Health in hostels: a survey of hostel dwelling women

S. V. L. Marriott, R. H. Harvey and D. Bonner

Direct access residents in an inner London homeless women's hostel were interviewed and asked to provide information on medical, personal and social history. For each a DSM-III-R diagnosis, General Health Questionnaire, CAGE and Global Assessment Scale score was assigned, and their views on future housing were sought. The effect of severe mental illness (SMI) and age on dependent variables was examined. A third of the sample (*n*=14) suffered from SMI, and a further quarter from other mental illness (*n*=10). A quarter had a DSM-III-R substance misuse disorder. The prevalence of SMI was similar across age groups. Younger women had a different pattern of service needs, with greater levels of psychological distress, substance misuse and residential instability, than older residents.

Changing the organisation of psychiatric institutions has been shown to be associated with improvements in the disability of their residents (Wing & Brown, 1970). It is well established that those with mental health problems remain substantially over-represented among the homeless population, who may be accommodated in a range of settings including temporary bed and breakfast, on the street, and a range of resettlement and direct access hostels. The Office of Population Censuses and Surveys of Psychiatric Morbidity in Great Britain devoted a special bulletin to homeless people (Jenkins & Meltzer, 1995). Direct-access hostels often support large numbers of residents at any one time, and can provide little more than basic food and shelter, in an impersonal and inevitably dilapidated environment. Evidence of one particular group of homeless people, homeless women, suggests that their numbers have been increasing disproportionately (Scott, 1993). One important study of homeless women suggested they might be more vulnerable to severe psychiatric morbidity than their male counterparts, while indices of social functioning suggested greater social stability (Marshall, 1992). Like homeless men, these women are often inadequately engaged with services, and their physical health neglected.

This study examines the self-report of direct access residents of a hostel for homeless women regarding past and present health and social problems, accommodation history and preferences, together with normative measures of their social functioning and psychiatric morbidity. Severe mental illness and resident's age were examined as independent variables, to study the relationship of each to residents' health and social status, and attitudes to accommodation.

The study

The hostel

Our sample was drawn from an inner London charitable hostel. It provided a single room, one meal (breakfast), shared washing and toilet facilities, and a staff tannoy system which operated throughout the building. The premises were clean but dimly lit and impersonal, and included two large sitting rooms, and a small chapel. Two workers at any time supported the total resident population of 72, aged between 18–60 years. The main referral route was direct access, with an important secondary route through a network of aid organisations supporting East African refugees.

The residents

Approximately one-third (26) of the residents were refugees from East Africa. Since the referral route for this group was not direct access, and the survey project was inadequately resourced to support the required interpreting services, we had to exclude this group from the sampling frame. Our sample comprised those women resident on the day the survey commenced, or becoming resident during the course of the survey, and settled there for at least one week.

The survey

The researchers, both female psychiatrists (S. M. and D. B.), made preliminary visits to familiarise themselves with the hostel, and its routine. All residents received initial written information about the proposed survey. The hostel was visited on a weekly basis to register new residents, and to approach potential participants for interviews. A semi-structured interview incorporated social, demographic and psychiatric topics. Self-reported data included socio-demographic

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background, perceived health problems, and views and preferences for accommodation. Normative measures were DSM-III-R diagnoses (American Psychiatric Association, 1987), the Global Assessment Scale (GAS; Endicott *et al*, 1976), and CAGE Questionnaire (Mayfield *et al*, 1974). CAGE caseness was achieved with one positive response. Twenty-seven direct access residents left before they could be approached, six declined an interview. The results are based on 40 interviews which were performed over a period of 26 weeks and took between 45–90 minutes. Not all the women interviewed were willing to answer all questions. When an answer was given to a question it was included in the analysis.

The data were analysed using "diagnosis of SMI" as the independent variable; SMI was defined as a DSM-III-R diagnosis of schizophrenia, major depressive episode, schizoaffective disorder, or other psychotic condition. Dependent variables used to measure the effect of age were DSM—III-R axis 1 diagnosis; Global Health Questionnaire (GHQ; Goldberg, 1978); CAGE; GAS; length of hostel stay ('new arrivals' (< 1 year); 'residents' (> 1 year)) and expressed wish to settle down. The data were also analysed by age, using the median age (45 years) as the cut-off for categorical variables, and the same dependent variables.

The information was compiled into a database, which was used to calculate summary statistics. Confidence intervals were calculated using the British Medical Association Confidence Interval Analysis (CIA) program. Means are presented with 95% CI.

Findings

Socio-demographic information

The mean age of the residents interviewed was 46 years (95% CI: 41.9–46.7), ranging from 19 to 82 years. None of the sample were in a stable relationship. Twenty-seven (68%) were single and 13 (33%) divorced, separated or widowed. Fourteen (35%) reported a significant separation from home during childhood, and of these five (12%) had been in institutional care. The mean time since any partnership had broken down was 10 years (range: 4 months to 40 years).

Thirteen (33%) had children. Of these, about half remained in contact. Long-term unemployment rates were extremely high. Only one woman was currently employed, and there was a mean length of 9.7 (CI: 6.76–12.6) years since last employed. Five (13%) had never been employed.

Physical and mental health

General health Thirty-eight (95%) women reported at least one current, specific health complaint. Eleven (28%) attributed their worst health complaint to a psychological origin, and 18 (45%) to a physical one. Twenty-seven (68%) rated their health as only fair (15), or poor (12).

Mental health Fourteen (35%) of the sample fulfilled DSM-III-R diagnostic criteria for SMI. Ten (25%) had a substance misuse disorder. Of these, no cases of drug dependence were identified; one resident fulfilled criteria for DSM-III-R benzodiazepine misuse. Six (15%) had an alcohol-related diagnosis (alcohol dependence, 2; alcohol misuse, 4), but nine (23%) achieved caseness using the CAGE. Three had coexisting SMI and substance misuse diagnoses. No organic brain disorder was identified. Ten repondents (25%) achieved caseness on the GHQ. GAS scores ranged from 21 to 85, mean 59 (CI: 51.5–66.5).

Eighteen (45%) reported past contact with mental health services. Ten (25%) had received one or more episodes of in-patient care. The mean number of episodes in the past 10 years was 2.93 (range: 0 to 20), and their mean duration was 3.71 months (range: 0 to 14). Six (15%) reported regular psychotropic prescriptions. These were any form of major tranquillisers (6), antidepressants (3), and minor tranquillisers (1).

Housing history

Immediately before coming to the hostel, all but one resident had been in other temporary accommodation (hostel or B&B (22); rented accommodation (13); sleeping rough (3); prison (1)). The women had stayed in a mean of 0.9 previous hostels (range 0–5). Eighteen (45%) respondents had slept rough at some time.

Views on current accommodation Thirty-four (85%) said their intention was to find stable accommodation. Only four (10%) said living in a hostel was their preferred place of residence. The women attributed their homelessness to a wide range of factors. The most common was relationship breakdown (33%), and then unemployment (28%). Five (13%) attributed their homelessness to psychiatric illness, of whom three were suffering from SMI. When asked what they liked about the hostel, 20 (50%) could think of nothing they liked. The two most valued features of the hostel related to its non-intrusive style (33%), and the perceived support and community atmosphere (18%), or both of these (13%). The main dislikes concerned institutional rigidity and constraints (28%), the deteriorated interior structure of the building (8%) and 'living with the mentally ill' (8%; all of whom were in the non-SMI group).

Views on future accommodation Fifteen (38%) said they would choose shared accommodation in the future, but only 3 (8%) were prepared to

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share a bedroom. Avoiding isolation was the most common reason given for wanting to share (15%). Asked about difficulties foreseen in living alone if there was no alternative, seven (18%) felt they would be unable to cope. Fifteen (38%) said they would prefer some form of in-house professional support, and 14 (35%) were against any such support.

The older age group were significantly more likely to have been resident for more than a year ($P<0.0001$), and were less likely to express a wish to settle down.

Comment

Although a number of distinctive features were identified in this population, the frequency with which a history of family and relationship breakdown, unemployment, treated and untreated physical and mental illness, and dissatisfaction with their circumstances was reported was a striking feature. Virtually all had arrived from other temporary accommodation. Overt psychiatric morbidity was very common, and minor mental illness was identified in a quarter of respondents, and SMI in a further one-third. Substance misuse was the second most common axis I disorder. These findings are consistent with many other studies of homeless populations (Scott, 1993).

Younger residents were more likely to have a non-psychotic psychiatric illness, detected with the GHQ, to report alcohol misuse, and to be transient in their stay. The older residents were no more likely to suffer from SMI or have impaired psychosocial function, measured with the GAS, but viewed themselves as more stably accommodated. Irrespective of health or social problems, housing was one of the residents' foremost concerns. Older residents were more likely to regard themselves as 'settled'. Such indifference to leaving can be understood as a response to a familiar and 'safe' environment. It is also at the heart of 'institutionalism' (Wing & Brown, 1970), and appeared to operate independently of a diagnosis of SMI. The recent introduction of a resettlement team had generated both hopes and uncertainties within the hostel community. Fully independent accommodation was most often stated as the favoured alternative, but at the same time many residents had significant misgivings about living alone. The hostel's institutional features figured significantly in their daily routine, and not always unfavourably. Many valued the hostel as a social resource, providing the core to their social network, which not infrequently comprised one, sometimes a few acquaintances, but rarely confiding relationships or other opportunities for intimacy.

A similar earlier study (Marshall, 1992) found substantially higher rates of SMI, drug misuse and dual diagnoses than those reported here, although the prevalence of alcohol-related problems was similar. Clearly, sampling methods can easily confound surveys of this type of population. For instance, in our survey the sampling frame excluded a substantial refugee population who, although their complex needs are well documented (Boehnein, 1987), were not "direct access"; a very short-stay resident group (termed elsewhere the "restless homeless" (Harris & Backrach, 1990)), who were not captured by our weekly sampling interval; and those who were unwilling to participate. Each of these groups have been described elsewhere as likely to have distinct patterns, and high levels, of service needs, and their exclusion alone may account for the differences we found. Individual hostels may exert an influence on who uses the hostel, or settles there. This hostel's routine and facilities offered little encouragement for social interaction, and its ethos included an intolerance of drug misuse. The privacy of this hostel's accommodation was stated as one of the aspects most valued by the residents who settled there, and may well have been one of the more oppressive to those who soon moved on.

Local surveys of residential settings and their communities are time consuming, and methodologically difficult, but there is no substitute for such preliminary 'fieldwork' for local service planners. This survey promoted a far richer understanding of the nature of these residents' needs than extrapolation from epidemiological data alone would have allowed.

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