = .80
Factor 3: *Social Advocacy*	α = .60

All factors were significantly correlated to each other. Factor 1 (*Cynicism*) was significantly correlated to Factor 2 (*Personal Advocacy*), $r = .72$, 95% BCa CI [.601, .808], $p = .01$. Factor 1 (*Cynicism*) was also significantly correlated to Factor 3 (*Social Advocacy*), $r = .63$, 95% BCa CI [.446, .775], $p = .01$, and Factor 2 (*Personal Advocacy*) was significantly correlated to Factor 3 (*Social Advocacy*), $r = .48$, 95% BCa CI [.277, .663], $p = .01$.

Table 5

Factor Correlations

Factor 1 and Factor 2	$r = .72$, 95% BCa CI [.601, .808], $p = .01$
Factor 2 and Factor 3	$r = .48$, 95% BCa CI [.277, .663], $p = .01$
Factor 1 and Factor 3	$r = .63$, 95% BCa CI [.446, .775], $p = .01$

DISCUSSION

The American Psychological Association in their *Health and Homelessness* fact sheet states that psychologists must increase their efforts to end homelessness (APA, 2019). This study aimed to contribute to the scientific literature of the public issue of homelessness by providing a Spanish inventory that would facilitate the assessment of Puerto Rican health professionals' attitudes toward the homeless population in Puerto Rico. As Buck et al. (2005) argued, the information attainable from such an inventory could influence the "design and implementation of educational activities that foster more compassionate homeless health care" (Buck et al., 2005, para. 1).

Items whose subject was worded in terms of medical practitioners were changed as part of the process of cultural adaptation of the HPATHI and in an attempt to broaden the item's relevance to health professionals beyond the medical professions to include other health professions such as psychology. Additionally, given that some items seemed to assume professionals were currently working or interested in working with the homeless population, some rewording was done so that the inventory could capture health professionals' attitudes toward the homeless even if from a distance, clinically speaking.

Construct validity, health professional's attitudes towards homeless people, was determined through corresponding item and factor analyses. Conceptually, the same three factors were identified as were in Buck et al. (2005), however some items loaded differently as compared to their original study. This could be due to the relatively low sample size N = 86 used for the analyses in this research paper, which is a definite limitation of this pilot study for the HPATHI-Spanish. On the other hand, perhaps the items behaved differently in part because of the sample being in its majority composed of Hispanic mental health professionals. Two items loaded positively and significantly to more than one factor in the 14-item version of the instrument and were kept given that the loadings corresponded to both factors relating to advocacy for homeless individuals' needs. It is possible that these items (12 and 18) were worded in a way that did not distinguish Personal Advocacy from Social Advocacy effectively. It is also possible that these dual factor loadings merely reflect the correlation between the variables Personal Advocacy and Social Advocacy for the wellbeing of homeless individuals.

Limitations and Future Recommendations

Sample size is a limitation in this study that could be improved upon in another study in order to obtain more robust results concerning the validity of the 14-item HPATHI-Spanish's factor analysis. According to Comrey and Lee (1992), the recommended sample size for factorial analyses is at least 300 participants, although a sample of 200 participants could be considered "fair." In this study the obtained sample size was N = 86. Additionally, a more diverse sample career wise would broaden the utility of instrument. At present, most of those who participated in the study had careers in Clinical Psychology or in Medicine. Other important health related professions include Social Work, Counseling Psychology, and Speech Pathology to name a few.

CONCLUSION

There was no instrument found during the literature review process via online academic data bases for the evaluation of health professionals' attitudes towards the homeless population going back from 2018 that was available in Spanish. Additionally, psychology research pertaining to this vulnerable minority group in Puerto Rico is scarce. This study aimed to translate, adapt, and initially validate the Health Professional's Attitude Toward the Homeless Inventory (HPATHI) for Puerto Rican health professionals in Puerto Rico. The sample was innovative given that it included a variety of health professionals, including mental health professionals. The instrument's original authors (Buck et al., 2005) had written about their interest in expanding their sample to include health professionals that were not only medical professionals or medical doctors in training. This study, thus, aimed to contribute to an international growing body of research directed towards homeless individuals receiving more empathic and individualized treatment by health care professionals from both the mental and medical health perspective both in and out of the primary care environment.

REFERENCES

American Psychological Association (2019). *Health and homelessness*. https://www.apa.org/pi/ses/resources/publications/homelessness-health

Buck, D. S., Monteiro, F. M., Kneuper, S., Rochon, D., Clark, D. L., Melillo, A., & Volk, R. J. (2005). Design and validation of the health professionals' attitudes toward the homeless inventory (HPATHI). *BMC Medical Education*, *5*(1), 2. https://doi.org/10.1186/1472-6920-5-2

Chávez, L. M., & Canino, G. (2005). Toolkit on translating and adapting instruments. *http://www.hsri.org/files/uploads/publications/PN54_Translating_and_Adapting. pdf*.

Comrey, L.A. & Lee, H.B. (1992). *A first course in factor analysis* (2nd ed.). Lawrence Erlbaum Associates.

Cronbach, L. J. (1951). Coefficient alpha and the internal structure of tests. *Psychometrika*, *16*(3), 297-334.

Darbyshire, P., Muir-Cochrane, E., Fereday, J., Jureidini, J., & Drummond, A. (2006). Engagement with health and social care services: Perceptions of homeless young people with mental health problems. *Health & Social Care in the Community*, *14*(6), 553-562. https://doi.org/10.1111/j.1365-2524.2006.00643.x

Departamento de la Familia (2007). Conteo de Personas Sin Hogar: Enero 2007 Informe Ejecutivo. *Comisión Para la Implantación de la Política Pública Para las Personas Deambulantes*. Retrieved from: https://estadisticas.pr/files/Inventario/publicaciones/DF_ConteoPersonasSinHogar_2007. pdf

Departamento de la Familia (2015). Conteo de Personas Sin Hogar 2017. *Estudios Técnicos, Inc*. Retrieved from: https://estadisticas.pr/files/Inventario/publicaciones/DF_ConteoPersonasSinHogar_2015_0.pdf

Departamento de la Familia (2017). Conteo de Personas Sin Hogar 2017. *Estudios Técnicos, Inc*. Retrieved from: https://www.coalicionpr.com/documentos/PRESENTACION_COC_2017.pdf

Donovan, S., & Shinseki, E. K. (2013). Homelessness is a public health issue. *American Journal of Public Health*, *103*(Suppl 2), S180. https://doi.org/10.2105/AJPH.2013.301727

Erkut, S., Alarcón, O., Coll, C. G., Tropp, L. R., & García, H. A. V. (1999). The dual-focus approach to creating bilingual measures. *Journal of Cross-Cultural Psychology*, *30*(2), 206-218. https://doi.org/10.1177/0022022199030002004

Frisbie, D. A., & Ebel, R.L. (1991). *Essentials of educational measurement*. (5th ed.), Prentice-Hall.

Field, A. (2017). *Discovering statistics using IBM SPSS statistics* (5th ed.). Sage.

Hernández Sampieri, R., Fernández Collado, C., & Baptista Lucio, P. (2014). *Metodología de la investigación*. (6ta ed.). Editorial Mc Graw Hill.

Hutcheson, G. D., & Sofroniou, N. (1999). *The multivariate social scientist: Introductory statistics using generalized linear models*. SAGE.

Kingree, J. B., & Daves, W. F. (1997). Preliminary validation of the attitudes toward homelessness inventory. *Journal of Community Psychology*, *25*(3), 265-288. https://doi.org/10.1002/(SICI)1520-6629(199705)25:3<265:AID-JCOP4>3.0.CO;2-V

Kline, P. (1999). *The handbook of psychological testing* (2nd ed.). London: Routledge.

Lester, H. E., & Pattison, H. M. (2000). Development and validation of the attitudes towards the homeless questionnaire. *Medical Education-Oxford-*, *34*(4), 266-268.

McNaughton Nicholls, C., & Atherton, I. (2011). Housing First: Considering components for successful resettlement of homeless people with multiple needs. *Housing Studies*, *26*(5), 767-777. https://doi.org/10.1080/02673037.2011.581907

Pearson, C., Locke, G., Montgomery, A. & Buron, L. (2007) The applicability of housing first models to persons with serious mental illness (Washington DC: US Department of Housing and Urban Development). Available at: https://www.huduser.gov/portal/publications/hsgfirst.pdf.

Phelan, J., Link, B. G., Moore, R. E., & Stueve, A. (1997). The stigma of homelessness: The impact of the label" homeless" on attitudes toward poor persons. *Social Psychology Quarterly*, 323-337.

Price, L. R. (2016). *Psychometric methods: Theory into practice*. Guilford Publications.

Rae, B. E., & Rees, S. (2015). The perceptions of homeless people regarding their healthcare needs and experiences of receiving health care. *Journal of Advanced Nursing*, *71*(9), 2096-2107. https://doi.org/10.1111/jan.12675

Taylor, E. M., Kendzor, D. E., Reitzel, L. R., & Businelle, M. S. (2016). Health risk factors and desire to change among homeless adults. *American Journal of Health Behavior*, *40*(4), 455-460. https://doi.org/10.5993/AJHB.40.4.7

Torres, A., Garcia-Carrasquillo, A., & Nogueras, J. (2010). Sociodemographic variables, childhood characteristics, and family risk factors for homelessness: A "Puerto Rican Paradox?". *Hispanic Journal of Behavioral Sciences*, *32*(4), 532-548. https://doi.org/10.1177/0739986310378235

Tsemberis, S., Kent, D. & Respress, C. (2012). Housing stability and recovery among chronically homeless persons with co-occurring disorders in Washington DC. *American Journal of Public Health, 102*(1), 13–16. https://doi.org/10.2105/AJPH.2011.300320

U.S. Department of Housing and Urban Development (2018). The 2018 Annual Homelessness Assessment Report (AHAR) to Congress, Part 1: Point-in-Time Estimates of Homelessness. Retrieved from: https://files.hudexchange.info/resources/documents/2018-AHAR-Part-1.pdf

Warnes, A. M., Crane, M., & Coward, S. E. (2013). Factors that influence the outcomes of single homeless people's rehousing. *Housing Studies*, *28*(5), 782-798. https://doi.org/10.1080/02673037.2013.760032

Wen, C.K., Hudak, P.L., & Hwang, S.W. (2007). Homeless people's perceptions of the welcomeness and unwelcomeness in healthcare encounters. *Journal of General Internal Medicine 22*(7), 1011– 1017. https://doi.org/10.1007/s11606-007-0183-7

APPENDIX A

Instrumento Traducido y Adaptado al Español Puertorriqueño

**INVENTARIO DE ACTITUDES DEL PROFESIONAL DE LA SALUD
HACIA PERSONAS SIN HOGAR**

Muchas gracias por participar voluntariamente de esta encuesta. Al completar este cuestionario usted está consintiendo a participar de ella. La información que usted provea será totalmente confidencial.

Por favor, **escoja** la opción que mejor describa cómo se siente acerca de cada una de las aseveraciones a continuación. Use la siguiente escala para responder:	**Muy en desacuerdo**	**En desacuerdo**	**Ni de acuerdo ni en desacuerdo**	**De acuerdo**	**Muy de acuerdo**
1. Las personas sin hogar son víctimas de las circunstancias.	①	②	③	④	⑤
2. Las personas sin hogar tienen el derecho a cuidado de salud básico.	①	②	③	④	⑤
3. El no tener hogar es un problema principal en nuestra sociedad.	①	②	③	④	⑤
4. Las personas sin hogar escogen vivir sin hogar.	①	②	③	④	⑤
5. Las personas sin hogar son vagas.	①	②	③	④	⑤
6. El presupuesto para el cuidado de la salud debe destinarse a proveer servicios a las personas pobres y sin hogar.	①	②	③	④	⑤
7. Me sentiría cómodo/a ofreciéndole servicios de salud a personas sin hogar que tienen un trastorno de salud mental grave.	①	②	③	④	⑤
8. Me sentiría cómodo/a siendo parte de un equipo que provea servicios de salud a personas sin hogar.	①	②	③	④	⑤
9. Me sentiría cómodo/a proveyéndole servicios de salud a diferentes grupos étnicos y minoritarios.	①	②	③	④	⑤
10. Siento que me abrumaría la complejidad de los problemas que tienen las personas sin hogar.	①	②	③	④	⑤
11. Entiendo que las prioridades de mis pacientes/clientes pueden ser más importantes que seguir mis recomendaciones de salud.	①	②	③	④	⑤
12. Los profesionales de la salud deben abordar los problemas físicos y sociales de las personas sin hogar.	①	②	③	④	⑤
13. Ingresé a una profesión de la salud porque quiero ayudar a los que lo necesiten.	①	②	③	④	⑤

14.	Me interesaría trabajar con personas desatendidas.	①	②	③	④	⑤
15.	Disfrutaría abordar asuntos psicosociales con los pacientes/clientes.	①	②	③	④	⑤
16.	Resentiría la cantidad de tiempo que me tomaría atender a pacientes/clientes sin hogar.	①	②	③	④	⑤
17.	Disfrutaría aprender de la vida de mis pacientes/clientes sin hogar.	①	②	③	④	⑤
18.	Creo que la justicia social es una parte importante del cuidado de salud.	①	②	③	④	⑤
19.	Creo que ofrecerle servicios de salud a las personas sin hogar no es económicamente viable para mi carrera.	①	②	③	④	⑤