but who, because of the decline of the state mental hospital, are now residing elsewhere. Some of the beliefs about them appear to be taking on the status of myths, reflecting more the intentions and hopes of community health than the uncomfortable realities.

REFERENCES


STEVEN P. SEGAL AND URI AVIRAM

Who Are the Mentally Ill in Sheltered Care?

In asking who are the mentally ill in sheltered care, we are concerned with what their experience has been with respect to social integration, what their current potential is for becoming socially integrated, and what seem to be the most formidable obstacles to integrating them into the community.

The data we present here indicate that the mentally ill population in sheltered care are a residual group, never integrated into society’s mainstream, with few prospects for complete economic and residential independence—that is, complete social integration into the mainstream of society. Our data show that the social-integration goal for this population should involve efforts to develop independent outreach and social involvements both within the facility or in the external community, on the assumption that the facility will be a base of operations.

We do not wish this rather strong statement to invoke the pessimistic attitude that assumes these residents cannot be helped. We believe their social integration can be greatly enhanced. We wish, however, to help define realistic expectations and prevent the disillusionment...
with helping efforts that has so often in the past led to the neglect of the population’s needs.

We have defined social integration in terms of five levels of involvement—that is, presence, access, participation, production, and consumption. The social characteristics of the sheltered-care population offer some significant insights into their past involvements and future opportunities for developing these types of involvements.

**Demographic Characteristics: A Unique Population**

Comparison by age, sex, and marital status with the general population of California demonstrates that the mentally ill in community-based sheltered care are a unique group with unique needs. Their social characteristics place them at a disadvantage with respect to integrating themselves into society’s mainstream.

**Age and Sex**

Almost half (46%) of the sheltered-care population between 18 and 65 years of age are 50 years old or older, compared with 25% of the general population in California and approximately 25% of the general population of mental-hospital releases (Heckel et al., 1973; Miller, 1965). This is extremely important in considering the feasibility of transition back into the community: These individuals are in need of support at a time society expects them to be most self-sufficient and is least willing to tolerate a lack of self-sufficiency.

The sex distribution of the sheltered-care population is equally balanced between male and female; yet our analysis reveals that females in the sheltered-care population are significantly older than males: 54% of them (compared with 39% of the males) are now between 50 and 65. In contrast the youth of this population are predominantly male: Almost 33% of the men are 18 to 33, compared with 19% of the women. We thus have two subgroups—older women and young men—who socially and economically have the most difficulty in finding a place in society’s mainstream.

Despite the concentration of younger males in sheltered care (33%) their numbers are smaller than would be expected, given the concentration of younger males in the general population (42%). Also, mental-hospital releases, while slightly older than the general population (regardless of sex), are not as old as the sheltered-care population (Heckel et al., 1973; Miller, 1965). Thus there can be little doubt that problems will arise for this population in relation to their seniority—for example, they will need more transportation aid to make use of community resources.

**Marital Status**

Marital status is an index of social participation. The marital-status characteristics of the sheltered-care population indicate a lack of resources available to facilitate community transition. Table 1 vividly illustrates this by comparing this population with California’s general population and with releases from state mental hospitals serving the Bay Area. While the general population figures in California show that 70% of the individuals between 18 and 65 years of age are married, this is the status of only 5% of those individuals in sheltered care. Conversely 18% of the general population compared

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<tbody>
<tr>
<td>Married</td>
<td>70%</td>
<td>39%</td>
<td>5%</td>
</tr>
<tr>
<td>Never married</td>
<td>18%</td>
<td>21%</td>
<td>60%</td>
</tr>
<tr>
<td>Dissolved relationship (separ. widowed, divorced)</td>
<td>12%</td>
<td>34%</td>
<td>35%</td>
</tr>
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\(^a\) Miller (1965) pp. 116–117 (marital status was unknown for 5%).
with 60% of the sheltered-care population have never been married; and 12% of the general population as opposed to 35% of those in sheltered care have had marital relationships that have since been dissolved. Without speculating on the etiologic relationship between marriage and mental disorder, one thing seems sure: Individuals who lack the support of a spouse are more likely to seek social support in a sheltered living environment.

Two trends relating to marital status in addition to the very high proportion of "never marrieds" within their ranks seem to indicate that individuals in sheltered care have never been integrated into the mainstream of social life. First, follow-up studies of released mental patients show a tendency for groups of individuals returning to the hospital to be increasingly composed of "never married" and people with dissolved marital relationships (Davis et al., 1974; Heckel et al., 1973; Miller, 1965; Pasamanick et al., 1967). Thus, as a group, individuals in sheltered care are a residual population of many cohorts of mental-hospital admissions. The second trend is illustrated in Table 2, which presents a breakdown of marital status in this population by age and sex. This table points to the high percentage of never-married males (73%) and the high percentage of females from dissolved marital relationships (50%). Specifically these two figures are indicative of how males and females fail socially to integrate into today's society.

These marital-status figures are not unique to California sheltered-care facilities but seem, in fact, to have much greater generality. Apte (1968), for example, in a study of transitional hostels in Great Britain, finds that 71% of his study population (both male and female) were single, but only 17% came from dissolved marital relationships. The difference between our population and that studied by Apte seems to lie in the fact that he chose to consider only the "transitional hostel," the hostel that had at least a 50% turnover in a given year. Apte notes that this choice of a study group made a significant difference in the age of his target population. Those individuals living in the transitional facilities were significantly younger than those living in hostels he eliminated from his study. We would therefore expect him to find a smaller concentration of dissolved marital relationships than we found because at least a third of our female population who had experienced a dissolved marital relationship were over 50.

The major indication, in terms of future potential for enhanced social integration, of the marital-status characteristics of the mentally ill in sheltered care is that as a population they lack support even from the most immediate of family members—a spouse. In addition they are limited in access to two major sources of social involvement—that is, interaction with a spouse and couple-based interaction.

### Socioeconomic Characteristics of the Population

In looking at the socioeconomic characteristics of the sheltered-care population, one is again struck by the extent to which individuals in this group have withdrawn from, or have never been involved in, the mainstream of social life.

### Work

Work or "production" as a type of social involvement is one of the most important aspects of everyday social life in the United States. It is important, therefore, to

### Table 2

<table>
<thead>
<tr>
<th>Age</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Single (n_1 = 4870)</td>
<td>Married (n_2 = 300)</td>
</tr>
<tr>
<td></td>
<td>29%</td>
<td>1%</td>
</tr>
<tr>
<td>18-33</td>
<td>20%</td>
<td>1%</td>
</tr>
<tr>
<td>34-49</td>
<td>24%</td>
<td>2%</td>
</tr>
<tr>
<td>50-65</td>
<td>73%</td>
<td>4%</td>
</tr>
<tr>
<td>All ages</td>
<td>n = 6710 Males (100%)</td>
<td>n = 5720 Females (100%)</td>
</tr>
</tbody>
</table>
look into this aspect of the lives of sheltered-care residents.

Study data demonstrate that 15% of the individuals in sheltered care are in fact in the labor force. This compares with 67% of the general population in California (as found by 1970 U.S. Census figures, U.S. Bureau of the Census, 1973). Moreover, 11% of the sheltered-care population is actually employed and 4% of the population is looking for work. Whereas 4% of the general population in this age group in California were looking for work in 1970, 63% were employed. Thus the percentage of sheltered-care residents looking for work is equivalent to the general population, while the number who have found work is much lower than in the general population.

Working residents and job-seeking residents appear to be different groups in a number of aspects. Workers are equally male and female, single, white, young if female, and middle aged if male. Job seekers, on the other hand, are two-thirds male and more likely to be young, married, or formerly married. Job seekers are also more likely to be minority-group members than workers are. Residents in sheltered care tend to look for work more, and work more, if they have more education. It is also true that the less time elapsed since previous employment, the better the chance that a resident will look for work. These characteristics parallel those of workers and job seekers in the general population, yet the majority of the sheltered-care population (85%) are neither working nor looking for employment.

Workers in the sheltered-care population are different from job seekers in some other important ways. Workers come from more skilled and high-status occupational backgrounds than those people do who are looking for work and those not working. None of the sheltered-care residents who actually have a job report that this is their first working experience. These job holders are more likely to report that they have previously worked in skilled occupations such as carpentry or skilled sheet-metal work or are members of some professional group (e.g., teachers or social workers). In most cases these individuals are no longer employed in their previous vocation; often they are employed at their residence in a more menial job such as cleaning, cooking, washing, or general repair work. They have obtained their work by virtue of previously acquired and generalized work skills (such as the ability to complete an assigned task). Job seekers are more likely to report that they have had no work experience at all.

The significance of these work-related statistics for understanding the potential of the sheltered-care population to become involved in "production"-type activities as a means of enhancing their social integration lies in the observations that those with the most potential for such involvement have shown a significant drift from stable to marginal employment; those with interest in obtaining employment—the job seekers—given their backgrounds, have little chance of obtaining employment; and the majority of the population have not expressed serious interest in this type of social involvement.

Work-Related Characteristics of the Sheltered-Care Population. The lack of involvement of the sheltered-care population in production-type activities is to a large extent a function of atrophied work skills and past failures in the area in addition to their psychiatric disability. More than half of this population have been out of the labor market or away from full-time employment for 6 years or more; only a tenth were employed during the past year. In a population of which three-fourths of the individuals are over 34 years of age, only one-third have had full-time employment for 6 years or more. The employment prospects of this population are further hampered by the fact that only 66% have ever had steady employment for a year or more.

A Comparison with the General Population of Released Mental Hospital Patients. If we look at previous studies of released hospital patients, we again see that individuals in sheltered care comprise a unique population in relation to employment. Both Freeman and Simmons (1963) and Miller (1965), reporting on studies of released state-hospital patients, indicate that significantly smaller numbers of people who return to the state hospitals are employed before their return than those who manage to stay out of the hospital during the studies' follow-up period. Freeman and Simmons note that, as a total group, 33% of their study population were employed at the time of the community follow-up interview. However, 41% of those released individuals who managed to remain out of the hospital during the follow-up period were employed in some manner, compared with 20% of their hospital returnees. Miller's findings are similar. Her study found a total employment rate of 32%; she also found that 40% of those individuals who managed to stay out of the hospital during the follow-up period were employed, compared with 29% of those who returned to the hospital. Since a large portion of our study group have had several readmissions to state hospitals—a point discussed in greater detail later in this chapter—we might speculate that sheltered-care residents are, in fact, a group with a greatly diminished employment potential, at least as indicated by their employment histories. This potential is, however, indicated solely by employment history; other indicators of
work potential must be considered before any final conclusions are drawn about ultimate employability.

A Perspective on Work Potential. Despite these bleak employment statistics, there is some evidence on sheltered care pointing to the possibility of improvement in California: Apte’s (1968) findings show that, with a concentrated effort, as much as an additional 31% of California’s sheltered-care population might be employed.

Apte (1968) reports that only 46% of the residents in the transitional hostels he studied were, in fact, totally unemployed. It is not clear what Apte means by “totally unemployed”—for example, does this mean that any type of money-making activity, even running errands, would be considered employment? If so, and this criterion is used for the California population, it could be said that 23% of the population are making some money, though the amount of work involved with 12% of the population is minimal and would not normally be considered as even part-time employment. At any rate, given Apte’s criteria, we would conclude that 77% of the California sheltered-care population are totally unemployed.

Apte’s population differed from the California population in two respects important in assessing employment potential: (1) Apte’s subjects lived in Great Britain at a time when there was full employment (i.e., anyone who wanted a job could get one—if one could stand, one could work); (2) they lived in a subset of “transitional” sheltered-care facilities that had a turnover rate of 50% per year and emphasized employment as a program requirement for residents. Bremer (1973) has pointed out the significance of economic factors in relation to mental hospital admission, noting that in hard times there are greater numbers of admissions to mental hospitals. We thus would expect that differences in the economy and the transitional nature of the facilities that Apte studied might well account for a portion of the 31% difference in total employment between his group and the one reported on in California. In any event, even with full employment and with facilities that emphasize employment as a requirement, some residents remain unemployed in Apte’s sample. In Great Britain, as in California, the types of jobs obtained by residents are menial; they tend to have little possibility for advancement and seem most vulnerable to hard times.

Socioeconomic Status

A comparison of the socioeconomic status of the resident population with that of their fathers, as demonstrated by scores on Reiss’ (1961) Socioeconomic Index (SEI), reveals that this particular population is downwardly mobile. That is, of five possible index categories (professional, business managerial, skilled worker, semiskilled worker, and unskilled worker) we find proportionately more fathers of sheltered-care residents in the professional category and proportionately more residents in the unskilled-worker category of the SEI. In general a clear downward drift is apparent from fathers of residents to the residents themselves.

Income

Income is primarily an index of ability to participate as a consumer. Only 6% of the sheltered-care population are supported solely by private funds (family, savings); the rest are supported totally or in part by welfare grants. Currently three-quarters of the residents are receiving financial support from the Supplemental Security Income (SSI); 19.5% have multiple financial sources other than SSI. To a large extent consumptive patterns in this population are determined by factors external to their control—the policies of their benefactors.

Future Prospects

Although the future prospects for social integration seem bleak, they are bleak only from the perspective of the goals of achieving totally independent living and full participation in the competitive labor market for those individuals in sheltered care. Goals emphasizing more modest achievement, such as maintaining adequate levels of social functioning and maximizing the strengths of this population for all types of social involvement, seem much more attainable and realistic. The achieve-
ment of these latter goals will, however, be most affected by current constraints on social involvements.

Constraints on Social Integration

The major constraints on social involvement for the former mental patient include geographic mobility, chronicity, psychopathology, and violence. Each of these four factors has been viewed as a characteristic of the former mental patient that detracts from his level of social integration. How do these constraints relate to the social integration of the mentally ill in sheltered care?

Geographic and Mobility Characteristics

Two geographic-mobility characteristics have been considered as important in affecting the social integration of the former mental patient. First the loss of social roles due to treatment outside of one’s local area was one of the primary reasons for the initiation of the community mental-health movement (Joint Commission on Mental Illness and Health, 1961). Second, mobility itself has been viewed as an indicator of mental disorder that inhibited people from forming close relationships (Odegaard, 1932).

Providing Care Close to Home. Fully 53% report that they are currently living in a place that they consider to be their home town. In fact 80% live within 50 miles of what they consider to be their home town. This finding must be tempered by the observation that ‘psychiatric immigration’ may occur whereby long-term hospitalized patients come to view the area around the hospital as ‘home’ (Satin & Gruenberg, 1975). However, since the description of the current area of residence as one’s home town was in our sample, a response no more characteristic of the long-term than of the short-term hospitalized group, we would conclude that ‘psychiatric immigration’ is not a factor in the resident’s report of residing in his home town. Thus our findings indicate strongly that the community mental-health movement is meeting its goal of providing care for the mentally ill close to their actual home environments and that this constraint to social integration may be minimized.

A Relatively Stable Population. The population currently living in sheltered care is relatively stable; 60% have lived in their current facilities more than a year. Discounting rehospitalization as a move to a different living situation, only one-third of the group had moved within the last year. Yet a small portion of the population changes its residence frequently. For example, 16% of the group made several moves in the past year, and 23% lived in more than one facility in addition to their current placement.

Comparing the total sheltered-care population with 1970 U.S. Census figures for the general population in California, we note little difference between these two groups in view of their stability, though there is a slight trend for individuals in sheltered care to be more mobile. This mobility differential, however, may be a slight artifact of the overall newness of the sheltered-care system.

Young males are definitely the most mobile in the sheltered-care population; 63% of the young males have been in facilities for less than a year. In comparison we find that only 42% of young females have been in facilities for less than a year. Being female (in all age categories), as well as increasing age, is associated with residential stability. These findings regarding the mobility of young male residents are congruent with those of Segal, Baumohl, and Johnson (1977), which report a high rate of mental illness in the young, primarily male, vagrant population.

The findings that people in sheltered care are generally stable and that a small group of them tend to be more mobile are consistent with the expressed desire of residents for a stable life-style; 55% say that they wish to stay on at their facility for a long period of time.

Ambivalence about moving and its meaning is reflected in the following example:

Judy, age 34, is one of the few board-and-care residents who is working. If she scrimps and saves, the money she makes is enough to live on. She thinks that eventually she might like to be a psychiatric nurse; her experience in the hospital prompted her interest in that field.

Judy thinks that it would be wise for her to wait another year before going out to look for an apartment of her own. She has been living here since she left the hospital three years ago and is quite satisfied with her present living situation. ‘Like I say, it’s something like taking the place of a family. Although you know deep down it never could be. It’s just someone to talk to, someone that knows and understands and yet keeps their nose to themselves. So that means a lot.’ (F.N.).

Some mobility within the sheltered care system results from a very small number of disruptive residents who have been bounced from facility to facility within a given geographic area, usually ending up in a particular

* F.N. refers to field notes taken at the time of a structured open-ended interview.
facility informally reputed to accept more difficult individuals. In addition to movement of difficult and hard-to-handle residents within this primarily stable system, there is apparently also movement of a small group of individuals out of the system. (This latter conclusion is, however, based primarily on open-ended data and is not accounted for in geographic-mobility statistics provided by the survey data.)

Those individuals moving out of the system do not necessarily move into stable life situations. They gain a modicum of independence often connected with their efforts and those of their former sheltered-living environment. For example:

Two months before the interview, Kenneth, 32, had made his move from sheltered care into an apartment. He shares his new home with a long-time school friend, a fellow with similar interests. Moving out was not an easy task for Kenneth; the longer he stayed, the more difficult it was to leave. This difficulty was attributed to the feeling of security that he derived from his former living situation, a feeling that prevailed despite the constant turnover of residents.

It was Kenneth's intention to move out with other residents as apartment mates, but these plans fell through. Fortunately for Kenneth, he grew up in this area and has a father living near the sheltered-care facility. When he first moved out of the facility he arranged to live with his father until he could move into his new apartment. Kenneth has maintained a long-term relationship with a woman who often visited him while he was living in sheltered care. Although he had little contact with the people from the facility during the first couple of weeks after he left, some new problems in his relationship with this woman have prompted him to turn to them for emotional support. The facility has hired him to work on their staff on a part-time basis; he attends staff meetings and seminars.

Given the data on geographic mobility in the sheltered-care population, we currently think that this is not a major constraint for the social integration of this group.

**Chronicity: History of Mental Hospitalization**

Chronicity, that is, long-term hospitalization leading to the termination of social contacts, is another constraint on social integration. In considering the history of the sheltered-care population's involvement with the state mental hospital, we should note that a quarter of the population currently in these facilities did not have their first admission to a mental hospital until after the enactment of the Lanterman-Petris-Short (LPS) legislation in 1969. Thus whereas a significant portion of the sheltered-care population is new to the state hospital system, it seems that the policy of community care for the mentally ill has the potential for producing its own residual or chronic population: The recent admissions may now represent the same residual population that in the past filled the back wards of the state mental hospitals. The possible substitution of long-term community-based sheltered care for long-term hospitalization is reinforced by the fact that a full 35% of the individuals currently living in sheltered care have cumulatively spent a year or less in a mental hospital. In fact 57% have **never** spent 2 or more continuous years in a mental hospital. Such a history is not characteristic of the former long-term mental patients who were admitted under indefinite commitment to a state hospital.

In general we found that women residents were more involved with both the sheltered-care and the hospital-care systems: Women had slightly more admissions to the mental hospitals in each age category than their male counterparts; they were more likely to be in the chronic-hospital category than men—that is, they were more likely to have spent 2 or more continuous years in a state hospital (35% of young females versus 27% of all women also spent more years in sheltered care and had been in more sheltered-care homes). In all of these figures age is an important factor. The older one is, the longer one tends to have been involved with the mental-health system. This is a traditional and expected trend. An opposite trend emerges, however, from the initiation of a revolving-door policy (i.e., a policy of easy admission and quick release, often applying to the same individual over many experiences with the mental hospital) precipitated in California by the 1969 LPS Act. For the younger and middle-aged residents we see an increase in admissions over the older group. For example, 46% of the young residents, but only 39% of the old residents, have between 3 and 25 admissions.

The effects of the 1969 LPS changes in admission and retention policies of state hospitals were studied by cross-tabulating the "years since a resident's first admission" (the assumed date of onset of his illness) with "whether or not he had spent 2 or more continuous years in a state hospital." In this analysis we are particularly interested in comparing the group of individuals whose illness began after LPS as compared with the group whose first hospitalization was before 1969. Controlling for age, we find that only 11% of the people within each age category whose first admission was since 1969 report having been hospitalized 2 or more continuous years, but within the group hospitalized before 1969 a minimum of 41% in each age category are likely to
The Mentally Ill Resident in Sheltered Care

The typical sheltered-care resident is between 50 and 65 years of age, white, Protestant, has less than a high-school education, and has been out of the labor market for several years. The resident is generally not living far from his or her home town and is fairly settled into a stable life situation in the sheltered-care facility. The major source of financial support for the typical resident is SSI. The resident does not provoke much trouble for the community from the perspective of social disorder and manifests a mild level of psychological and emotional disturbance. Prospects for making the transition to full community life in terms of obtaining gainful employment seem small, as are prospects of establishing some sort of conjugal unit on which to base social life.

The impediments to social integration of the sheltered-care resident are those relating primarily to establishing himself more as an independent self-supporting individual. Constraints on social interaction, such as severe psychopathology, community reaction to patient stereotypes, or lack of social contacts due to mobility or long-term hospitalization, must be viewed as factors adding to the difficulties posed by a lack of previous social integration. Our efforts emphasize, therefore, the basics of social integration. The goal of our study, then, is—current constraints being taken into consideration—to assess those factors that can help improve the sheltered-care experience of these individuals and promote their efforts to reach out in a more independent manner to the external community. With this goal in mind, we now turn to a consideration of how residents use their environment.

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