RESIDENTIAL INSTABILITY IN A PSYCHIATRIC EMERGENCY SETTING

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INTRODUCTION

This paper focuses on the phenomenon of residential instability within a psychiatric emergency setting: its dimensions, its association with clinical status, and its implications for mental health professionals. For the purposes of this research, we defined two levels of residential instability. The first refers to a lack of shelter or to the use of refuges such as doorways, public waiting areas, and, in Baxter and Hopper's words, "other well hidden sites" known to the homeless. The second, more moderate level describes highly transient and tenuous living arrangements. Movement between short term hotels, "crash" housing, and institutions may afford a roof and a bed, but does not provide stability of residence in any meaningful sense. For this perspective, we considered conditions of living at a point in time for a given individual. We did not examine the characteristics of populations thought to be habitually affected by these conditions.

Whatever our attempts to impose conceptual boundaries on this phenomenon, residential stability remained a difficult research problem to contain. As a function of ongoing social and economic developments, it is subject to continuing changes, affecting a population far broader than those persons who may be psychiatrically defined and exceeding a clinical sphere of influence. If we felt compelled to enter this research area, it was because of its significance in the emergency setting, where the problem of undomiciled clients had reached serious proportions. Their presence was not altogether surprising, given the fact that where general homelessness has increased, the mentally ill appear to be especially at risk. However, the human dimension of this situation and the treatment issues it raised comprised urgent matters for clinical staff.

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Despite a general awareness of these issues, we had little precise data which concerned the exact living situations of the PES clientele, the number who could be considered residentially unstable, their demographic characteristics, and the manner, if any, in which homelessness and transiency influenced clinical status at the moment of emergency care. This research was conducted to answer these questions. It was broadly exploratory, with the major goal of establishing baseline information, separating impression from fact, and using these facts to generate further study.

BACKGROUND

Susan Larew observes that “it is during periods of social change and its impending disorganization that homelessness becomes more visible and the social abhorrence more pronounced.” During times of relative prosperity and stability, when population mobility is low, the undomiciled or transient tend to be seen as examples of individual poverty and deviance, rather than as a class or group. The traditional denizens of our “skid rows,” “hobotowns,” and “boweries” have been considered as isolates who opt for a marginal way of life on the basis of such personal factors as alcoholism or a desire for social distance. Words like “drifters,” “hobos,” “bums,” “loners,” and “skid-row alcoholics” describe individuals, not social problems.

Large-scale residential instability brings the issue of group poverty and deviance to our awareness. This has occurred before in our recent history, during the industrial revolution with its relocation of population, and later during the Great Depression of the 1930s, when the unemployed expanded the ranks of the undomiciled. However, the destitute and homeless immigrants of the early industrial period were removed to the first public mental hospitals, a fact which has been associated with their subsequent overcrowding and with the demise of “moral treatment.” Even during the 1930s, asylums continued to siphon off the most disturbed or disturbing of the residentially unstable.

The prominence of the mentally ill among a growing undomiciled population reflects the convergence of economic and demographic changes with deinstitutionalization. Unemployment today, as historically, appears to promote homelessness among the general population. Inflated rentals and urban development in many cities further threaten the supply of inexpensive housing to be found (often to be found in hotels). This displaces the elderly, the disabled, and the isolated poor. Those among the chronically mentally ill who reside in pockets of urban poverty may be particularly vulnerable to residential loss, sharing both economic disadvantage and the specific problems of psychiatric disorder. Concern has been expressed about their “ghettoization” and their need for decent low-cost housing. Rhoden links this to an emphasis by early patients’ rights advocates on issues such as refusal of treatment, without a counterbalancing focus on rights to fundamental services.

Several widely disseminated studies address the dimensions of homelessness and the over-representation of the mentally ill among undomiciled groups. Bax-