Predictors of Shelter Use among Low-Income Families: Psychiatric History, Substance Abuse, and Victimization

ABSTRACT

For poor housed and homeless families in New York City, NY, we examined the degree to which psychiatric and substance-abuse problems and victimization placed the families at elevated risk of requiring emergency housing, and we documented the prevalence of such problems. These problems were infrequently reported by both groups. However, past mental hospitalization, treatment in a detoxification center, childhood sexual abuse, and adult physical abuse were associated with increased risk of homelessness. (*Am J Public Health.* 1992;82:1547–1550)

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Introduction

In this paper we examine the degree to which psychiatric and substance problems and victimization place poor, New York City families at elevated risk of requiring emergency housing, and we document the prevalence of such problems among poor families who are housed and those who are homeless. Much of the previous research in this area has focused on documenting the prevalence of mental problems among homeless persons. Although in several of these studies relatively high rates of disorder were found among the people in the homeless samples, these rates were not sufficiently high to support the idea that psychiatric and substance-abuse problems are the principal causes of homelessness.[1,2] Moreover, there is reason to believe that psychiatric and substance-abuse problems are less of an issue for the growing numbers of homeless families than they are for single adults.[2–5] For example, rates of past psychiatric hospitalization for homeless women with children have ranged from 8 to 14%,[6–9] whereas hospitalization rates for samples comprised primarily of single homeless adults have ranged from 10 to 35%.[7,10–20] With some notable exceptions,[21–23] many of these earlier studies of homeless people have been limited by a lack of comparison groups, an inability to employ random sampling, and a use of cross-sectional samples of currently homeless people rather than of new entrants into homelessness.

Although the main focuses of our study included the roles of psychiatric history and substance abuse in homelessness, we also considered victimization (i.e., physical or sexual abuse, or the threat of such abuse). Previous work has shown childhood victimization to be related to some mental health indicators (such as alcoholism[24]) and to homelessness.[6,9,13] Victimization among adults has been related to alcoholism, mental illness, poor social adjustment,[14,24,25] and homelessness[6,9]; other studies have linked lifetime victimization to similar conditions.[26]

Methods

Data for this study were gathered as part of a larger New York City study to identify factors that place public-assistance families at elevated risk of homelessness.[27] Although this study's measures of psychiatric history, substance abuse, and victimization were not as sophisticated as they might have been in a data set whose principle focus was mental health issues, we had the advantage of being able to explore these important risk factors in a large, randomly selected sample with an appropriate comparison group.

Our sample of homeless families was confined to families requesting shelter at New York City's Emergency Assistance Units who (1) had been on welfare within the last 6 months (90% of the shelter population in New York City), (2) had not been in a shelter for at least 30 days, and (3) included children (or had a female head who was pregnant) at the time of the request for shelter. Of 969 eligible respondents screened at Emergency Assistance Units between January and July 1988, 701 completed interviews for the study for a response rate of 72%.

The comparison sample was randomly drawn from the public-assistance rolls via a multistage cluster sample. Of 745 families scheduled for interviews, 524 agreed to participate, for a response rate of 70%. (Because the initial comparison sample included more Latino families than expected, we added an over-sample of 76

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TABLE 1—Demographic Characteristics of Mothers in Homeless and Housed Public-Assistance Families in New York City

	Shelter Requesters	Housed	t test or χ^2
No.	677	495	
Mean age	27.7	34.5	13.05
Marital status,[a] %			122.99
Married/living with	21.9	6.5	
Separated/divorced	19.3	44.8	
Widowed	0.6	2.8	
Single	58.2	45.9	
Education, %			39.99
Less than 8th grade	9.3	21.8	
8th–11th grade	51.7	41.0	
12th grade	25.0	26.3	
Post-secondary	14.0	10.9	
Ethnicity,[b] %			69.96
Black	54.8	33.1	
Puerto Rican	32.4	41.8	
Other Latino	6.5	18.0	
White	4.3	4.4	
Other	1.9	2.6	
Family size			
Mean number of children	2.2	2.7	4.98
Currently pregnant or baby last year, %	55.5	16.2	184.87
Previous shelter use,[c] %	34.3	9.1	99.04

Note. $P < .001$.
[a]Housed respondents may have been reluctant to acknowledge living with a man due to fears that this would affect eligibility for welfare. Shelter requesters have an incentive to do so in that, if the man is included in the family, the entire family can be placed together in emergency housing.
[b]Includes oversample of black respondents in housed sample.
[c]Includes shelters for domestic violence as well as shelters for homeless families.

African-American respondents. The data presented in this paper exclude male respondents [4% of shelter requesters and 5% of housed families] because the prevalence of psychiatric disorders, substance abuse, and victimization is markedly different for men and women. Therefore, the final study sample included 677 mothers in families requesting shelter and 495 housed mothers.) All interviews were conducted by Louis Harris and Associates.

Our indicators of psychiatric history, substance abuse, and victimization are based on self-reported data gathered during 25-minute interviews. As with all analysis based on survey data of sensitive topics like substance abuse, underreporting may have been present, although underreporting should be comparable across samples. Also, because some measures were based on utilization of services, they may have been influenced by both access and need. To help overcome these problems, multiple questions were used to evaluate each construct (see the Appendix for the specific questions).

We used odds ratios to compare the risk of homelessness for individuals who had and did not have each of the psychiatric, substance-abuse, and victimization risk factors we considered. The odds ratio provides a good approximation of relative risk for low probability events; in this case, the risk of homelessness was only 3% for the general public-assistance family population. It is worth noting that, because the underlying risk of shelter use was low, large increases in relative risk do not necessarily indicate that attributable risk (i.e., the difference in risk between groups with and without the specified factor) is large.

Results

As Table 1 indicates, mothers in the requesting families were typically younger, somewhat better educated, and more likely to be pregnant or to have had a child in the last year than those mothers in housed families. The families requesting shelter were smaller than their housed counterparts, and black families constituted a much greater share of shelter requesters. Mothers requesting shelter were more likely to report themselves as married than were mothers in the comparison sample. Although families who had been in a shelter within the last month were excluded from the sample of shelter requesters, requesters were far more likely than currently housed families to have been in a shelter at some point.

Table 2 indicates that only 4% of shelter requesters had ever experienced mental hospitalization. The odds that a respondent with prior mental hospitalization would request shelter were 5.2 times greater than the odds for other respondents. The other two indicators of psychiatric stress—the use of counselors, therapists, and mental health clinics and the use of prescription drugs for nervous problems—did not serve as significant risk factors for homelessness.

Eight percent of the shelter requesters had been patients in a detoxification center for either drug or alcohol abuse, compared with just 2% of the respondents from the housed families ($\chi^2 = 22.0$, $P < .01$). Respondents who reported that a substance-abuse problem affected their ability to do required daily activities had 5.1 times greater odds to be shelter requesters than respondents who did not report such a problem ($\chi^2 = 13.6, P < .01$). (Given that the base rate of homelessness is 3%, the relative risk of 5.1 for those with substance-abuse problems results in an actual risk of 15.3% [that is, 5.1 × 3.0%]. Attributable risk, or added risk, would be 12.3% [15.3 − 3.0].) Even when the disruptive substance-abuse problem was caused by a requester's close friend's or relative's abuse, these requesters' risk of homelessness was elevated compared with the risk in those families who said they were unaffected by substance abuse.

Indicators of victimization were also significant predictors of shelter use. The families who included mothers who had been sexually or physically abused as children had approximately double the risk of shelter use. Similarly elevated risk was also found for women who had been abused, or threatened with abuse, as adults.

Discussion

None of the three types of risk factors explored were highly prevalent among housed low-income or homeless families. Only 4% of the homeless sample—a far lower rate than is cited elsewhere in the literature—had a prior mental hospitalization, reflecting the relative health of families who are entering shelters for the first time. Twice as many of the homeless respondents (8%) had been in a detoxification center. However, despite low preva-

TABLE 2—Potential Risk Factors of Shelter Use

	Sample Distribution, %		Relative Risk/ Odds Ratio (95% CI)
	Shelter Requesters (n = 677)	Housed (n = 495)	
Psychiatric history			
Mental hospitalization	4.0	0.8	
Never admitted to mental hospital	96.0	99.2	5.2** (1.5, 12.1)
Use of prescription drugs for mental problem	3.1	6.9	
No utilization	96.9	93.1	0.4** (0.3, 0.7)
Use of counselor/therapist/ mental health clinic	6.5	7.3	
No utilization	93.5	92.7	0.9 (0.6, 1.4)
Substance abuse			
Past use of detox center for substance abuse	8.1	1.8	
Never detox patient	91.9	98.2	4.8** (2.4, 9.7)
Reported problem with substance abuse in past 6 months (self problem)	4.9	1.0	
Did not report the problem	95.1	99.0	5.1** (2.0, 12.9)
Reported problem with substance abuse in past 6 months (friend/relative problem)	9.0	5.1	
Did not report problem	91.0	94.9	1.8* (1.2, 2.9)
Reported either form of the problem	11.8	5.7	
Did not report problem	88.2	94.3	2.2** (1.4, 3.4)
Victimization			
Physically abused or threatened as adult	27.0	16.6	
Not abused or threatened	73.0	83.4	1.9** (1.4, 2.5)
Sexually abused as a child	9.9	4.2	
Not sexually abused	91.1	95.8	2.5** (1.5, 4.1)
Physically abused as a child	11.4	6.5	
Not physically abused	88.6	93.5	1.9** (1.2, 2.8)
Ever had protective services caseworker	9.2	1.8	
Never had such caseworker	90.8	98.2	5.5** (2.8, 11.1)

*Significant at 95% confidence level.
**Significant at 99% confidence level.

lence these factors significantly and sometimes dramatically increased a family's risk of requiring public shelter.

Both adult and childhood victimization were more prevalent among both homeless and housed mothers, although these indicators may be underreported. However, in contrast to the other factors, victimizations are less powerful predictors of risk of homelessness.

From a public policy perspective, these findings suggest that low-income families who have one or more of the risk factors studied should be targeted to receive preventive support services, because these families are at relatively high risk of requiring emergency housing. However, in order to alter the dynamic that leads to high rates of homelessness among low-income families, other risk factors must be identified. □

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APPENDIX—Questions Used to Assess Psychiatric History, Substance Abuse, and Victimization Among Homeless and Housed Families

Psychiatric History

Please tell me whether you have ever

- been admitted to a mental hospital so that you stayed overnight?
- used the services of a therapist, counselor, or mental health clinic?

Has a doctor prescribed medications for you to take every day? What medication has been prescribed?

Substance Abuse

Please tell me whether you have ever been a patient in a detox or treatment center for

- alcohol abuse?
- drug abuse?

Has use of drugs or alcohol affected your ability to do the things you have to do at any time in the last 6 months?

Has use of drugs or alcohol by a friend or relative affected your ability to work, or do the things you have to do, any time in the last 6 months?

Victimization

As a child or teenager, were you ever

- physically abused?
- sexually abused?

As an adult, have you ever been physically abused or threatened with violence by a person you were involved with?

Have you ever had a caseworker or social worker other than your Income Maintenance Center worker? From Special Services for Children/Bureau of Child Welfare?

Cumulative Trauma Disorders of the Hand and Wrist in the Auto Industry

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ABSTRACT

Surveillance for cumulative trauma disorders (CTDs) of the hand and wrist was carried out in five US automotive plants from 1985 to 1986, using Occupational Safety and Health Administration (OSHA) Form 200 injury and illness logs and medical insurance claims. Results using both record sources indicated that hand and wrist disorders may be more common in foundries than in other types of automotive plants. Similarly, in assembly plants, employees in certain departments appeared to be at higher risk for CTDs. Although our results are based on small numbers of cases, they suggest plants and departments that might be targeted for more detailed investigation. (*Am J Public Health.* 1992;82: 1550–1552)

Introduction

Considerable attention has been given to developing surveillance systems to detect workplace illnesses and injuries.[1–10] Most efforts have focused on population-based systems designed to monitor mortality and morbidity in mixed industries across large geographic areas. In this study, we used employer-maintained Occupational Safety and Health Administration (OSHA) Form 200 reports and medical insurance claims to examine the occurrence of cumulative trauma disorders of the hand and wrist in five US auto plants over a 2-year period.

At the outset, we assumed that both sources would have limitations but that, as preexisting sources, they represented rapid and economical means of monitoring at least some portion of occupational illnesses and injuries. This report compares the two sources with regard to numbers of cases, overlap, and high-risk groups identified.

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