A comparison of the socio-demographic and clinical characteristics of private household and communal establishment residents in a multi-ethnic inner-city area

Abstract This study compares the socio-demographic, physical and psychiatric profiles of representative samples of adults resident in communal establishments \( n = 170 \) with those living in private households \( n = 544 \) in a deprived multi-ethnic inner-city health district. Respondents were interviewed about their psychiatric and physical health as well as their early life experiences, close personal relationships, experiences of police contact and episodes of deliberate self-harm. Communal establishment residents were more likely to be single, white men and to be out of work than those in the private household sample. They typically left school at an earlier age, had a more disrupted upbringing, were less likely to have close personal relationships and reported more contact with the police. Both physical and psychiatric morbidity were substantially higher in the communal establishment residents than among those living in private households (especially for psychotic disorders). In contrast to these findings, comparisons between communal establishment residents with and without mental health problems revealed few differences.

Our data highlight the extensive needs of those living in communal establishments and the need for a wide range of agencies to co-ordinate their efforts effectively if services to this population are to be effective.

Introduction

There has been considerable interest during the last decade in the psychiatric morbidity of people (predominantly men) living in hostels, shelters and board and lodging establishments (Scott 1993). Although important in identifying the extent of mental health needs in these residents, the research undertaken has been criticised for distracting attention away from the broader social issues contributing to their impoverished circumstances (Cohen and Thompson 1992). Little consideration has been given to identifying factors that people with mental illness living in such establishments share with their mentally well counterparts. This has been reflected in the debate surrounding service provision, which has usually been confined to the specific requirements of the mentally ill (Lamb 1990) and not to the more fundamental needs pertaining to all members of this disadvantaged section of the community (Mossman and Perlin 1992). A more holistic approach to surveys of communal establishment residents is required, assessing social and physical as well as psychiatric needs and examining variation both within this population and between it and those resident in private households. As yet, there have been few studies able to make such comparisons and with notable exceptions, in particular the Office of Population Censuses and Surveys (OPCS) Surveys of Psychiatric Morbidity in Great Britain (Meltzer and Jenkins 1994), these have been undertaken in the United States (Koegel et al. 1988; Fischer et al. 1992), thus limiting opportunities to generalise the findings to the different circumstances that prevail in the United Kingdom.

The aim of this study was to compare the socio-demographic, physical and psychiatric profiles of representative samples of adults (16–65 years) resident in communal establishments with those in private households living in the same geographical area, i.e. West Birmingham Health District (WBHD). WBHD comprises the north west of the City of Birmingham. The
1991 census estimated that there were 203,000 people living in this area, of whom 123,896 were between the ages 16 and 65 years. The district includes a substantial ethnic minority population, 14% of the adult population being black and 23% Asian (1991 census). The average unemployment rate was 19.5% (1991 national average 7.7%). The proportion of households owning their own property is low (55%), and the area has a preponderance of care homes, hostels and other types of multi-occupancy accommodation. The district was ranked the fourth most deprived in England based upon the Jarman 8 underprivileged area score (1981 census; Jarman 1984).

Methods

Sampling

Communal establishment survey

No comprehensive register of communal establishments existed. Care and nursing homes, educational and correctional institutions and hospitals were excluded at the outset as were hotels and bed and breakfast establishments serving people who had a permanent address elsewhere. In order to establish a sampling frame for the remaining properties, a wide range of addresses were contacted. Each property identified was then approached for further information. Only those establishments with places for four or more residents and providing communal catering were eligible. Identification of smaller properties and those where residents were self-catering was deemed to be unreliable. Subjects were drawn from all eligible properties. In those with less than ten residents on a specified day for that property, all residents were selected to be interviewed and in establishments with ten or more residents a 50% random sample was chosen. There was no replacement for people who refused, could not be contacted or were aged 65 years or more. All interviews were completed between January and May 1994.

Private household survey

A random sample of people resident within WBHD (defined by a postcode file) and aged between 16 and 65 years (determined by the date of sampling, 1 May 1994) was drawn from the Family Health Services Authority (FHSA) database on general practitioner (GP) registration. Consent was sought from GPs to access their practice data held by the FHSA. GPs were then contacted with lists of their patients and asked to inform us of any specific reason why we should not approach them. There was no replacement for people who were ineligible (including those living in communal establishments) or who refused to be interviewed (or could not be contacted). Sampling continued until over 500 interviews had been achieved. The interviews were completed between December 1994 and May 1995.

Data collection

In addition to demographic data, information was collected from samples on early life experiences and close personal relationships as well as experiences of police contact and episodes of deliberate self-harm during the previous 6 months. Self-reported physical health was assessed using items from the schedules used in the Medical Outcomes Study (Tarlov et al. 1989). A semi-structured interview, the Structured Clinical Interview for DSM-IIIR (American Psychiatric Association 1987, Spitzer et al. 1992), was used to assess mental state. Questions about lifetime history of psychotic symptomatology were only asked in the communal establishment survey. The interview in both samples covered the DSM-IIIR criteria for depression, dysthymia, panic disorder, agoraphobia and generalised anxiety disorder during the previous 6 months. Those subjects in the communal establishment survey identified as having a psychotic disorder were not questioned about additional diagnoses. When a disorder was identified, information was obtained on the subject's use of primary care and specialist mental health services. If the person had not been ill for the full 6 months, questions focused on the period when they were unwell. Finally, a history of substance use disorder during the previous 6 months was obtained for everyone and again use of services was ascertained for 'cases'.

The interviewers (all with a background in mental health) were trained in the use of the interview schedule using role play and audio-taped interviews. All interviews were cross-checked by research staff and each interviewer audio-taped a sub-sample of their interviews, which were also reviewed. Where interviews in either Punjabi or Urdu were required, these were completed by staff fluent in those languages. Relevant sections of the interview schedules were translated to ensure consistent presentation of material.

Analysis

Data were analysed using SPSS version 6.0 (SPSS 1993). Levels of significance were tested using the $\chi^2$ statistic where appropriate. Ordinal variables were analysed using the Mantel-Haenszel $\chi^2$ (MH $\chi^2$). Six-month period prevalence rates were calculated for psychiatric disorders.

Results

Response

Communal establishment survey

Of the 33 properties identified that fulfilled the inclusion criteria for the study, 30 agreed to participate. Twenty were privately run, 6 by housing associations, 2 by voluntary organisations and 2 by social services. Although 9 specified that they were for mentally ill people, 6 identified homeless people as their target group, 2 were for young homeless people while 13 had no criteria at all. A total of 313 residents were selected for interview, of whom 59 had to be excluded because of their age, 2 because they had already been interviewed elsewhere and 4 as they were not actually resident. Of the remainder ($n = 248$), 66 refused to participate and a further 12 could not be contacted. Interviews were conducted with 170 residents (68% of those eligible). Data on age, sex, ethnicity, duration of residence and type of establishment were collected from an informant for all refusers. Those refusing were found to be more common in establishments with 10 or more residents (37% vs 20%; $\chi^2 = 7.4$, $df = 1$, $P = 0.006$).

Private household survey

In order to achieve the target of over 500 interviews, 1500 people from the FHSA database were sampled. Of