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Satisfaction and Distress

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Emergency and specialized mental health shelters represent different service philosophies and are meant to appeal to different segments of the homeless and homeless mentally ill population. This article describes the different characteristics and needs of users of emergency and specialized mental health shelters for homeless persons in Boston. Service satisfaction is described in relation to these characteristics and needs as well as in terms of shelter type. Implications are identified for social and mental health service policies for the homeless.

Seriously mentally ill persons comprise one of the largest and neediest subgroups among the homeless adult population. Representing from 20 to 40 percent of single homeless adults, seriously mentally ill people tend to be more vulnerable on the streets and less adequately served within the emergency shelter system. Yet despite their grave needs, many mentally ill persons remain homeless for lengthy periods, rejected by, or rejecting, traditional mental health services.[1] Although there is general consensus that, ideally, these individuals should be provided with permanent housing and mental health services, insufficient resources have precluded achievement of this ideal for many homeless mentally ill people.[2]

Special service-oriented shelters for this subgroup represent a partial response to their unique problems. More structured and supportive than large emergency facilities, service-oriented shelters provide a more secure environment and a range of health-related programs, but without the regulations about entry, exit, and program participation that characterize traditional mental health services. Clearly less adequate than independent or supervised permanent housing, they nonetheless fill a niche in the service continuum. Boston is one of several cities in which the state mental health agency has funded special shelters.[3]

We investigate the role that the specialized mental health shelters play in Boston's service system, employing survey data collected from users of three emergency and two specialized shelters. First, we evaluate the extent to which these shelters are

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used by a particular subgroup among Boston's mentally ill shelter users. Next, we identify differences in feelings of personal distress and service satisfaction among users of the specialized and emergency shelters. Finally, we determine whether intershelter differences in feelings are due to corresponding differences in personal characteristics. Our conclusions highlight policy implications.

Background

Many shelters opened in the early 1980s in response to growing public recognition of the homelessness crisis. Attempting to forestall hunger and even death among individuals who had no discernible means of subsistence, emergency shelters provided food, a place to sleep, and, sometimes, nursing care. Many shelters expected to "work themselves out of business" quickly, and few sought to respond to more chronic problems of their guests; some shelters abjured service provision in order to pressure health and welfare agencies to provide adequate services.

The "emergency" approach to shelter provision was not intended to meet the needs of seriously mentally ill persons, yet early research indicated that many among the homeless were mentally ill.[4] As the problem of homelessness grew throughout the 1980s, shelter staff found themselves unable to stem the progressive deterioration of these most needy guests. Moreover, mental health agencies often lacked the means or the will to engage potential homeless clients.[5]

Service-oriented shelters for mentally ill homeless persons were a partial response to these problems. Service providers in cities including Boston, New York, and San Francisco sought to provide a shelter environment that at least would be less threatening to mentally ill persons than large, barracks-style shelters and, they hoped, would engage these people in meaningful transitional programs.[6] Such service-oriented shelters used mental health professionals to engage homeless individuals in treatment-oriented activities. Many offered day programs either on site or through associated mental health centers, and attempted to create a stable, more predictable environment.

In the absence of sufficient housing opportunities for homeless people, particularly for those who are mentally ill, specialized mental health shelters seem to provide an important service option. However, little is known about the role actually performed by these shelters. Service systems for homeless people in most cities are a patchwork of public and private shelters and other programs with varying degrees of coordination, few eligibility regulations, and no central authority.[7] The mix of users at any particular shelter is determined to a variable and unknown extent by client needs and preferences, physical accessibility, program orientation, and, in some cases, by outreach staff.

Nor is there much basis for predicting the reactions of homeless mentally ill people to particular service approaches. Reports from outreach service providers document disinterest among some potential clients in traditional mental health services and a desire for independent living,[8] but other studies report that homeless mentally ill persons willingly accept services that are sensitively provided.[9]

Previous research also suggests that homeless mentally ill persons' service experiences and orientations vary with substance abuse: many of the "dually diagnosed" — mentally ill persons who abuse substances — eschew services and are in any case often viewed as inappropriate clients by service providers.[10]

These studies do not yield clear implications for predicting or explaining the reactions of homeless mentally ill persons to different types of shelter, although it seems

likely that these reactions will be associated with service interests and thus reflect some of the same influences.

Methodology

Homeless people were interviewed in five Boston shelters: two specialized shelters for homeless mentally ill persons and three generic shelters for homeless adults.[11] Both specialized psychiatric shelters are funded by the Massachusetts Department of Mental Health (DMH) and provide beds and a range of services for about sixty persons; one is adjacent to a detoxification center on an island and provides special programs for substance abusers, while the other is located within a downtown Boston community mental health center that offers several day programs. Unlike most generic shelters, the mental health shelters offer permanent bed assignments and lockers, on-site psychiatric nurses and other staff trained in mental health services, and referrals to day and prevocational programs at community mental health centers. A DMH outreach team identifies individuals in the generic shelters or on the streets who might benefit from the special shelters; those who are interested in moving into the special shelters are put on a waiting list until a bed is available.

Each of the three generic shelters is open to all adult homeless persons, basically without restriction (other than for inebriation or past disruptions). As a result, those using these generic shelters are diverse, including some who are employed during the day, others who are medically ill, and many who are substance abusers or mentally ill. Although the generic shelters offer some services for these and other groups — AA meetings, a psychiatric nurse, in-shelter employment programs, and "respite beds" for those recovering from hospitalization — the number of programs offered and the staff/guest ratio are much lower than in the mental health shelters.

Guests at each of the five shelters were asked to participate in an interview between June and November 1990. In the three large "generic" shelters, guests were selected randomly from shelter bed lists. Eighty percent of the guests who were sampled were interviewed.

At the mental health shelters, all guests were asked to participate in an interview; 72 percent agreed. Staff helped to approach them for interviews and small incentives were used to encourage participation.

Interview schedules used in the mental health shelters and in the emergency shelters differed somewhat, but this analysis uses only those questions asked in both settings (see Table 1). Mental health measures used in this analysis are three questions concerning prior or current treatment (with a reliability coefficient of 0.67) and two questions from the Mental Health Inventory — one indicating suicidal thoughts and one indicating feelings of distress or depression.[12] Neither approach indicates actual mental illness at the time of the survey, but both provide evidence of current or past psychiatric problems.[13]

Substance abuse was measured with subsets of items from the Addiction Severity Index (ASI);[14] Cronbach's alpha for the four-item alcohol abuse scale was 0.78; alpha for the three-item drug abuse scale was 0.84. Available social supports were measured with The 39-item ISEL,[15] which yielded a reliability coefficient of 0.88 (one item was omitted as inappropriate for this population and two were slightly reworded).

Residential experience was assessed by recording the length of time since a person first became homeless and whether the person reported staying with family, friends,

or in a regular place on his or her own since first becoming homeless. In addition, individuals were asked if they had been assaulted on the streets and if they had any legal problems. Satisfaction with shelter arrangements was measured with three individual questions. The subjects were asked to compare the shelter to their last regular housing and to other shelters, and to rate the quality of shelter services. In addition, an index was used, composed of responses to eight questions about such specific shelter features as the amount of room, staff, security, other residents, and convenient location (Cronbach's alpha was 0.77).

Physical health was measured with four questions: rating of physical health relative to others of similar age, satisfaction with physical ability to do things, having been hospitalized or seen by a doctor for a physical health problem in the last year, and having any physical health problem. These questions were combined into an index with a reliability coefficient of 0.66.

Table 1

Individual Characteristics by Shelter Type

	Shelter		
Characteristic	Generic	Mental Health, City	Mental Health, Island
Demographics			
Age: 20s–30s	65%	49%	59%
Education: less than high school	36%	30%	41%
Gender: female	20%	32%	15%
Veteran: yes	16%	13%	7%
Race: white	40%	71%	58%[a]
Social Supports			
Divorced/separated	31%	23%	15%
Children in Boston	24%	13%	12%
Relatives in Boston	61%	61%	56%
Friends in Boston	77%	52%	41%[b]
Interpersonal support evaluation list (ISEL)	2.7	2.5	2.6
Employment and Benefits			
Employed	22%	7%	12%
Looking for work	42%	32%	24%
Received benefits	52%	86%	84%[c]
Health insurance	63%	71%	64%
Difficult to afford things	51%	32%	40%
Residential Experience			
1+ years homeless	55%	97%	82%[c]
1+ years in shelter	46%	53%	54%
Stayed here often	59%	90%	93%[c]
<1 Year since last hospitalized	46%	18%	50%[a,d]
Assaulted	44%	52%	62%
Worse physical health	55%	40%	32%
Approximate N	48	31	28

[a]p< = .05 (difference among three shelter types)
[b]p< = .01 (difference among three shelter types)
[c]p< = .001 (difference among three shelter types)
[d]p<.05 (difference between two mental health shelters)

Since the focus of this article is on individuals with mental health problems, the analysis of the generic shelter sample is restricted to those sample members who reported any prior or current treatment for mental health problems. These generic shelter users who had been treated for mental health problems were comparable to other generic shelter users in terms of demographic characteristics, social supports, labor force participation, and residential experience. However, previously treated generic shelter users reported poorer physical health, more suicidal thoughts, and more distress (see Appendix).

Because of the potential impact of the expected higher proportion of substance abusers at the island mental health shelter, the two mental health shelters are distinguished in all analyses. The analysis has two goals: to describe the characteristics and needs of persons with a mental health treatment history in the three shelter types and to identify the effect of shelter type on shelter satisfaction.

Cross-tabular analysis is used to achieve both goals, with tests of significance presented for the comparison between individuals staying in the two mental health shelters and those in the generic shelters who had previously been treated for a psychiatric problem. Analysis of covariance is used to identify the unique effect of shelter type on distress and shelter satisfaction.

Findings

Age, education, gender, and veteran status did not vary substantially among the three shelter types (Table 1). The one statistically significant demographic difference between the shelters was in race: more of the mental health shelter users were white, particularly at the central city site.

Few respondents in any setting were married at the time of the interview, and the proportion who were divorced varied little by location. Other indicators of respondents' social relations also varied little between shelters. However, mental health shelter users reported significantly fewer friends in the area than than did those at the generic shelters.

Attachment to the labor force varied little by shelter type, although the proportion of guests who were working was somewhat lower at the two mental health shelters. Receipt of benefits, on the other hand, was markedly more common among mental health shelter users.

Length of time homeless was much higher for those staying at the mental health shelters, although this difference did not extend to length of time at the current shelter. In addition, guests at both mental health shelters reported staying there much more regularly since becoming homeless. There was one difference between the two mental health shelters in residential history: it had been much longer since the central city shelter users had last been discharged from a psychiatric hospital. Many respondents had been assaulted or robbed since becoming homeless, but frequency of having been assaulted varied only slightly among guests at the three shelters.

Respondents' self-reported physical health did not differ significantly among the three shelter types, but the generic shelter users had a higher score (indicating poorer physical health) than users of the mental health shelters ($p = 0.1$).

About one quarter of the respondents had thought of suicide within the previous month — a proportion that did not vary significantly among the shelters (Table 2).

Table 2

Current Feelings and Substance Abuse by Shelter Type

Feelings/Substance Abuse	Shelter		
	Generic	Mental Health, City	Mental Health, Island
Suicidal	25%	29%	20%
Down/depressed	48%	29%	20%[a]
Alcohol abuse	40%	30%	50%
Drug abuse	35%	4%	12%[b,c]
Approximate N	48	31	28

[a]p< = .05 (difference among three shelter types)
[b]p< = .01 (difference among three shelter types)
[c]p<.05 (difference between generic and combined mental health shelters)

Feelings of being down and depressed, however, were much less common among mental health shelter users.

Alcohol abuse was reported by between a third and half of the respondents at each shelter type. The frequency of drug abuse was about one-third in two of the three shelter settings. Users of the central city mental health shelter reported lower rates of both alcohol and drug abuse, although the difference was not statistically significant.

Respondents at the city mental health shelter reported higher levels of satisfaction with their shelter than did the other groups, with almost three-quarters assessing the shelter as better than their last regular housing. However, island mental health shelter users were more likely to believe that their shelter was superior to others (Table 3).

Table 3

Shelter Satisfaction by Shelter Type

Satisfaction	Shelter		
	Generic	Mental Health, City	Mental Health, Island
Satisfied with shelter	65%	87%	57%[c,d]
This shelter better compared to last regular housing	47%	72%	41%[a,d]
This shelter better compared to other shelters	66%	79%	96%[b,d]
Good services	62%	81%	48%[a,d]
Move now	57%	48%	65%
Want own apartment	90%	68%	86%[a]
Approximate N	48	31	28

[a]p< = .05 (difference among three shelter types)
[b]p< = .01 (difference among three shelter types)
[c]p< = .001 (difference among three shelter types)
[d]p<.05 (difference between two mental health shelters)

Desire to leave the shelter was somewhat lower among central city mental health shelter users than others. Differences in type of living arrangement sought were more marked: two thirds of the central city mental health shelter users wanted their own apartment, compared to nine in ten of the other two groups.

Controlling for length of time homeless and the other individual characteristics associated with shelter type reduced to insignificance the effect of shelter type on feelings of depression: persons who had been homeless longer were less depressed, and such persons were concentrated disproportionately in the mental health shelters (Table 4).

Table 4

Analysis of Covariance of Feeling Depressed by Shelter Type

Main Effect	Degrees of Freedom (DF)	F = Value	P (Probability)
Shelter type	2	.38	.68
Covariates			
Race	1	.56	.46
Financial benefits	1	.04	.85
Friends	1	.88	.35
Time homeless	1	5.22	.02
Explained sum of squares 9.13	DF = 6	F = 1.08	P = .38
Residual sum of squares 119.18	DF = 85		

The effect of shelter type on service satisfaction was independent of the covariates: irrespective of their race, financial benefits, number of friends, and length of time homeless, users of the central city mental health shelter were more satisfied with the services they received at the shelter than either the island mental health shelter users or those in generic shelters who had been treated for psychiatric problems (the greater interest in group living among the central city mental health shelter users also was independent of the covariates) (Table 5).

Discussion

Individuals who had been treated for a psychiatric problem in the generic shelters and those staying in the two mental health shelters were similar in terms of gender, age, and veteran status. There was little difference among guests at the three shelters in frequency of suicidal thoughts. However, mental health shelter users had

Table 5

Analysis of Covariance of Service Satisfaction by Shelter Type

Main Effect	Degrees of Freedom (DF)	F = Value	P (Probability)
Shelter type	2	.38	.68
Covariates			
Race	1	1.12	.29
Financial benefits	1	.71	.40
Friends	1	.29	.59
Time homeless	1	1.40	.18
Explained sum of squares 12.86	DF = 6	F = 2.81	P = .02
Residual sum of squares 51.04	DF = 67		

been homeless longer and were less likely to have friends in Boston; they were also more likely to be receiving financial benefits, appeared somewhat less physically ill, and at the time of the interview felt less depressed.

A tentative explanation of the apparent paradox in these findings — fewer feelings of distress and more financial benefits among mental health shelter users who also had been homeless longer and had fewer friends — is suggested by the concept of "entrenchment": the adaptation to street or shelter living made by persons who have been homeless for a long period.[16] The potential value of this explanation is reinforced by the ability of length of time homeless to explain the lower distress levels among the mental health shelter users: persons who had been homeless for longer periods were more likely to use the mental health shelters, but wherever they were found, they experienced lower levels of distress.

Users of the two different mental health shelters were comparable in most respects, although substance abuse was less common and latest hospital discharge was less recent among users of the central city mental health shelter than at either the island mental health shelter or the generic shelters. Current feelings differed in several respects between users of the two shelters: central city shelter users were more satisfied with their shelter and more interested in group, rather than independent, living.

The higher level of service satisfaction was not explained by the other differences among users of the three shelters — it seemed more likely to be a product of the shelter experience itself.

There was thus little evidence that the mental health shelters served a clientele that was either more stable or more severely ill, but mental health shelter users did seem to be more entrenched in the state of homelessness.

Homeless persons in Boston's generic shelters who had been treated for a psychiatric problem were similar to other homeless persons in most respects, but they gave many more indications of physical illness and had had more suicidal thoughts. These differences alone suggest the possible need for specialized services for these individuals.

Those who resided at the mental health shelters were similar in many respects to those with a psychiatric treatment history who were using the generic shelters at the time of the survey. However, their more regular shelter use, their higher levels of benefits, their longer time of homelessness, and their less depressed feelings suggest that the mental health shelter users were more adapted to shelter living than their generic shelter counterparts. Central city shelter users were particularly satisfied with the quality of services they received and even tended to rate their shelter accommodations as superior to their last regular housing.

We do not know if the people surveyed in the generic shelters would have moved into a mental health shelter if they had the option, nor do we know if mental health shelter users also had been more satisfied with previous shelter accommodations and less distressed when they were in them. However, the evidence we have reviewed suggests that the mental health shelters were successful in providing a form of accommodation that was viewed as superior to generic shelters and was associated with less distressed feelings. In the chaotic and threatening environment that homeless individuals confront, and in light of the particular vulnerabilities of those who are mentally ill, this is an important achievement.

The appeal of the mental health shelters must be weighed against the vulnerability of their residents to the process of "shelterization": the acceptance among shelter

users of the state of being homeless, coupled with a decreased interest in independent living, that is also reflected in our findings. The fact that lower levels of distress among the mental health shelter users could be explained by their longer time of homelessness suggests that shelterization may reflect in part the process of entrenchment of individuals in the state of being homeless.[17] It is only within the context of inadequate opportunities for regular housing that our findings can be seen as providing clear support for maintaining mental health shelters.

Our findings also indicate that researchers who seek to understand the sources of depression and demoralization among mentally ill homeless persons as well as the bases of their reactions to service provision must take into account the specific shelter environment to which their respondents are exposed. The widely recognized heterogeneity of the homeless population is now complemented by a differentiated population of shelters. The bases of the feelings of persons who are homeless and mentally ill must be sought in the accommodations and other services they encounter as well as in the other, more personal aspects of their life histories and circumstances. Even the two different special mental health shelters we studied elicited markedly different levels of shelter satisfaction, net of the characteristics of the individuals who use them.

But this study can provide only incomplete answers to the questions we have raised. Longitudinal data must be collected to determine whether the special mental health shelters attract persons who are already more acclimated to being homeless, or instead result in their users' "settling in" over time. More refined measures of mental health status and other key concepts must be used to distinguish situationally induced variation in distress from underlying clinical states. Only comparative studies that draw samples from many different types of shelters will be able to determine which specific shelter approaches elicit higher levels of satisfaction. ❧

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Appendix

Characteristics and Feelings of Generic Shelter Users by Psychiatric Treatment

	Ever Treated for Psychiatric Problem	
	No	Yes
Age: 20s–30s	59%	65%
Education: less than high school	30%	36%
Gender: female	17%	20%
Veteran: yes	27%	16%
Race: white	33%	40%
Divorced/separated	26%	31%
Children in Boston	36%	24%
Relatives in Boston	69%	61%
Friends in Boston	79%	77%
Interpersonal support evaluation list (ISEL)	2.9	2.7
Employed	26%	22%
Looking for work	54%	42%
Received benefits	35%	52%[a]
Health Insurance	46%	63%[a]
Difficult to afford things	29%	51%[b]
1+ years homeless	50	55%
1+ years in shelter	45	46%
Stayed here often	59%	59%
Assaulted	32%	44%
Health: worse	15%	33%[b]
Very dissatisfied	12%	26%[b]
Health problems	41%	62%[a]
Hospitalized or seen by physician	51%	69%[a]
Suicidal	12%	25%[a]
Down/depressed	28%	48%[a]
Alcohol abuse	46%	40%
Drug abuse	33%	35%
Satisfied with shelter	74%	65%
This shelter better compared to last regular housing	32%	47%
Good services	56%	62%
This shelter better compared to other shelters	74%	66%
Move now	65%	57%
Want own apartment	92%	90%

[a]$p <= .05$.
[b]$p <= .01$.

Notes

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