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A Qualitative Exploration of the Spatial Needs of Homeless Drug Users Living in Hostels and Night Shelters

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Qualitative data were deployed to explore the spatial needs of homeless drug users staying in hostels and night shelters. Findings indicated that Fitzpatrick and LaGory's four categories of spatial need ('privacy', 'personal space', 'social interaction', 'safe and defensible spaces') all had good analytical purchase. However, three further need categories ('institutional support', 'amenities and standards', 'spatiotemporal structures and boundaries') were identified. While hostels and night shelters met the spatial needs of some homeless drug users, there was considerable scope for improvement; indeed, failure to meet spatial needs could result in increased drug use, risky injecting practices, worsening health and a return to the streets. Our seven-fold categorisation of spatial needs requires further empirical study but could potentially inform other place-based approaches to health.

Keywords: Hostels, night shelters, homelessness, drug use, homeless drug users, spatial needs.

Introduction

This article focuses on people and places located at the margins of society; namely, homeless drug users (HDUs), hostels and night shelters. Utilising primary data collected as part of a qualitative research study, our aims are: (1) to identify the core spatial needs of HDUs who stay in hostels and shelters, and (2) to consider how well hostels and shelters appear to be meeting those core spatial needs. Our analyses are located within the context of relevant policy and practice relating to homeless hostel provision and the generic place-based approach to health developed by the urban sociologists Fitzpatrick and LaGory (2000). We begin, however, by introducing some central concepts.

Homelessness, drug use, hostels and night shelters

Homelessness and drug use are both historically, socially, culturally, psychologically and legally constructed concepts and therefore difficult to define (Neale, 2008; Neale, 2012). Homelessness, for example, can encompass sleeping on the street; staying in temporary forms of accommodation (such as hostels or bed and breakfast hotels); and living in overcrowded, substandard or insecure accommodation (see Fitzpatrick, 1998; Edgar and Meert, 2006; Fitzpatrick and Stephens, 2007; Neale, 2008). The term drug

user, meanwhile, generally refers to someone who uses, misuses or abuses one or more legal or illegal substance. Nonetheless, the meaning of use, misuse and abuse are open to interpretation, and the legal status of drugs varies over time and place (see Pleace, 2010).

Given such definitional ambiguity, estimating the numbers of homeless drug users (HDUs) is not easy. Reported figures depend on the definitions of homelessness and drug use adopted, when and where studies were undertaken, the populations sampled and the research methods employed (Kemp *et al*., 2006; Neale, 2012). Furthermore, the stigma attached to both homelessness and substance misuse, combined with the illegality of much drug-related behaviour, mean that survey data may fail to include many HDUs. Despite this, international research has repeatedly shown that a large proportion of homeless people use drugs and drug users experience high levels of homelessness (Downing-Orr, 1996; Robertson *et al*., 1997; Fountain *et al*., 2003; Glasser and Zywiak, 2003; Teeson *et al*., 2003; Kemp *et al*., 2006; March *et al*., 2006; Das-Douglas *et al*., 2007; Fazel *et al*., 2008; Neale, 2012).

The term homeless hostel is also challenging to define. Moreover, it is hard to distinguish hostel dwellers from homeless people living in other types of accommodation. This is because many people who use hostels also sleep on the streets, live in squats, occupy other kinds of supported accommodation or stay temporarily with friends or family (Anderson *et al*., 1993; Edgar and Meert, 2005). According to Busch-Geertsema and Sahlin (2007), hostels tend to involve shared spaces, limited (or no) private space and provide some kind of supervision. Night shelters, also known as shelters, emergency hostels, direct access hostels and nightstops, are one type of hostel accommodation. They mostly accommodate single homeless people, with individuals often sleeping in the same room, and sharing cooking, eating and bathing facilities (Edgar and Meert, 2005).

The policy and practice context

In recent years, there have been significant improvements in the physical standards of hostel accommodation across the UK and Europe (Fitzpatrick and Wygnańska, 2007). In particular, many large-scale hostels with dormitories have been replaced by smaller units, which offer more privacy and higher levels of individualised support to facilitate resettlement (Busch-Geertsema and Sahlin, 2007; Fitzpatrick and Wygnańska, 2007; Jones and Pleace, 2010). In England, for example, a £90m Hostels Capital Improvement Programme (HCIP) was launched in 2005, with the specific aim of enabling hostels to become 'places of change' (Department for Communities and Local Government, 2006). Additionally, the government produced a voluntary 'Hostels Review Toolkit', which was designed to help raise hostel standards (Fitzpatrick and Wygnańska, 2007). In spite of this progress, very basic large-scale shelters, including 'winter shelters' that close during the day and in the summer, are still common across Europe (Pleace, 1998; Crane and Warnes, 2000; Busch-Geertsema and Sahlin, 2007).

The likely future of hostel provision cannot be divorced from recent changes in homelessness policy, including an increased focus on preventing homelessness and a strongly re-integrationist approach to homeless service provision (Fitzpatrick and Stephens, 2007). Historically, the dominant international approach to housing homeless people has been a linear 'staircase' or 'continuum of care' model, with individuals progressing from temporary, low quality hostels to more independent better quality housing as they demonstrate 'success' in drug treatment and 'housing readiness'

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(Busch-Geertsema and Sahlin, 2007; Benjaminsen and Dyb, 2010; Jones and Pleace, 2010; Pleace, 2010). Today, newer 'housing first' models, originating from the USA and now increasingly operational in the economically developed world, provide homeless people with secure tenancies without requiring them to address their drug use or prove that they are housing ready. Instead, floating support, including assistance with drug problems, is offered within ordinary accommodation (Busch-Geertsema and Sahlin, 2007; Pleace, 2010, 2012; Tsemberis, 2010).

Housing first approaches to homelessness challenge the need for hostel accommodation as they are based on the premise that preparation for independent living is best provided in regular dwellings and support is more effective if recipients are not forced into accepting it. Nonetheless, at least some hostel provision is likely to remain for the foreseeable future, if only to provide physical shelter in emergency and transition situations where self-contained dwellings and regular hotels are unavailable or deficient (Busch-Geertsema and Sahlin, 2007; Fitzpatrick and Wygnańska, 2007). Furthermore, it has been argued that, while they exist, hostels and shelters should provide as high a quality of service as possible. This should, for example, include minimum requirements in relation to physical standards, privacy, space to socialise, safety, staffing and support, security of tenure, resettlement processes and user involvement (Busch-Geertsema and Sahlin, 2007; Fitzpatrick and Wygnańska, 2007).

Fitzpatrick and LaGory's generic thesis of basic human spatial needs

According to Fitzpatrick and LaGory (2000), all humans need 'privacy', 'personal space', 'social interaction' and 'safe and defensible spaces' in order to avoid illness and maintain a sense of identity, place and rootedness in the world (see Relph, 1985; Casimir and Rao, 1992). 'Privacy' means having the ability to withdraw from social settings in order to avoid public scrutiny, assimilate information derived from earlier interactions and prepare for subsequent social behaviours. Privacy also provides individuals with opportunities for intimacy (Westin, 1967). 'Personal space', meanwhile, refers to the minimum distance requirements necessary for healthy functioning. Optimal behaviour densities vary between cultures and social situations (Hall, 1966), with overcrowding being less a physical phenomenon than a cognitive state occasioned by physical circumstances, cultural expectations and social actors coinciding in a particular space (Hinde, 1987).

While too much social contact can have detrimental health consequences, Fitzpatrick and LaGory (2000) contend that humans still need access to 'social interaction'. People are naturally social (Eibl-Eibesfeldt, 1989) and those with strong social networks tend to have better physical and psychological health (Berkman and Breslow, 1983; Lin *et al*., 1986). Additionally, Fitzpatrick and LaGory (2000) stress the need for individuals to have 'safe and defensible spaces'. Security is a basic human need (Maslow, 1954) and this is particularly crucial within an individual's home, where there is a general expectation that people will be able to relax (Goffman, 1959; Newman, 1973; Taylor and Covington, 1988). Without access to safe and defensible spaces, individuals are likely to have reduced potential to develop, achieve and learn.

Although Fitzpatrick and LaGory present a generic thesis of basic human spatial needs, they particularly highlight the spatial deprivation occasioned by homelessness, identifying this as an extreme form of poverty, an inhuman condition and an unhealthy

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state. Homelessness, they argue, is a disorientating condition that is pathological and debasing. Moreover, homeless people – including those who stay in shelters – confront a plethora of everyday problems associated with noise, privacy, overcrowding, theft, poor safety and limited access to basic resources. Thus, homelessness generates spatial indignities as well as social injustices, which severely wound people physically and psychologically (Fitzpatrick and LaGory, 2000: 140).

Methods

Our study is based on data derived from semi-structured qualitative interviews conducted in 2010–11 with forty HDUs. These individuals were all currently staying, or had within the last six months stayed, in night shelters or emergency hostels. Ethical approval for the study was secured from a University Research Ethics Committee, with interviews occurring in six geographically and socio-economically diverse areas across the south of England. These areas were chosen because they had large homeless populations and provided a range of emergency hostel accommodation. They included five relatively small towns and cities and one large city.

Within each area, potential participants were approached via *Big Issue* vendors, homeless day centres, harm reduction centres, satellite drug and housing services, the street, service user groups and word of mouth. Hostels and night shelters were not used as recruitment sites in case this inhibited participants' responses. Individuals were purposively selected using maximum variation sampling (Patton, 1990; Sandelowski, 1995). This technique seeks to maximise heterogeneity in a qualitative sample; the logic being that any common patterns that emerge from great variation are of particular interest and value in capturing core experiences (Patton, 1990). Since basic demographic and drug use characteristics seemed likely to influence homeless drug users' needs and experiences (see Neale *et al*., 2007), we sought to maximise variation by sampling men and women of different ages and ethnic backgrounds, who reported varying lengths of homelessness and had diverse drug-taking patterns.

Our achieved sample included twenty-nine men and eleven women, all aged between twenty-one and fifty-four years. Thirty-three participants were White British, two were Black British, two were Black African, one was Black Caribbean, one was White European and one was Asian Vietnamese. Participants had been homeless for between two months and twenty-three years, and most had stayed in multiple hostels, with periods in individual services ranging from one night to two years. Thirty-six individuals reported that their primary drug was heroin or crack cocaine and twenty said that they drank alcohol to an extent that surpassed 'social drinking'. Only six had never injected drugs.

In total, our participants discussed their experiences of fifty-six separate hostel services. These included single and mixed sex provision that varied in terms of the number of people accommodated (from as few as 6 to more than 100 residents), type of accommodation available (from mattresses or camp beds in shared dormitories to independent flats provided as part of a staged move-on programme) and staffing and support (from occasional visits by a 'landlord' or 'caretaker' to key workers and twenty-four-hour on-site assistance). In addition to their use of hostels and shelters, those in the study described staying temporarily with friends and relatives, living in bed and breakfast hotels and sleeping in car parks, abandoned factories, public toilets, trains, buses and on the streets.

Interviews lasted between forty-five and 150 minutes and were based on a topic guide that covered demographic information, housing circumstances, drug use, support needed and received and ideal hostels. All participants were given a £10 supermarket voucher to compensate for their time. Audio files from all forty participants were professionally transcribed and entered into the qualitative software programme MAXqda10 for indexing. Initially, data were indexed according to descriptive codes derived from the topic guide. Subsequently, emerging and more conceptual codes were added. Following Fitzpatrick and LaGory (2000), we included codes for 'privacy', 'personal space', 'social interaction' and 'safe and defensible spaces'. However, we also added three further emergent codes relating to spatial needs. These were 'institutional support', 'amenities and standards' and 'spatiotemporal structures and boundaries'. All data relating to the seven spatial needs codes were retrieved from the coding frame and analysed using Framework (Ritchie and Spencer, 1994).

Findings

Privacy

Our participants' everyday lives were routinely played out in very public settings. For example, eating and sleeping were often outdoor activities, washing tended to occur in communal spaces, and intimate relationships, including arguments with partners, were frequently enacted in front of others. Drug use was also often a public affair.

In response to this, many of our participants emphasised how much they needed privacy. This included the ability to avoid other drug users and homeless people and to 'keep themselves to themselves'. Privacy offered an opportunity to be completely alone or alone with just a partner. It also facilitated avoidance of drugs and provided essential respite from the general hustle and bustle of both life on the streets and within hostels and shelters:

> It's just nice to have somewhere where you can lock the door and just be on your own. (Neil, aged 34)

Despite the evident importance of privacy and the fact that hostels and shelters did, at least for some, offer a degree of solitude, our findings showed that most hostel environments afforded their residents little backstage time. Not all residents had their own rooms, and, when they did, others constantly knocked on their doors either asking for, or wanting to sell, drugs:

> If people used to see you in certain hostels having your friends around, they'd think you're up to smoking crack. They're banging on your door . . . I found I never got any privacy in those sort of places. (Janet, aged 39)

Additionally, privacy was commonly interrupted by staff who entered rooms without knocking. Sometimes this occurred during spot checks for alcohol or drugs, but often it happened in the course of staff simply going about their daily work:

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> Yeah, they [staff] come straight in sometimes. Or sometimes they knock on the door and come in . . . even if you say 'wait' . . . I've been totally naked and a female member of staff has knocked on the door and I've said 'hang on a minute', and she's just come straight in . . . It made me feel very embarrassed, you know. I really felt as if my privacy had been infringed. (Barry, aged 37)

Our participants reported two common negative unintended consequences of regularly having their privacy violated in this way. First, they said that they used drugs rapidly in order to avoid detection. This increased the likelihood that they bypassed hygiene and safe injecting practices, thus enhancing the risk of vein damage, infections and overdosing. Second, they abandoned hostel and shelter rooms in order to find places where they could spend 'intimate' and 'back stage' time with others. As Tracy (aged thirty-nine) pointed out, 'we ended up doing more rough sleeping just to be together'.

Personal space

The importance of having personal space was also noted by the HDUs participating in the study. Leo had recently moved from having to share sleeping space to having his own bedroom:

> Well, it's much better I guess because it's my own room and I don't have to share with anyone. It's just having your own space, because I need that time. (Leo, aged 21)

Despite this, it was more often the case that hostel environments offered little physical distance from others. As already indicated, shelters mostly provide communal sleeping, eating, bathing and general living areas. This meant that individuals were constantly surrounded by others, including other residents' dogs. As Leo continued:

> People from the outside are coming in, using your services, and people's dogs jumping on you. I mean, don't get me wrong, I like dogs, but there's dog smells . . . No space basically. *[You]* don't have space for yourself. Because once you get kicked out of your room in the morning, you're mingling with these people. Well you're not mingling, you're all in one spot together and it does get a bit crazy sometimes. (Leo, aged 21)

The behaviours and hygiene standards of other residents were also often challenging when space was so confined. In addition to being drug users, many hostel residents drank problematically or had serious mental health problems. The difficulties of sleeping in close proximity to others who were snoring, coughing, shouting out and incontinent were graphically described:

> It's a big, big room and at night time they put all these camp beds out . . . So you've got like about fifty people in the one room . . . You've got people snoring, you've got people farting, you've got people coughing, you've got people screaming in their sleep. (Jim, aged 26)

Like the lack of privacy, the lack of personal space within hostels and shelters had negative consequences. Some HDUs explained that the claustrophobia was oppressive, leading to depression and low morale amongst both staff and residents. More commonly, individuals noted that being surrounded by drugs and drug users made it difficult for

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them to contemplate not using drugs themselves. Moreover, using drugs or drinking was frequently described as the only way of getting some peace in an otherwise highly disruptive environment.

Social interaction

During their interviews our participants often reflected on how important relationships, with friends, partners, children and other family members, were to them. Moreover, they frequently reported that these relationships offered them valuable support, companionship, emotional sustenance, practical assistance and help in managing and controlling their drug use. This is not to say that HDUs reported perfect relationships with others. On the contrary, they often talked of relationship breakdowns and complex relationship problems, including loss of contact with children. Nonetheless, they recognised that having meaningful relationships with others was essential, and they appreciated it when professionals, including hostel and shelter staff, helped them to sustain those relationships.

Despite this, shelter rules and policies, such as no overnight visitors or early evening curfews, hindered the formation and maintenance of supportive relationships with others in the outside world. For example, one man bemoaned the fact that when he visited his family, he could never stay for dinner because he had to get back to the shelter in case he lost his bed. Additionally, some shelters discouraged their residents from mixing socially with each other. As a result, several participants reported that social isolation within hostels and shelters had had a negative impact on their mental health:

> Well I suffer from claustrophobia. I've got a room not much bigger than a prison cell and not being allowed visitors really gets to me. (Janet, aged 41)

As indicated above, hostel living does engender constant contact with other people. However, this contact is frequently not of the meaningful nature that HDUs desired. Indeed, our participants were very conscious that relationships formed within hostels could often be unstable, violent and exploitative. Equally, they could result in co-dependency and escalating drug use. This was because many hostel and shelter residents were very vulnerable and also because hostel and shelter cultures fostered peer pressure to use and share drugs together:

> Looking back now, I wouldn't have had sex with some of the people that I had sex with if I wasn't off my head or if I didn't have that need for more drugs or if I didn't have such low self worth and self esteem; and also . . . sometimes mistaken sex for love. (Kate, aged 35)

Safe and defensible spaces

Wanting to feel safe and secure was a recurrent theme in our participants' accounts. Some reported that shelters provided a safer place to sleep and to use drugs than the street. Others were appreciative of services that offered ex-residents, including those who had previously been evicted, somewhere protected to visit during the day and a secure place to store their few worldly possessions:

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> Last winter, I used to go there [shelter] every day. Because I know the staff and they look after my sleeping stuff and things like that . . . look after my blankets and that. And you can go there if you ain't in the hostel or if you're on a ban for misbehaving. (Damien, aged 35)

These benefits notwithstanding, it was more commonly the case that HDUs described hostels and shelters as unsafe and frightening places where violence, bullying, theft, drug dealing, sexual harassment and intimidation between residents routinely occurred. Some even said that they had been threatened or harassed by staff, or that staff had thrown away their personal belongings if they had been evicted. Others reported that shelter and hostel living were associated with high levels of drug use, risky injecting practices, overdosing and exposure to the blood and injecting paraphernalia of others. Indeed, many participants stated that dried blood and discarded used injecting equipment were frequent features of hostel environments:

> I found loads of needles on the floor – no lids on them, with all blood on. (Hayley, aged 32)

As a result, our participants often said that they stayed away from hostels and shelters whenever possible, with some adding that they felt safer on the streets:

> I'd rather be outside. I'm safer outside on the streets. (James, aged 36)

Institutional support

Alongside the aforementioned needs, our participants indicated that they wanted hostels and shelters to provide them with, or direct them to, various forms of support. These included drug-related services: harm reduction interventions, opioid substitution treatment, residential detoxification and rehabilitation, counselling and psychological support and drug-related information. In addition, they identified a wide range of other more generic support needs, such as help in locating more permanent accommodation, managing their finances and identifying opportunities for education, training, and employment. Individuals also stated that they wanted help with physical and mental health problems.

HDUs in the study reported that many hostels and shelters provided support above and beyond accommodation. Indeed, some of our participants had stayed in services where staff had been willing to help them with any kind of difficulty. As Fiona reported:

> Brilliant, brilliant, oh aye, brilliant, very helpful . . . I mean, if you had a problem, you spoke to them. I mean it wouldnae matter who it was. If you had a problem . . . you could go to anybody. (Fiona, aged 37)

Despite this, the amount of drug-related and more generic support that participants received varied greatly. Some hostels and shelters provided a diverse range of assistance, whereas others seemed to offer very little help at all. Significantly, however, the aspect of support that HDUs most commonly prioritised was not the amount of assistance received, but the manner in which that support was provided. Specifically, our participants were very appreciative when staff helped them in a way that conveyed respect and dignity,

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a willingness to listen, and encouragement that they should talk honestly and openly. This, they argued, enabled them to identify the help they really needed. In contrast, our participants were very critical of staff who treated them judgementally, were intimidating and appeared not to care about them.

Amenities and standards

A further spatial requirement identified by the HDUs in our study related to amenities and the standards of those amenities. Their expectations were often rudimentary: that is, they wanted and hoped for a clean bed, reasonably nutritious food, access to a kettle and basic kitchen facilities, hygienic bathrooms and a toilet, with toilet paper, on the floor or landing where they were sleeping. This was not, however, always as straightforward as it seemed:

> It's old buildings, yeah, so you can't guarantee, you know. It's pot luck really whether you get a WC [toilet] on your floor or not. I mean it might be they should all be sort of like ripped apart internally . . . changed inside to make them appropriate to meet modern standards of hygiene. (Mark, aged 41)

As found in relation to the provision of support, amenities and standards within hostels and shelters were highly variable. Thus, some provided new or well-maintained buildings and facilities and well-lit, nicely furnished rooms, with homely touches such as plants and pictures. In contrast, others were described as prison-like, dirty and poorly maintained. Communal toilets were variously described as 'disgusting', 'horrible' and 'filthy', and there were frequent references to blood being splattered across floors, doors, walls and ceilings, with urine and excrement also covering floors and toilet bowls. Additionally, some shelters only provided camp beds without bedding, and some served poor quality food:

> Food was ridiculous . . . They used to give us stuff that was right out of order . . . Say a ten-inch pizza that had been defrosted and then frozen again and then in the fridge so it defrosts again. And it's half frozen . . . so it's in between cold and freezing, you know. But it was rotten. And the food, man. When they cooked it, even the bread, the bread, when they brung the bread out, the bread was weeks out of date . . . mould on the bloody sides of it. (Steven, aged 34)

Spatiotemporal structures and boundaries

Finally, our participants highlighted the need for structures and boundaries within hostels and shelters. Some individuals reported that predetermined routines, such as times to get up, mealtimes and times to go to bed, helped them to break the constant cycle of getting up, making money and using drugs. Fixed institutionalised routines could also facilitate improved eating and sleeping patterns. Staff suggestions of structured things to do or courses to attend at other services during the day were equally appreciated:

> All you need is something else to take your mind off it [drugs]. Something that interests you. Like down there [local drug service], I'm doing fishing . . . there's a canoe course coming up

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> where we're making canoes . . . I'm doing that. There's a chess tournament, I've put in for that . . . It's just finding something else to occupy your mind. (Luke, aged 50)

Boundaries in the form of more formal rules and regulations could, meanwhile, promote a sense of order and calm amidst the chaos of hostel life. In particular, rules and regulations around drug consumption, including the prohibition of drug use in certain designated areas, could help prevent drug taking from getting out of control and enable some HDUs to restrict or even cease their own use:

> The rules need to be, they need to be enforced. They need to be. There should be rules, because what it is in these places, if there's no rules, you have chaos. (Frank, aged 59)

Overly strict, inconsistently applied or seemingly pointless rules and regulations were not, however, welcomed. Bans on the possession of all drugs and any injecting paraphernalia resulted in some HDUs using drugs clandestinely and re-using old injecting equipment. Not being allowed to have overnight visitors, having to be back in the shelter by early evening, being told they had to go to bed at a certain time, and being forced to get up very early were all sources of stress and contention. For example, James (aged 36) left one shelter because the rules stated that individuals had to be in by seven in the evening and could not leave again until seven the next morning. Others, such as Malcolm, felt that not being allowed to return to the shelter during the day was punitive, particularly in the winter when it was very cold outside:

> When it's raining and snowing, things like that, you're out from eight in the morning until eight at night . . . That's twelve hours that you're out. There's times when you just don't want to be out twelve hours sitting on the street. And you just want somewhere to just go and sit, chill, have a cup of coffee, or even go to sleep. (Malcolm, aged 47)

Discussion

Qualitative research utilises in-depth information from relatively small sample sizes in order to understand people's lives and worlds (Miles and Huberman, 1994). In so doing, it seeks to comprehend the meanings that individuals attach to their behaviours, as well as the social or structural processes by which such meanings are created, reinforced and reproduced (Rhodes and Coomber, 2010). Common weaknesses of qualitative research, meanwhile, include an inability to quantify phenomena and limited generalisability. In this paper, we have analysed the self-reports of a relatively small number of HDUs who are currently staying, or have recently stayed, in hostels and shelters. From this, we can neither enumerate HDUs' spatial needs nor measure how good hostels and shelters are in meeting those needs. Equally, we cannot make empirical generalisations about our findings.

These limitations notwithstanding, our data have indicated that Fitpatrick and LaGory's concepts of 'privacy', 'personal space', 'social interaction' and 'safe and defensible spaces' all have good analytic purchase amongst HDUs who stay in hostels and shelters. Thus, our participants spoke of the importance of being able to withdraw from social settings, avoid overcrowding and close physical contact with others, maintain and develop meaningful relationships and have access to safe and secure places.

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Consistent with Fitzpatrick and LaGory's arguments, hostels and shelters were sites of both risk and resource. They presented HDUs with many challenges and dangers, yet simultaneously offered them opportunities, support and protection. Furthermore, hostels both affected and were affected by the health behaviours of HDUs. For example, the drug use of some exposed others to unsafe environments contaminated by blood and used injecting equipment. In contrast, personal space and privacy could help individuals 'keep themselves to themselves' and avoid drug consumption.

Fitzpatrick and LaGory's four-fold categorisation did not, however, capture the full range of spatial needs experienced by those participating in our research. Indeed, we identified three further need categories: 'institutional support', 'amenities and standards' and 'spatiotemporal structures and boundaries'. Importantly, our data revealed that these seven categories of spatial need were not mutually exclusive: there was considerable overlap between them and the various types of spatial need could affect and be affected by each other. For example, privacy, personal space and institutional support could provide opportunities for meaningful social interaction; institutional support (such as help with education, training and employment) could promote spatiotemporal structures and boundaries; and spatiotemporal structures and boundaries (particularly rules relating to drug use and other anti-social behaviours) could improve hostel safety.

Our findings suggested that hostels were meeting the spatial needs of some HDUs, but there was much variability between services and between HDUs' accounts. Additionally, many hostels and shelters appeared to be failing HDUs badly. For example, our participants routinely reported conditions that they felt were inimical to their health, findings corroborated by other recent UK research which has associated hostels with noise, poor facilities, inadequate health care, discarded drug paraphernalia, theft, bullying and intimidation (Bowpitt *et al.*, 2011; Joly *et al.*, 2011). HDUs had modest expectations from hostel living (some private space, a place to leave their few belongings, basic cleanliness and hygiene, for example), and were very appreciative when they felt that their needs were being met. Nonetheless, failure to meet those basic needs could result in increased drug use, risky injecting practices, worsening health and even a return to the streets (see Fitzpatrick *et al.*, 2000; Neale, 2001).

Conclusions

The HDUs in our study wanted, needed and appreciated the various forms of assistance that hostels offered. However, it was evident that hostels could be doing more if they really wanted to function as 'places of change' (Office of the Deputy Prime Minister, 2005; Department for Communities and Local Government, 2006). At a very basic level, this might include encouraging and enabling residents to visit supportive friends and relatives in the community, referring individuals who need specialist support onto other appropriate professionals, providing good cleaning services so that people do not have to live amidst the injecting detritus of others and treating all homeless people with dignity and respect (see Busch-Geertsema and Sahlin, 2007; Fitzpatrick and Wygnańska, 2007).

Fitzpatrick and LaGory's spatial needs framework has provided a useful lens for exploring both the positive and negative aspects of hostel living. The three new categories of spatial need identified in our study ('institutional support', 'amenities and standards' and 'spatiotemporal structures and boundaries') are preliminary and require further empirical inquiry. Nonetheless, it does not seem too contentious to suggest that most individuals

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are likely to benefit from enabling environments, comfortable material surroundings and institutions that employ a degree of governance, order and regulation so that they function safely and effectively. From this, we tentatively suggest that our seven-fold categorisation of spatial needs may have relevance beyond hostel settings and could potentially inform other place-based approaches to health.

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