Sheltered-Care Needs of the Mentally Ill

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HEALTH AND SOCIAL WORK, Vol. 4, No. 2, May 1979
0360-7283/79/0402-0041 $0.50 © 1979
National Association of Social Workers, Inc.
The recent emphasis on housing formerly hospitalized mental patients in community-based facilities has caused the number of such facilities to proliferate. This article examines five characteristics that affect individuals' needs for sheltered care and must be considered in selecting the most appropriate type of facility.

A rapid change has taken place in the past twenty years in the provision of care to the mentally ill. During this time mental health services have moved away from a monolithic system in which individuals were cared for within one type of facility only, namely, large state mental hospitals, to a system that emphasizes a broad spectrum of arrangements for residential care. These sheltered living arrangements offer different levels of social and psychological support to residents. In addition, instead of being established in isolated, centralized locations, facilities providing sheltered care—that is, community-based supervised housing—have been set up in local communities representing many different physical and social environments. This increased variety in type and location of facilities requires mental health professionals to examine the characteristics of the sheltered-care population and determine appropriate placements.
in specific environments that will promote the social integration of these individuals.

**POPULATION**

In discussing the mentally ill, the author is referring to individuals between 18 and 65 years old who are not mentally retarded, physically disabled, or disabled primarily because of problems associated with alcohol or drug abuse. According to the U.S. Department of Health, Education, and Welfare, such individuals by reason of severe or persistent mental or emotional illness or disability experience a diminished level of functioning relative to the primary aspects of daily living such as personal relations, living arrangements, work, recreation, and the like.¹

In addition, those in the group this article will discuss have at some point in their adult life been considered a danger to themselves or others.

Having specified the population of interest, the author will now consider the characteristics that determine the type of sheltered care most likely to enhance the individual's social involvement and integration. The simple recitation of statistics, especially those relating to populations currently under treatment, is of little value in identifying these characteristics. Such statistics do not illuminate the interaction between the individual and his or her social environment and therefore do not help make clear the specific type of facility most suitable for specific types of people. In addition, figures tend to refer to a population in treatment, but many of the individuals with which this article is concerned are not in treatment and tend to avoid contact with treatment facilities.
The author will therefore discuss five characteristics that can be used to categorize a population or describe an individual. Consideration of each one of these characteristics is crucial in determining the most appropriate sheltered living situation for a person or group. The characteristics are the following:

1. Age and extent of residential stability.
2. Extent of social margin.
3. Degree of psychological disturbance and distress.
4. Nature of the individual's illness.
5. Length of involvement with the mental health system.

It should be noted that age and residential stability are considered by the author to be interrelated to such a degree that they constitute a single factor.

AGE AND STABILITY

Between 1964 and 1973, the population in this country's state hospitals became younger. That is, individuals over 65 years old were siphoned off into nursing homes, and younger patients, primarily between the ages of 15 and 35, now constitute the largest segment of the state hospital population. Although many of these younger people use drugs and alcohol, they also suffer from the symptoms of mental illness. A large proportion of them undergo a number of brief hospitalizations and become caught up in what has come to be known as the "revolving door syndrome." Individuals in this group are generally not retained in the hospital beyond an initial holding period, and they usually leave before a liaison can be set up for them between the hospital and the community or before a relationship between them and community agency can be established.
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Their presence is disturbing to the community, they are often self-destructive, and repeated hospitalization fails to stabilize their behavior. The mental health system is less able to provide effective services for these individuals than for any other group.

Accommodating these young adults with services is difficult because of their high degree of transience and their inability to come to terms with the mental health system itself. In most cases, they come from large blue-collar or working-class families. They have usually not completed high school, have run away from home, or have been asked by their families to leave. Often their only possession is their self-respect or self-pride. The mental health system poses a threat to this pride, because in order to receive services these individuals must admit that they are ill and in need of them.

In general, these young people are admitted to mental hospitals after being picked up by the police. On their release from the hospital, a letter is sent to their last known address, which is usually that of the police precinct house where they were picked up. Such letters are intended to facilitate contact between patients and local social service agencies. At this point, however, most of these young people are lost to the system. They frequently neither have an address at which to receive a letter nor the ability or wish to take
care of the interviews and correspondence arising from a community service contact.

These young transients receive little or no support from the local community, and by virtue of their mental illness they are excluded from whatever minimal social support is available within the vagrant subculture to which they belong. A recent survey of this population based on contacts made during a one-week period on the street—that is, at the only place in which to get a free meal in a particular area—involved 295 young adults whose modal age was 21. A startling 22 percent of those surveyed had a history of psychiatric hospitalization. These individuals are at the bottom of the social scale even on the street; they are significantly at risk of becoming the chronically ill population of tomorrow.

Between 1964 and 1973, individuals over 50 years of age came to constitute a smaller proportion than before of the population of state and county mental hospitals. This group now makes up a major proportion of the individuals residing in community-based facilities providing sheltered care. Approximately half the 12,430 people (46 percent) in community-based facilities in California who are between the ages of 18 and 65 are over 50 years old. Older individuals such as these seek a more stable environment and wish to find a sheltered-care facility in which to live and establish some kind of security for themselves.

Because they frequently do not have personal relationships with people outside the facility in which they live, many of these individuals seek a supportive environment within the facility itself. They do not pose a serious threat to the communities in which they live. Contacts between themselves and the police primarily
stem from their sometimes becoming lost and wandering around their neighborhoods. They do not possess significant vocational skills or a high degree of education. Those who have had careers in the past usually have long since ended any involvement with them. Their chances for future employment in their former occupation are limited, although a small proportion of them have the capabilities to obtain jobs calling for basic skills. Members of this older and more stable segment of the mentally ill population are likely to be seen in community-care facilities without anything to do and without any means of occupying their time other than sitting in front of a television set.

SOCIAL MARGIN

Another factor to be considered in regard to the placement of individuals in sheltered-care facilities is their access to personal resources and social support systems. This factor has elsewhere been referred to as social margin by Segal, Baumohl, and Johnson, and it is more fully defined as follows:

Social margin refers to the set of resources and relationships on which an individual can draw either to advance or survive in society. It consists of family relations, friendships, possessions, skills and personal attributes that can be mortgaged, used, sold, or bartered in return for necessary assistance. Social margin functions to enable the upward bound, and protect, or soften the fall of the downwardly mobile.

Social margin may be thought of in terms of a credit and debit account that each individual possesses with respect to his or her relations with others. The author has observed that those who are in need of a
sheltered living arrangement over a long period of time are in fact individuals who may be characterized as having few, if any, credits in terms of social margin. One way of illustrating this point is by considering the same characteristic in regard to the general population, those who have been readmitted to mental hospitals, and those currently receiving sheltered care in community-based facilities such as board and care homes, halfway houses, and family care homes. Marital status is the characteristic examined here as an indicator of social margin and to represent the individual's ability to sustain a close relationship with someone who can be depended on in time of need. In 1970, 70 percent of the general population in California between 18 and 65 years of age were married; 39 percent of those who had been released from California's mental hospitals were married; and only 5 percent of those individuals in community-based facilities were married.\(^8\) It would seem, then, that of the three groups compared, those receiving sheltered care were most vulnerable in terms of social margin.

Individuals placed in sheltered-care facilities are selected by virtue of their mental illness and their lack of social margin. As they become older, young transients who are at the bottom of the social margin scale will make up the population of those in need of sheltered-care living arrangements. This is because individuals who have an education, some resources, and relationships to fall back on are ultimately more likely to manage without sheltered care despite being handicapped by mental illness, even though there can be no doubt that one draws on all one's resources in dealing with long-term mental disability. Nevertheless, the lack of social margin observable in the sheltered-care popula-
tion at present is more likely the result of these individuals' never having a substantial pool of resources than of their having exhausted their resources during the course of their illness.

DISTURBANCE AND DISTRESS

In discussing psychological disturbance, the author is referring to behaviors that are considered gross symptoms, are observable, and might be considered deviant. Such behaviors include motor retardation, hallucinations, grandiosity, mannerisms and posturing, physical and motor manifestations of tension, hostility, suspiciousness, and uncooperativeness. On the other hand, in discussing psychological distress, he is referring to the ability of the individual to verbalize his or her internal discomfort as measured by the items in the Langner Psychiatric Impairment Scale. Those regarded as psychologically distressed, then, respond positively to such statements as "I feel weak all over much of the time" and "I have had periods of days, weeks, or months when I couldn't take care of things because I couldn't 'get going.'" 10

Although these two types of psychological problems are significantly and positively correlated, they differ in important ways in regard to the characteristics of the population in need of sheltered care. In terms of social margin, those who are psychologically disturbed are in a much more vulnerable position than those who are psychologically distressed, for they are of lower socioeconomic status and experience less contact, if any, with interested family members. Furthermore, if access to treatment is considered another indicator of social margin, it should be noted that the psychologi-
cally distressed are more likely than the psychologically disturbed to be in halfway houses where treatment is most available. In contrast, the psychologically disturbed are more likely to be found in board and care homes, which are not treatment oriented. In view of this factor, it would seem that the prognosis for the psychologically distressed is much better than the outlook for those who are disturbed.

It should be noted, however, that a large proportion of those constituting the sheltered-care population in California are neither severely disturbed nor distressed. These individuals exhibit an ability to adapt to and use various aspects of the sheltered-care system to their advantage. In addition, they reveal themselves to be capable of assessing the quality of care they receive.

The author and Aviram have reported that the intensity of personal involvement the mentally ill experience with others in their environment is significant. They also found that individuals with lesser degrees of psychological disturbance have the ability to cope with such involvements but that those who constitute the most psychologically disturbed segment of the sheltered-care population—approximately 16 percent of the total—show little interest in the quality and character of their social environment. If given the opportunity, individuals in this group attempt to leave their environment and continually be on the move.

These findings are consistent with those of Brown, Birley, and Wing, who report that some people leaving mental hospitals function more successfully when they return to situations in which they have no deep personal involvement. Such individuals do best when they can maintain a social distance between themselves and others in a structured environment supportive of
friendly relationships that are not necessarily intense. However, developing personal involvements seems important for those constituting the less psychologically disturbed population, who make use of these involvements in a way that enhances their integration in the external community.

NATURE OF THE ILLNESS

The condition of a mentally ill individual may be categorized as chronic or acute. The acute phase of an illness involves the rapid, unanticipated onset of florid symptomatology. Individuals undergoing such acute episodes require intensive care aimed at helping them control themselves and become stabilized on psychoactive medication.

Throughout the course of their illness, a great number of individuals experience acute episodes that often involve their being admitted to a state or county hospital and being classified as dangerous to themselves or others. Although many people experience only a single acute episode of this nature, a smaller number experience numerous episodes over a period of several years. Such individuals are chronically ill. In addition to involving intensive treatment, these episodes of acute illness require a large commitment of financial, personal, and social resources from the patient. Those who are chronically ill therefore have progressively less social margin to draw on for dealing with subsequent acute episodes. As their resources are exhausted over a period of time, they must seek out new sources of social support in between these bouts of illness. Often, the only sources available lie within the mental health system.
IN VolvEMENT WITH THE SYSTEM

Individuals do not undergo extensive contact with the mental health system without being affected in some way. Those who have been hospitalized only once and for a limited period are more similar to the general population in regard to their level of social margin than are those who remain within the system for a long period. People hospitalized briefly have a greater number of resources to draw on and do not have to cope to a great extent with the social stigma attached to the long-term mental patient.

In examining figures relating to the hospitalization of patients between 18 and 65 years of age, it can be seen that the greatest proportion of those admitted to the hospital for the first time consists of individuals between 25 and 44 years old. The concentration of first-time admissions in this approximate age group did not change between 1962 and 1972, although a significant increase took place in the number of younger people hospitalized for the first time. On the other hand, the greatest proportion of people remaining in the hospital as residents are over 45 years of age. Thus, while many individuals are admitted once to the hospital and never return, others grow old never having left the system.

Individuals who have been hospitalized or in sheltered care for a long period of time often experience institutional neurosis. They have learned to live with their environment and have settled into their situation in life, as we all do. However, having settled in and come to understand their obligations, roles, and whatever else is required of them, they are unwilling to reach out and engage in the risky business of developing new roles, a
task whose difficulty is heightened for them by the social stigma associated with mental illness. These individuals have accepted a position of powerlessness in exchange for a protective environment. They express feelings of great obligation to the operators of their sheltered-care facilities or the people who operate the hospitals in which they live. In many cases, this sense of obligation results from fear; in others, it is prompted by the quality of service they have received.

Long-term residents of sheltered-care facilities and mental hospitals are likely to be on maintenance doses of psychoactive medications. Often the medication of those in community-based facilities has not been changed since they left the hospital. Since the members of this population have little gross psychological disturbance, their level of social functioning is frequently reduced by the relatively high dosages of psychoactive medication they receive. They are seeking a comfortable environment in which to spend their lives with the greatest level of self-respect that can be obtained in a dependent situation.

DISCUSSION

In considering the effect of certain characteristics on the needs of the mentally ill for sheltered care, the author has discussed certain groups whose specific needs determine the type of sheltered care that will facilitate their adjustment to the community. Perhaps those most vulnerable and at risk of becoming chronic mental patients are the young mobile individuals who have been described as exhibiting a high degree of psychological disturbance, avoiding personal involvements, lacking social margin, and, in general, undergoing an acute
phase of their illness. These individuals, especially those among them with a lack of social margin, have not been catered to or effectively served by the present mental health system. New models are needed for their care, for overcoming the hostility they feel toward the mental health system, and for enabling them to make use of available services.

In contrast, another group of young adults experiences a high degree of psychological distress. They often have personal and social resources as well as families who are interested in them, but, like the group just discussed, avoid personal involvements and are in general undergoing an acute phase of their illness. However, the prognosis for these individuals is relatively promising. A recent experiment has shown that even without medication they manage well in a halfway house. The mental health practitioner finds them easier to work with because they are distressed as opposed to disturbed and are capable of verbalizing their problems. Such individuals do best in halfway houses or with brief crisis intervention.

A third population to be considered are those middle-aged individuals hospitalized for perhaps the first time. A great proportion of this group will never return to the hospital. They are undergoing an acute phase of their illness and have access to social resources. However, since the resources of these patients are not inexhaustible, should they be forced by virtue of their disability to remain in the system for longer periods of time, they may join the more chronic population and come to be in need of long-term placement.

The last group to be considered is composed of chronic, long-term patients above 50 years old, who have few personal and social resources, have been in-
involved with the mental health system for a long time and have been stigmatized by this involvement, and are seeking some stability in their life. These individuals do not manifest a high degree of psychological disturbance or distress. They may appear odd or different, often because of the side effects of their psychoactive medications. They have little to look forward to beyond what is available in their current living situation, and they need encouragement and social support to maximize their potential within that situation.

Four groups with differing needs have thus been considered. Different problems are associated with providing these groups with sheltered care, and delivering services to them presents a basic challenge to those involved in helping the mentally ill in sheltered care.

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About the Author

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Notes and References


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8. Segal and Aviram, op. cit., p. 131.


11. Segal and Aviram, op. cit.


