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A case study of involuntary hospitalization of homeless mentally ill adults

Itzkowitz, Murray, D.S.W.

City University of New York, 1994

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A CASE STUDY OF INVOLUNTARY HOSPITALIZATION

OF HOMELESS MENTALLY ILL ADULTS

BY

MURRAY ITZKOWITZ

A dissertation submitted to the Graduate Faculty in Social Welfare in partial fulfillment of the requirements for the degree of Doctor of Social Welfare, The City University of New York

1994

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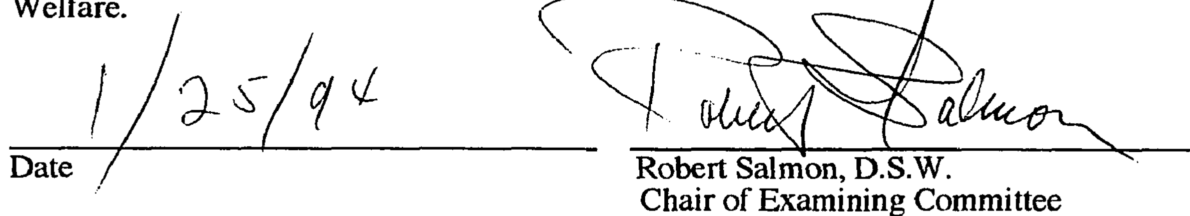
This manuscript has been read and accepted for the Graduate Faculty in Social Welfare in satisfaction of the dissertation requirement for the degree of Doctor of Social Welfare.



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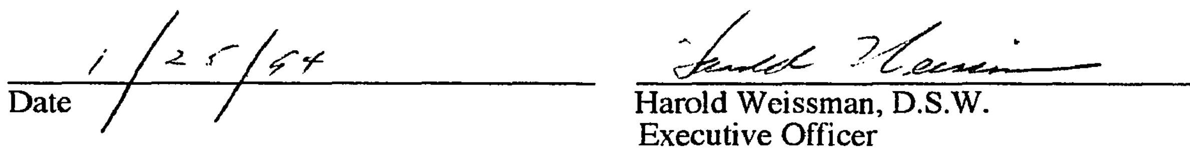

1/25/94
Date

Harold Weissman, D.S.W.
Executive Officer

Marsha Martin
Marsha Martin, D.S.W.

Michael Smith
Michael Smith, D.S.W.

Supervisory Committee

THE CITY UNIVERSITY OF NEW YORK

ABSTRACT

A CASE STUDY OF INVOLUNTARY HOSPITALIZATION OF HOMELESS MENTALLY ILL ADULTS

by

Murray Itzkowitz

Adviser: Professor Robert Salmon

This case study is an exploration of the three questions of **who** among the street-dwelling mentally ill in New York City from 1991-1993 were being "designated" for trips to psychiatric emergency rooms; **why** these individuals are selected for "designation"; and **how** and when such activity occurs. The study also examines the social policies and statutes that establish the programs and services which are available to assist this vulnerable patient population.

The idea for the study began with the investigator's concern that the increase in the mentally ill among the number of homeless was attributable to statutes that mde it too difficult to take people to hospitals against their wishes and the belief that hospitals were turning them away and forcing them into "revolving door" patterns. The investigator's bias also included a belief that there were too few professionals and others engaged in this specialized work and that not enough people in and outside government were concerned with finding solutions to problems which have existed since the era of emptying psychiatric hospitals known as "de-institutionalization".

The study's literature review reveals only recent interest on the subject of involuntary hospitalization of the homeless mentally ill. What has been written highlights the debate between clinicians and civil libertarian lawyers over issues of personal freedom and the need for treatment. Writers are either for individual rights or for liberalizing the basis for removing people from potentially lethal situations.

The investigator utilized a participant-observer method to study practices and policy in the field. This method included visits to outreach programs, reading case records, interviewing staffs, visiting the courtroom and traveling with outreach teams.

The investigator learned that four outreach programs in Manhattan have contacted and worked with several thousand undomiciled, mentally ill persons and that utilizing sections of New York State Statutes (9.37 and 9.39) have gotten many patients into hospitals and ongoing treatments. The investigator concludes that within the areas served by outreach programs it has become possible, through rapid response, to identify, assess and plan for treatment of homeless mentally ill. It appears that statutes are adequate to insure that those who need hospital care can get it and that **only** those who need it get this kind of treatment.

The investigator finds there are well-trained dedicated workers who could train others, including police, and recommends that outreach programs be established that are organized and administered by social workers in each community of 100,000 persons. This is similar to the French system of

"sectorization" which combines hospital and community-based, coordinate services.

This case study arose out of the investigator's concern that there were increasing numbers of homeless mentally ill in the streets, in transportation terminals and other parts of the city and that insufficient efforts were being made to get them to hospitals or other safe places. The investigator assumed at the outset that state law was restrictive and may have made it difficult to remove mentally or physically ill persons to hospitals and that too few professionals and other personnel were engaged in such activity. He also had the idea that patients were being turned away at hospitals by resident psychiatrists who were hostile to those patients or unfamiliar with them and therefore reluctant to hospitalize them. The investigator also questioned whether the plight of mentally ill people in the streets was of concern to anyone in government and whether there were people who knew how to assist this especially vulnerable population.

ACKNOWLEDGEMENTS

My sincere thanks to my wife, Phyllis, to my son, Jacob, for encouraging me and making sure I had the time to do the work of this dissertation and to my sons David and Steven for their support and cheer-leading.

My appreciation to staff at The Bridge who helped with ideas, suggestions, time and support. Thanks to Peter Beitchman for help with the literature and his critique of the work. Also, thanks to the Board of Directors of The Bridge, Inc. for their support.

My special thanks to Dorothy Kay, my long-time co-worker and Executive Assistant for her editorial help and her preparation of the many drafts of the report.

This report could not have happened without the generous participation of Dr. Sam Tsemberis, Helen Greer and the staff of Project H.E.L.P. Equally important was Diane Sonde's kindness in providing me with a view of a most successful program assisting the subjects of this report.

My deep gratitude to Drs. Robert Salmon, Chairman and Marsha Martin and Mike Smith for serving as my Committee. Their wisdom, which they shared with me, helped me to avoid serious pitfalls and bumps in the road on this journey to a completed dissertation.

A CASE STUDY OF INVOLUNTARY HOSPITALIZATION OF HOMELESS MENTALLY ILL ADULTS

BY

MURRAY ITZKOWITZ

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CHAPTER I

INTRODUCTION

In January, 1982, a 61 year old woman, a former psychiatric hospital patient, froze to death in a corrugated box on an out-of-the-way street corner on the West Side of Manhattan. Police and municipal authorities, including the New York City Commissioner of Mental Health had known that she "lived" in the carton for some time and the Commissioner, following statutory requirements, had ordered the woman observed to determine whether, as a result of her way of living, she was in danger of causing harm to herself. Under these early statutes, the individual had to be observed by the Commissioner or her designee for 72-hours to secure a Court certificate authorizing the Commissioner to order police to move the woman involuntarily from her cardboard carton to a hospital. The woman was said by the Commissioner's office to have rebuffed earlier efforts to assist her and that she had not been persuaded to voluntarily seek aid at a hospital emergency room or move to a shelter. "Rebecca Smith froze to death in the home she constructed for herself inside a cardboard box. She preferred it, she said, to any other home. Rebecca Smith had spent much of her life in a state psychiatric hospital-life in the box was preferable" (Ann B. Johnson 1990). The woman never was removed involuntarily from her cardboard "home" because on the day before the

conclusion of the 72 hour observation, there was a sudden and steep drop in temperature and the woman froze to death--a victim of exposure, hypothermia, and social policy dilemas.

The death was followed by a public outcry that this lonely, maddened person had been left to perish alone on the streets, a victim of the elements and of society's neglect and outdated policy. This tragic incident revealed to the public and professional community the deep underlying issues and conflicts associated with involuntarily admitting for hospital observation and treatment those persons who are likely to harm themselves or others if left unattended. Involuntary psychiatric admission, or commitment, has pitted mental health professionals against lawyers, physicians against magistrates and citizens against each other. The choice between allowing persons with obvious mental and medical problems to suffer and deteriorate in the streets until they become emergencies, or ordering them earlier to be transported by police to a hospital, embroils proponents on either side of the debate in ethical, civil rights, privacy and policy arguments.

The number of street-dwelling mentally ill rapidly increased during and since the period from 1955 to 1978, generally referred to as the "deinstitutionalization" of the nation's psychiatric hospital patients. The frenzied emptying of psychiatric hospitals greatly expanded the number of potential recipients of emergency room psychiatric and medical care, including those who would need to be served involuntarily. As reported by the Governor's Select Commission On The Future Of The State/Local Mental System-1984 New York State's hospital census of 93,000 patients in 1955 was reduced to

76,000 in 1968, 35,000 in 1975, and is less than 10,000 in 1993. Many of those released have been unable to adapt successfully unaided to life in the community and serving them required changes in statutes, policies and programs.

The shift in locus of treatment and care of the mentally ill from hospitals to community had three ambitious goals. According to the 1984 report of the Governor's Select Commission these were:

-- to prevent inappropriate mental hospital admissions through provision of community alternatives for treatment;

-- to release to the community all institutional patients who had been adequately prepared for release;

-- to establish and maintain community support systems for persons receiving mental health services in the community.

The Commission Report goes on to indicate that:

> ...in addition to the development of psychotropic medications, the philosophy that community treatment is better, other factors also contributed to de-institutionalization. In the social reform era of the 1960's a more activist judiciary began listening sympathetically to patients rights advocates who challenged the manner in which states dealt with mentally disabled citizens.

Social reform, including improvements in the care of the mentally ill; legal decisions; and medicines to control psychotic symptoms combined to set the stage for the re-definition of services to the seriously and persistantly mentally ill. The most important of these was the availability in 1953 of tranquilizing medications, without which de-institutionalization could not have occurred. The rapid spread of their use emboldened hard-pressed, fiscally conservative governors and state legislators to join libertarians and physicians

in advocating the reduction of costly hospital populations and the shift of responsibility for patient care to localities. The Select Commisison Report states:

> A concomitant development which profoundly influenced mental health treatment at this time was the introduction of psychotropic drugs....This breakthrough in pharmacology changed the treatment of mental illness and led to an optimistic perception that mental illness could be cured. **Because of this mistaken belief, the needs of some patients for lifelong care were not fully acknowledged.**

The idea that mentally ill persons could be taken care of in the community and that such care would be curative had great appeal and was supported by civilians as well as elected or appointed officials and those critics of hospitals who wanted all patients "liberated" from the psychiatric care system. The federal government in 1963 created community mental health centers in which patients now in the community would receive their mental health services. These local centers, together with inexpensive housing and income supports and Medicaid were to complete the arrangement for care.

As is now known, only a one-third of the 2,000 authorized community mental health centers were developed. Of these, few centers provide services to seriously mentally ill. The additional required community-based mental health and rehabilitation services required substantial expense and so were slow to develop. The funds saved by reducing hospital populations did not precede patients to communities and were slow to follow patients into the community. Those communities into which patients were placed or found their way were not always glad to receive them. The 1984 Select Commission Report points out:

In the early years, it was thought that most patients would immediately be welcomed into and respond positively to community life. However, community services for the chronically mentally ill were not adequately developed, guidelines for discharge were unclear, and state/local coordination was lacking.

In addition, many mentally ill persons who were totally unprepared for community living were released into various kinds of low-income housing including SRO hotels and rooming houses.

During the 1970's and early 1980's, many former patients became homeless, as the sub-standard dwellings that had formerly provided them with asylum fell prey to gentrification pressures and were converted to higher-income co-ops. Select Commission Report

The poorly implemented and failed policies of shifting care of the mentally ill from the traditional long-term psychiatric hospital to the community are the direct antecedents for the presence of street-dwelling mentally ill who often voluntarily use emergency rooms and acute-care hospitals in a revolving door pattern and those who also need to receive such services against their desires. The 1984 Select Commission concluded few of those released were actively served once they left the hospital. In New York State, the policy of releasing most psychiatric hospital patients was accompanied by a revised admission policy in 1968 which emphasized non-admission and diversion[1]. This made it difficult to return a patient to the hospital or to hospitalize a "new" patient. The new admissions policy has meant additional reliance on local general hospitals and increased tensions between state and local systems. Since the late 1980's, New York has continued downsizing its hospital and after-care services, including consolidating hospitals and closing community-based clinics. The State Legislature and Budget Bureau regularly reduce the Office of Mental

Health budgets but paradoxically insist on keeping open psychiatric facilities in their districts which no longer serve patients but which employ local residents. There is an effort being made in 1993 to have the New York State Legislature direct the Commissioner of Mental Health "re-invest" all savings from hospital consolidation and closing in community-based programs, a plan which was first proposed by the Select Commission in 1984. On November 17, 1993, it was announced that the NY Legislature and Governor Cuomo had reached agreement on a bill which would shift $210 million from in-patient to community-based services over five years. The money was to come from closing 5 state facilities and reducing the hospital services. Of the $210 million, $30 million are specifically allocated to serving the homeless mentally ill. The compromise bill was scheduled for passage and signing in December 1993.

Social workers have played a uniquely important role in services to the chronically mentally ill. The psychiatric facility social worker was historically responsible for the patients' discharges and after-care planning. Their responsibility for the mentally ill population with whom they had the closest contact has carried over to community-based services which are frequently organized as social agencies. Social workers have developed psychosocial centers, day treatment programs, community residences, and outreach programs which serve homeless mentally ill. They encourage street-dwellers to "come indoors" and frequently participate in arranging involuntary trips to hospitals. The social worker "must meet the client's needs without violating client rights, even though those rights are often preserved at the expense of basic needs. (John R. Belcher - 1988)

As required by mental hygiene statutes, individuals for whom hospitalization is requested must demonstrate that their condition warrants such action. Hospitalization is, after all, a form of restraint, especially when involuntarily imposed. The person who is taken to a hospital for treatment of festering sores, bizarre behavior, infection, or worse will be seen by some as "rescued" from the streets but others will see them as deprived of liberty and personal choice. Some writers make the case that amended statutes now enable all who need hospital treatment to receive it. Others, feel that statutes and their interpretation by emergency room physicians are too conservative. In their 1991 book, **Madness in the Streets** R.J. Isaac and V.C. Armat argue for liberalizing standards for involuntary admission and make the point that, in mental illness, the brain, which is responsible for making judgments, is diseased and should not be relied on by society to make lifesaving judgments. Since the early 1970's, libertarians, public defenders and other lawyers, have opposed such liberalization and have advocated in and out of the courts, for leaving to the individual the decision to seek medical and psychological help. The issue of "freedom" to choose pain, suffering and even death, has been central to the modern day debate about who will be involuntarily hospitalized and when such admissions should occur. To this investigator it seems that removing an individual from a potentially lethal or even seriously harmful situation is of a higher order of priority than assuring that no civil right has been abridged.

In the period since 1972 lawyers succeeded, through case law and statute, to add extensive legal process to the seemingly simple and humane act of bringing a confused, suffering individual to a hospital for assessment

and needed treatment. Belcher (1988) writes that, "Before 1970, loosely defined civil commitment statutes allowed unwarranted intrusions into people's lives." Libertarian lawyers used such "abuses" to create the opening for Court proceedings and stricter limitations on involuntary admissions. These new hospital-based court procedures have come to resemble criminal cases. They begin with identifying the individual brought to the hospital as a person "accused" of mental illness and stress heavily the patient's rights to the same safeguards and "due process" as an accused criminal. When this includes the right to remain silent, it makes diagnosis difficult and treatment doubtful.

The search for a standard by which to judge a person's need to be removed from the community was first answered by the 1972 landmark Lessard case in Wisconsin, which provided the precedent for the standard of "dangerousness". Under this standard the individual is to be examined by physicians who will determine the degree of danger to the person of remaining on the streets. "Dangerousness" became defined as evidence that the person threatens to do physical harm to self or others. In the absence of a finding of danger of physical harm to self or others, it was successfully argued in the Lessard case that the individual should remain at liberty. This case raises questions about whether libertarians and some lawyers have swung the pendulum too far in championing **rights** over **needs** by promoting "dangerousness" as the only basis for admission. The debate between rights and needs seems illustrated by citing the case of the woman in the cardboard box whose needs were not met and who "died with her rights on".

The January, 1982 death by freezing in New York City was followed

by an easing of local policy and practice which did not require changes in the state statutes. Following the incident, outreach workers and police began bringing those who "gravely" endanger their health by not seeking shelter against the elements, to emergency rooms or shelters. In October, 1982, Mayor Edward Koch ordered police to remove homeless mentally impaired people from the streets to shelters when the temperature fell below 5 degrees centigrade. (In later years, this was changed to "below freezing".) Mobile teams from newly created outreach programs, working from vans, were assigned to assist police in evaluating those to be escorted to shelters. By October, 1982, outreach programs had been developed in several cities around the nation, including New York with the mission of locating and assisting mentally ill on the streets, offering such services as food, medical care, shelter, and when indicated, transportation to hospital emergency rooms. A corps of mental health professionals were being trained, first to introduce an array of community-based services to uninformed or resistive persons and secondly to evaluate individuals for potential involuntary hospital admission. There appears to have been an important shift in attitude and policy regarding more aggressive outreach and hospitalizations in the ten years following Lessard. This may well have been in response to a rapid build-up in numbers of homeless and street-bound mentally ill.

In New York, Project Reach-Out (P.R.O.), sponsored by Goddard-Riverside Community Center, funded in 1979 through the Community Support Services was the city's first outreach program. This was followed by Manhattan Bowery Project's Mid-town Outreach Program started in 1981 and

then in 1982 by Homeless Emergency Liaison Project (H.E.L.P.), and several additional outreach programs which were organized to serve specific areas of Manhattan.

Outreach programs have demonstrated their unique abililty to locate, identify and refer patients who would probably otherwise go untreated and unserved. Their mandate to track and follow-up with reluctant, resistant and incompetent patients makes them an important player in the service continuum. During the five years from 1982 to 1987 these projects working collaboratively identified many street-dwelling mentally ill and were able to have a small number voluntarily hospitalized every year. A small number were also involuntarily taken to hospitals where emergency room physicians were not yet familiar with the population and their needs. Although Project H.E.L.P. was authorized to arrange involuntary trips principally to Bellevue Hospital, it was some time before the hospital was receptive to admitting their clients. In 1987 Mayor Koch ordered an additional initiative to alleviate the suffering of streetbound mentally ill. By his order a special unit was created at Bellevue Hospital to receive and treat Project H.E.L.P. admissions, with a resulting increase in hospitalizations. It seems that bureaucracies which move slowly needed executive orders before implementing policy changes. Such process is the nature of this organizational form.

Dr. Luis Marcos, who was associated with the creation of Project H.E.L.P. and later became New York City's Commissioner of Mental Health, describes the 1987 initiative as, "an unprecedented policy to remove from the streets to hospitals those mentally ill homeless individuals who were neglecting

their essential needs...and who by reason of their mental illness lacked the capability to comprehend the need to protect themselves from obvious danger and were at risk of physical harm". (Marcos, L. 1990)

Shortly after the second initiative in 1987, a mentally ill young woman who had staked out a mid-town Manhattan sidewalk space as her "turf" was approached by outreach workers responding to numerous complaints about the woman's physical condition and her verbally abusive behavior. The team determined that the woman needed care in the hospital. When she rejected voluntary treatment at a psychiatric emergency room, the mental health team ordered police to transport her to the hospital.

Once at the hospital, the patient, the first person admitted under the 1987 initiative, drew immediate attention to herself by protesting her involuntary hospitalization and psychiatric treatment and demanding her release. Her protests mobilized patients' attorneys stationed at the hospital to do their part to protect her rights. They appealed to the Court to have the patient released under the "72-hour"[2] provision in the Mental Hygiene Law and invoked her right to refuse psychiatric treatment. The case tested the liberalization of rules for involuntary transportion of patients to the hospital and garnered wide attention locally as well as from the many states that had similarly modified "dangerousness" standards in their statutes to include self-neglect and reasonable assumption of grave harm to self if left unattended.

A lengthy legal battle followed over whether the woman, Joyce Brown, (also known as Billie Boggs) could be committed involuntarily or detained for an extended period of observation and whether she could be involuntarily treated.

Mayor Koch supported the psychiatrists' decisions to commit the patient and to have her treated. He and the hospital were opposed by patient's rights advocates such as the American Civil Liberties Union. There were a number of appearances in the State Supreme Court which is located in Bellevue Hospital, testimony by expert witnesses including psychiatrists. There were several judicial decisions and appeals. The proceedings, during which the patient remained hospitalized for an extended period, were regularly reported in newspapers and on television. This added to the cases's notoriety which soon resembled a criminal case and made hospital commitment seem like a conviction and sentence.

The procedures resembling a criminal case included informing the patient of "charges" against her, establishing her right to representation and even informing her of the right to remain silent, making psychiatric evaluation or treatment difficult. After a time the patient was referred by the hospital to a community-based mental health program which provided her with housing and supportive services. Once in the community, the patient enjoyed brief celebrity status, including speaking to law students at an Ivy League university. The patient, however, like other chronic mentally ill, has over time, demonstrated the episodic nature of her mental illness by having several relapses leading to revolving-door episodes of returning to emergency rooms, to the streets, to community-based programs and, at times, disappearances.

The publicity surrounding the case led outreach professionals in New York City to try harder to get street-bound patients to go to hospitals voluntarily and to escort only those they felt would surely be hospitalized without publicity.

In New York City no other case has received the attention given the Billie Boggs case. Individuals brought to Bellevue Hospital continued to request release after 72 hours and appear before magistrates in court where they are represented by attorneys of Mental Health Legal Services provided by the state. These proceedings involve testimony, evidence and can lead to court remanded hospitalization. The American Civil Liberties Union, criticized in the press for their over-zealous actions in the Joyce Brown case, appear to have since taken a more relaxed position about involuntary commitment. Since this case, Project H.E.L.P. has escorted or transported about 300 persons a year to Bellevue Hospital, where the special unit at the hospital developed to receive Project H.E.L.P. patients has functioned as an effective receiving unit. An additional service operated for a short time at Creedmor, a New York State Office of Mental Health facility. This unit cared for fifty patients transferred from Bellevue for longer term treatment and to await admission to community-based residential programs.

The cases of Joyce Brown and the woman who froze to death illustrate policy changes influencing involuntary admission of mentally ill persons living on the streets. The New York City policy and procedure changes in 1982 and 1987 occurred while state law remained essentially unchanged. Policies and procedures are more sensitive to public sentiment than law making and therefore, more readily modified. In recent years the acknowledged rise in the number of undomiciled persons, especially those with mental illness, has required states and localities to review policy, procedures, and statutes for involuntary commitment to insure that those who need such intervention, and

only those, receive it. Clinicians and advocates agree that reasons for involuntary admission must be compelling and sufficiently urgent to warrant the suspension, even temporarily, of some of an individual's rights. In order to do what is "right" clinicians, law-makers and others responsible for policy making have, over time, sought to establish standards for uniform, non-controversial determination of who should be admitted or treated against their wishes.

The most frequently applied standards are the level of adaptation to street-living and the estimate of harm the person will cause to self or others if left on the streets. This frequently includes determining whether there have been threats or acts against self or others and whether those occurred within hours or days of the evaluation or will be likely to occur within a definable time period. Another measure, often meant to replace whether the person is a danger to self or others, is that of "gravely ill" and unable to make self-preserving decisions.

Abolitionists and anti-psychiatrists among advocates for the mentally ill traditionally seek to eliminate all involuntary admission and commitment. They, in turn, are opposed by radical groups on the political right and more moderate groups who have sought to re-open psychiatric facilities to hospitalize or rehospitalize the increasingly visible mentally ill in shelters and on the streets. They have called on government to increase its exercise of Parens Patrae [3] powers for the civil commitment of those seen as difficult to control and dangerous to others and to society.

These positions emphasize the controversy between concern for the

individual's well-being, insistance on preserving individual rights to freedom and an insistance on protecting society. It becomes evident that the best that can be achieved is a statute arrived at through compromise and with periodic shifts in policy and practice.

An emerging concept for serving mental patients in the community acknowledges the policy of non-institutionalization and proposes the social control of mentally ill through "outpatient commitment". As an involuntary procedure it appears similar to the Convalescent Status release of patients from psychiatric hospitals used for many years prior to "deinstitutionalization". Under such outpatient commitment programs, a mentally ill person deemed not to require in-hospital treatment would be committed by the court to a community-based program for case management and supervision. According to Alexander D. Brooks (1987), such commitment would provide "necessary coercion to prevent backsliding". Brooks writes:

> Thus the basic idea of out-patient commitment is that certain chronically mentally ill persons should no longer be released into the community as totally free agents (often with disastrous results) but should be committed to an agency in the community and made subject to conditions that would ensure their ability to sustain themselves and to remain in the community free of frequent decompensations and rehospitalizations.

It is not likely that there will be a large-scale reopening of psychiatric hospitals or widespread use of out-patient commitment. It is more reasonable to assume that in response to public sentiment over time, states and localities will evolve policies and procedures to liberalize rules for involuntary admission and commitment. The former standard of "dangerousness" is under review everywhere with a shift to a concept of self-neglect as a more acceptible basis

for calling the person impaired and taking him to hospitals involuntarily before he deteriorates in the streets and becomes an emergency admission, or perishes.

In the ongoing effort to assure proper treatment of seriously mentally ill among the homeless and especially those living on the streets and not in shelters, the idea of being "dangerous" to oneself or others had the most widespread acceptance for many years. While this seemed adequate to allow voluntary and involuntary hospitalization, it is losing ground to a more liberal concept of "self-neglect" as a basis for hospitalization against one's wishes. A third, more structured method for insuring that identified mentally ill persons are monitored and receive treatment after and perhaps instead of hospitalization is being promoted. This method called "outpatient commitment" is now in use in half the states although specifically not allowed in New York State. This practice allows magistrates to order psychiatric patients to enroll in a specified community-based mental health program which will provide supervision as well as case management. It is similar to a parole system in which the individual, in order to remain in the community, must abide by the conditions set by the court or face some form of incarceration. Outpatient commitment is an alternative to extended in-hospital stays.

This case study arose out of the investigator's concrn that there were increasing numbers of homeless mentally ill living in the streets, in transportation terminals and other parts of the city and that insufficient efforts were being made to get them to hospitals or other safe places. The investigator assumed at the outset that state law was restrictive and may have made it difficult to remove mentally or physically ill persons to hospitals and that too

few professionals and other personnel were engaged in such activity. He also had the idea that patients were being turned away at hospitals by resident psychiatrists who were hostile to those patients or unfamiliar with them and therefore, reluctant to hospitalize them. The investigator also questioned whether the plight of the mentally ill people in the streets was of concern to anyone in government and whether there were people who knew how to assist this especially vulnerable population.

This case study will examine the policies, standards and practices for involuntary admission in New York City. The study will explore the ethical, economic, social, legal, political and clinical issues which are imbedded in policy dilemas involving services for the homeless mentally ill. It will describe how involuntary admissions occur, where the perceived need for services to the homeless mentally ill is and it will compare practice with statutes and policy.

FOOTNOTES

1. Beginning in 1965, systematic efforts were made to implement a policy of diverting patients away from general hospital psychiatric units to community-based mental health services. Special teams were assigned to municipal hospitals to implement this policy.

2. A patient who has been in the hospital 72 hours has the right to request release. If the hospital disagrees and seeks to continue hospital observation and treatment, the matter is presented to the magistrate holding court in the hospital to decide on the patient's release or retention.

3. Parens Patria is the legal term to identify the state's power to act as the parent of citizens in matters of safety or health.

CHAPTER 2

DEFINING THE PROBLEM

There is a long history in the United States regarding involuntary commitment and treatment of the mentally ill. Dr. John Talbott, a leading historian of treatment of the mentally ill writes:

> Since the first public hospital opened in Williamsburg, Virginia in 1773, (100 years after colonization began) responsibility for treating the mentally ill has shifted from local to state to federal auspices - and has not returned to the local. In the earliest days of the colonies, the mentally ill were left to wander the countryside or, if they were too disruptive of community life, shunted to county workhouses, poor-houses and almshouses.

According to Dr. Talbott's statement, the decision to remove a person from the community and his placement in a restraining environment (the equivalent of today's commitment), was made arbitrarily by local authorities and magistrates who had no laws or standards to guide them. There was no appeal from their decision and we know that early local governments were hard pressed to pay for care of the disabled. Those "deemed to be disruptive" languished in facilities tht were not designed to be therapeutic or helpful to the detainee but rather meant to protect the community by exercising control over the deviant individual. After 1773 and up to 1840, localities developed a variety of institutions to provide more specific types of lodgings for different cohorts of deviants. With their appearance, the mentally ill began to be housed

separately from convicted criminals, but often with the destitute and disabled. It appears that all such early civil commitments were involuntary and, one wonders whether individuals voluntarily requested care in the early institutions.

Beginning in the 1840's, advocates for the mentally ill, led by the legendary Dorothea Dix, were instrumental in creating "asylums" for the mentally ill which provided them separate, better care, greater safety and "moral treatment". Ms. Dix and her co-workers are said to have succeeded in getting Congress and the Senate to pass bills authorizing the sale of public land, similar to railroad right of ways, with the proceeds to be used to build asylums in which to care for the mentally disabled. The Bill was vetoed by President Filmore, who did not want to be the President who broke with tradition and brought the Federal Government into the health care of its citizens. One hundred years passed until 1946 when President Harry Truman brought the federal government into mental health research and education when he signed legislation creating the National Institute of Mental Health. The states, however, had created the asylums and continue to the present to finance their construction and fund their operation. Management and treatment of citizens with mental illness remains a state responsibility although many localities have assumed more important roles in creating programs and services with state aid.

The story of mental health in the United States during the one hundred years from 1840 to the 1940's was the story of state and a small number of voluntary mental hospitals. Few, if any, community-based services existed before World War II (19401945) and treatment of any kind for the seriously

mentally ill meant hospitalization, often involuntarily, and almost always for extended periods. Hospitals were built in rural areas, distant from the cities where more and more people lived. They became self-contained organizations, at times profit-making communities with farming and industries staffed by patients who were kept busy and cared for. Commitment of a mentally deranged person often meant lifetime removal from the community and the process was obviously open to serious abuse, including wrongful detention. To deal with possible abuses, standards and procedures for involuntary commitment were periodically introduced into state law to protect individuals from vindictive commitments and other common abuses of psychiatric hospitlization, such as families institutionalizing a troublesome but not necessarily mentally ill family member.

Treatment for mental illness during this hundred year period was primitive and evolving in ways parallel to the developments in medicine prior to the 1940's when sulfa and other antibiotics were discovered. Psychiatric hospitals were large, accomodating several thousand each. In 1950 there were more than 500,000 patients in American psychiatric hospitals. New York State facilities then held more than 90,000 men and women. These "asylums" created in the mid to late 1800's, provided all life essentials, including patients' work and as they were often located far from cities, kept the "insane" at a safe distance. [1]

During the period 1940-1945, there were important advances in general medicine and surgery including the treatment of the mentally ill. Electric and insulin convulsive shock therapy, psychosurgery and then anti-psychotic

medications were active interventions, presenting the possibility of shortened hospital stays and the return of individuals to the community. These new treatments initially made claims to cure mental illness but were useful only to reduce and control the troubling symptoms and consequences of the illness. Such developments had great appeal to hospital critics, fiscal conservatives, civil liberties advocates and state governments. By 1950 it was being argued that if medical treatments would control patients' behavior well enough for them to live outside hospitals, state budgets would benefit and custodial hospitals which were old and outdated could be closed. The development in 1953 of "tranqualizing" medications and their widespread availability by 1955 paved the way for major changes in how and where the mentally ill would be treated and sheltered.

Beginning in the mid-1950's and continuing until the late 1970's, there was a frenzied emptying of psychiatric hospitals in America with the resulting "dumping" of several hundred thousand mentally ill persons into unprepared and unwelcoming communities. This policy of "de-institutionalization" is generally credited with adding to, if not creating, homelessness, among the large numbers of mentally ill now in the community. The supervised, state-supported Community Residence was not invented until 1979 when the United States Department of Housing and Urban Development extended financing for low income housing for the elderly to include the disabled, and specifically the chronic mentally ill. Prior to 1979 and the arrival of the supervised community residence, the available housing during the 1960's and 1970's was primarily Single Room Occupancy hotels and other inexpensive hotel buildings.

The story of the Single Room Occupancy phenomenon on Manhattan's West Side was told by Joan Shapiro, a social worker, in her book "Communities of the Alone". As those were emptied for renovation to more expensive housing, the mentally ill were herded into less good housing and finally into the shelters and streets.

Programs to provide clinical and rehabilitation services as well as housing were rapidly developed in the 1970's and 1980's. Day programs began to appear to provide patients places to go and an opportunity to socialize in protected settings. In New York, the State Office of Mental Health provides clinical services to many released patients but the bulk of such care was shifted to voluntary agencies under contract. These developments required time, space, personnel and funding which was, for the most part, tax-levy money from city and state. The cost of developing these new community-based services and residences while maintaining its own psychiatric facilities, now nearly empty, has burdened New York State. The promise of saving money by releasing patients does not seem to have been fulfilled. [2]

Since the 1970's there are many more mentally ill in the community than in psychiatric hospitals. New York State's 1992 psychiatric hospital census is less than 10,000 compared to the more than 90,000 in 1955. There is no evidence that the incidence of mental illness has decreased in this period during which people have been turned away from psychiatric hospitals. When the locus of care and treatment of the mentally ill shifted from hospitals to the community, the expected savings to be used for community-based services did not follow the patients.[3] The concept of treating mentally ill in the

community is admirable but did not occur in an organized and orderly manner. Services were not in place to receive the volume of patients leaving hospitals and it also soon became apparent that psychiatry had over-promised the benefits of anit-psychotic medications. The failed policy led to more pain and suffering than to successful outcomes. The movement away from institutional care was followed by the national and local policy of non-admission to hospitals or "non-institutionalization". The policy of non-admission and the resulting patient diversion may have pleased fiscal conservatives and some civil libertarians but has created severe hardships for those mentally ill in the community who do not, or cannot on their own find shelter and services they require.

To aleviate problems of the severly mentally ill homeless in the streets who have been sent out of hospitals or denied admission, states and localities have recently (1980's) initiated programs to identify and bring services to them. When patients voluntarily "signed up" for shelter, food, health care, clinical/psychiatric and, even in-hospital services there is no controversy about civil liberties or personal freedom. Since such services are not always voluntariy accepted, states have adopted statutes, based on their powers of Parens Patria to impose hospitalization and treatment, even against the individuals' wishes. The idea of imposing hospitalization and treatment has created controversy which effects policy and practice and ultimately the statutes themselves. A summary of New York State Statutes governing involuntary hospitalization is appended (Appendix 3).

Much has been written both by those who favor aiding people by involuntary trips to psychiatric emergency rooms and by those who oppose such

measures. This investigator as the Executive Director of a program providing clinical, residential and comprehensive rehabilitation services to seriously mentally ill has seen previously homeless individuals profit from the continuum of care, having been brought to emergency rooms, hospitalized, stabilized, treated and admitted to program. Some who are involuntarily treated are so dysfunctional that after a short stay they are drawn to return to the streets and revolving-door hospitalizations. Others are readily stabilized, make positive use of the services and make good community adjustments. For them, the issues of personal freedom and civil liberties appear to be abstractions, seldom raised in the course of their treatment.

The subject of this investigation is an exploration of the system in New York City for identifying, assessing and implementing plans to treat those mentally ill who have spilled into the streets, are homeless and not being re-admitted or admitted to state facilities. The study will describe the statutes which govern providing services to disaffiliated, isolated and treatment resistent persons and the adequacy of such statutes.

FOOTNOTES

1. One area of Long Island in New York located about 50 miles from Manhattan was the site of Pilgrim State Hospital, Central Islip, and King's Park with a combined population of perhaps 30,000 patients.

2. The final Report of the Governor's Select Commission (1984) makes the point that the state's mental health budget has grown rather than being reduced.

3. See the Select Commission Report - 1984.

CHAPTER 3

LITERATURE REVIEW

The literature on the subject of involuntary hospitalization of homeless mentally ill is recent and is divided between: (a) the work of mental health professionals urging that such admissions be determined based on clinical judgment and patient needs; and (b) the work of lawyers who argue for their client's personal freedom, defending them in courts, much the way they would represent a client in a criminal proceeding. Much of the literature began appearing in the early 1970;s, prior to which the legal profession seemed interested only in issues of competence, and conservatorship in involuntary psychiatric commitment. The presence of large numbers of chronic and homeless mentally ill on the streets and in the community after their release from hospitals during the 1950's and 1960's, seems to have stimulated lawyers' interest and involvement. Isaac and Armat (1991) refer critically to the lawyers and jurists whose work began appearing in the literature after 1970 as the "mental health bar" and label attorneys who believe in abolishing psychiatric hospitals as the "mental patient libertarian bar".

In addition to clinicians and lawyers, other writers include patient advocates, anti-psychiatry or patient rights advocates and, recently, outpatient commitment enthusiasts. Several writers are lawyers who are sensitive to

patient needs and some are psychiatrists who understand and appreciate the need for laws protecting patient rights. Most of the literature appeals for support of either the author's clinical, patients' rights or legal positions, while several writers advocate a balanced approach. There is little research in the area. Sarah Cleveland (1989) and her colleagues point out that:

> The literature's silence is surprising considering the controverseriness of this issue to both the debate over the dangerousness commitment standard and policy formation. Discussion of the social costs of the dangerousness standard, in terms of the amount of individual patient suffering produced by such an approach, have been largely theoretical, or based on clinical observation.

There is one major report from Washington State describing the effects of a policy change moving from "dangerousness" to "gravely disabled" as the basis for involuntary hospitalization. There is very little literature offering accounts of patients' experience of involuntary removal by police or others to the emergency room.

An important factor in understanding the prevalence of street-bound mentally ill persons is the role of de-institutionalization and the de-populating of psychiatric hospitals. Ann Braden Johnson (1990) has written a fascinating and complete story about this important chapter in American histoy of caring for the mentally ill. Her book, **Out Of Bedlam"--The Truth About De-Institutionalization** is her compilation of the facts and the not-so-factual information leading up to and following the era of wholesale, uncoordinated "dumping" of mentally ill into unprepared communmities. The work, begun as a doctoral project, debunks some myths about causes and effects of the phenomenon. Her book is filled with comments about what mentally ill persons

need for successful community adaptation and she is generally critical of today's care systems. The book should be required reading for those interested in American psychiatric services since 1940 and the failed policies of the 1960's and 1970's.

There is limited demographic information about those being identified as potentially needing aggressive outreach including trips to the emergency room. The present case study does not appear to duplicate other studies and will, hopefully, add to interest and research in this area.

The following is a review of literature of involuntary psychiatric hospital admission.

Neal Cohen and Luis Marcos are two psychiatrists who write about their 1982 experiences in New York City where they established Homeless Emergency Liaison Project (Project H.E.L.P.). Dr. Marcos was then Director of Psychiatry of the New York City Health and Hospital Corporation of which H.E.L.P. was a part. In 1992 he became Commissioner of the New York City Department of Mental Health, Mental Retardation and Alcoholism Services. Dr. Cohen (at Mt. Sinai Hospital since 1991), was Director of Project H.E..L.P. In their Psychiatric Quarterly article, **Law, Policy and Involuntary Emergency Room Visits,** Cohen and Marcos (1990) describe the increase in emergency room visits following Mayor Koch's 1982 and 1987 initiatives authorizing more aggressive outreach to streetbound mentally ill. They write that increased hospital visits from 1983 to 1989 are related to:

> ...the recent implementation of public policies that facilitate the hospital care of indigent mentally ill individuals. In the process, policy makers and law enforcement officials are interpreting current statutory criteria on the removal by

police officers of suspected mentally ill in a less restricting manner.

The authors point out the 1982 initiative followed the tragic death of a woman who froze to death before she could be removed involuntarily from her cardboard carton home and the public's response which resulted in a policy which fostered rescuing people. According to Cohen and Marcos, the second Mayoral initiative in 1987 was based on public demand to get more mentally ill, undomiciled persons off the streets. The authors further emphasize that policy and its implementation occur more readily than changes in statutes. Their experience has led to a recognition that with less restricting interpretation of statutes there will be increased need for additional in-and post-hospital services, which they recommend.

In a second article, **Psychiatric Care of the Homeless Mentally Ill,** Cohen and Marcos (1988) describe Project H.E.L.P.'s beginning work from 1982 to 1985. The program initially operated under mental hygiene statutes unchanged since the 1970's which required clear evidence of danger to self or others as the only basis for involuntary trips to a hospital emergency room.

In the 1982-85 period, Project H.E.L.P. contacted 1,600 persons but because they and hospital psychiatrists were interpreting statutes strictly, transported only 41. The October, 1982 "cold weather emergency" policy of taking people to shelters when the temperature dropped to 5°c relaxed such interpretation, made it possible to remove many more at risk mentally ill persons to hospitals and shelters. This activity of removing more people to hospitals and shelters received public support for the policy changes which modified the "dangerousness" standard to include self-neglect as an indicator of psychiatric impairment and need for assistance.

Dr. Francine Cournos contributes a brief article discussing the public's interest and involvement in the dilemas of public policy. Dr. Cournos is a psychiatrist who served as independent consultant to the court during hearings on involuntary treatment in the 1987 "Billie Boggs" case. Billie Boggs was the first patient taken involuntarily to Bellevue Hospital under Mayor Koch's 1987 initiative. In her Hospital and Community Psychiatric article, **Involuntary Medication in the Case of Joyce Brown,** Dr. Cournos (1989) writes:

> Rarely has a case of involuntary psychiatric intervention inspired such wide public attention, suggesting that the public has become increasingly interested in whether forced psychiatric care is the proper response to certain kinds of homelessness.

Dr. Cournos does not discuss her own recommendations to the Court on involuntary treatment. She does, highlight ethical and policy dilemas in the case such as, "Should we praise the efforts of the city to remove her from her debased circumstances or support her struggle to assert her individual rights in the face of overwhelming state law?" The court ultimately upheld the patient's right to refuse treatment. The Court decision places increased burdens on case managers, psychiatrists and other professionals to work with oppositional and treatment resistive patients to gain cooperation on medication regimens. The decision also means that courts will be asked to rule more often in individual cases.

Dr. Paul S. Appelbaum (1984), a prominent psychiatrist who is knowledgeable and writes about mental hygiene law provides very useful, well written background and insight into the development and evolution of statutes, policies and practice. His chapter in the book **The Chronic Mental Patient Five**

Years Later is informative and should be required reading for those interested in the subject of involuntary admission and commitment.

Appelbaum in this chapter neatly and succinctly tells the story of the shift away from clinical judgment as the determinant for involuntary commitment and the role of judicial proceedings. He points to the far-reaching impact of the 1972 Lessard vs. Schmidt case leading to the courts' acceptance of the concept of "dangerousness" as the standard for hospital treatment against one's wishes. Civil commitment has become more like criminal proceedings, involving rules of evidence and Court decisions which are similar to convicting a criminal and depriving the guilty person of freedom. He states that "by 1982, all but two states had statutorally replaced treatment oriented commitment criteria with "dangerousness" criteria and even in the two exceptional states, actual practice corresponded to a dangerousness standard".

Applebaum leans toward clinical judgment as the preferred basis for admission and goes on to say that:

> The new statutes have made little difference to psychiatrists and judges who continue to commit those who appear to be in need of care...but many clinicians clearly believe that this "criminalization" of the commitment process has deprived a large number of patients of care they desperately need and are, by virtue of their illness, not capable of seeking for themselves.

The "rights" model, which according to Applebaum, encourages an adversarial relationship between treaters and patients, impedes the provision of care and creates some very unexpected side-effects such as deprivation of treatment for those it was intended to benefit.

The recently published book, **Madness in the Streets** by Rael Isaac

and Virginia Armat (1991) has attracted considerable attention, possibly due to the authors' strong views which are in opposition to the equally extreme stance of libertarians and abolishionist lawyers. Isaac and Armat support liberalizing statutes and policies to extend outreach services to more street-bound mentally ill. They see lawyers who encourage patients to reject hospital care and treatment as responsible for the pain and suffering of many mentally ill in the streets and make a strong connection between these lawyers and the anti-psychiatrists of the 1960's. Lawyers are seen as misinterpreting hospital treatment as only incarceration and in a very caustic passage they write:

> They (lawyers) had no knowledge of, or interest in mental illness as such, rather, they saw themselves on the frontier of the civil rights movement...The goal was sweeping...elimination of involuntary civil commitment. And since they saw involuntary commitment as the keystone of the state hospital system, they believed its end would spell the demise of the state mental hospitals.

The authors cite such lawyers as Ennis as serious culprits for having influenced lawmakers as well as policymakers to deny hospitalization and treatment to those who need it the most. They write, "Prior to the emergence of the mental health bar, the fundamental assumptions of the system were not challenged; mental illness existed and severely ill patients had to be treated, involuntarily if necessary". Isaac and Armat have produced an important addition to the literature for laymen of the policies and statutes affecting chronic and homeless mentally ill but have done so in an unbalanced way, overlooking an awareness that individual civil rights had often been disregarded. The authors also seem to have forgotten that de-institutionalization

was well under way by 1970, the date they give as the emergence of the "mental health bar". They also miss the opportunity to make the case that a more serious impact of the libertarian lawyers has been their influence in the new admission policy of "non-institutionalization" which has overburdened community-based programs and has left many homeless mentally ill with nowhere to go.

In his critical review of the book John Talbott points out that the reasons and blame for large numbers of mentally ill wandering the streets is complex and not attributable to any person or group. He provides the great one-liner about the failed policy of sending back-ward people out into the community, "As it turned out, of course, psychosis is not cured by a change of address".

A more balanced history of care of the mentally ill is provided by Mary L. Durham (1989) in her article, **The Impact of De-Institutionalization On the Current Treatment of the Mentally Ill**. Ms. Durham uses history to introduce the dilemas which face policy makers, politicians, social reformers and mental health professionals responsible for deciding which mentally ill will be treated and how that treatment will be given. Beginning with management of the mentally ill during colonial times, she traces the cycles of care which have evolved to the present. Her writing style and the weight of her historical knowledge are well suited to her conclusion that these cycles occur because of society's failed attempts to adequately identify and treat the mentally ill. She outlines the shifts in the locus of care from farm cellars to almshouses, to asylums and hospitals and back to the community and her emphasis on the cyclical nature of mental health policy reform is helpful in gaining perspective on policy making.

A conservative legal position is presented by Leslie J. Scallet (1986) who does not enter the controversy of how individuals get hospitalized but presents a very useful account of the protectors of a mentally ill person's rights once hospitalized. In this 1986 article, **Protection and Advocacy Systems for People Receiving Mental Health Services,** Scallet reports on the elaborate range of protections mandated by federal statutes and corresponding state programs which have been developing since the early 1970's. Scallet sees lawyers and legislators as sympathetic to the plight of all disabled, including the mentally ill, enacting laws and regulations for their protection. Such measures include Quality Assurance and Utilization Review Procedures. Scallet does not, however, include research findings to demonstrate that new costly programs insuring protection of individual rights are producing positive results or whether they primarily meet legal requirements.

This literature review includes review of a study which explored ways in which emergency room physicians did or did not follow involuntary admission statutes in making decisions about admitting patients. In the 1985 study, Sarah Cleveland, Paul Appelbaum and colleagues (1989), reviewed 390 cases seen in a general hospital emergency room to determine the number of those admitted and specifically to learn if and how involuntary admissions occurred when individuals failed to meet statutory standards of "dangerousness". The brief report titled, **Do Dangerousness Oriented Commitment Laws Restrict Hospitalization of Patients Who Need Treatment: A Test**, generalizes from the findings that the dangerousness statute is not always strictly enforced and that patients are more often hospitalized because their presenting condition

requires treatment. These findings and their interpretation have been reported by others who describe this as the "common sense" basis for hospitalization.

There is general agreement among all writers that the increase in the numbers of mentally ill homeless influences public sentiment and policy regarding hospitalization. Robert W. Collin, a social worker who is also a lawyer writes that, "Homelessness represents the complete abandonment of individuals in life threatening situations. Provision of temporary shelter alone neither prevents or solves the problem". In his article, **Homelessness: The Policy and the Law**, Collins (1984) briefly reviews policies of the past one hundred years for the treatment of the mentally ill, and directs severe criticism at the failed policies of de-institutionalization and non-hospitalization. He recognizes that the root causes of homelessness are many and complex but concludes that, "De-institutionalization failed because of problems in human service planning and a lack of public financial commitment to the formation of community-based facilities, and is the major cause of homelessness".

A 1982 outreach program to identify and assist homeless mentally ill in New York City is described by Jane F. Putman, Neal L. Cohen and Ann M. Sullivan (1986). As the original staff of Project H.E.L.P. (Homeless Emergency Liaison Project) their article, **Innovation Outreach Services for the Homeless Mentally Ill**, is a report of their activity during the project's first two years. They emphasize the clinical, health and basic social services they provided rather than involuntary hospitalizing they achieved in the early days of the project. The writers stress their activity as part of the solution to problems and do not discuss the policy isues such as Mayor Koch's 1982 cold

weather emergency initiatives, which created Project H.E.L.P. They also avoid discussing changes in statutes which allowed the Commisisoner of Mental Health to authorize Project H.E.L.P. psychiatrists to order police to transport persons to hospitals.

The Project and its activity were important to the many individuals they served, including the small number in the early years who were transported to hospitals. On the basis of their two year experience, the authors conclude there are serious gaps in services and that those homeless mentally ill who are "rescued" by the extended efforts of dedicated outreach staff then need ongoing programs and such resources as housing. Their conclusion and recommendation is echoed by the Susan Barrow (1989) study of five outreach programs. Her work emphasized the importance of creating clinical treatment services together with housing to be available over the extended periods necessary for stabilization and rehabilitation.

In contrast to Mayor Koch's proud position in creating Project H.E.L.P. and special Bellevue units for the homeless mentally ill, Rudolph Guiliani, a mayoral candidate in 1989 and 1993 has publicly announced that he will close the New York City Department of Mental Health, eliminate the Commissioner's position and limit shelter stays if elected. This position by the candidate of a major political party indicates that there are still opposing views on whether to help the mentally ill among the homeless.

Two reports about Involuntary Outpatient Commitment (IOC) are included here to illustrate recent concepts for the control of the mentally ill who are increasingly seen in the community. Ingo Keilitz and Terry Hall

(1985) define Involuntary Outpatient Commitment as: "The legal and psychological process whereby an **allegedly** mentally disordered and dangerous person is forced to undergo mental health treatment or care in an outpatient setting".[1] The authors do not seem to question why an allegedly mentally disordered and dangerous person is in the community in the first place or how such an individual can be "forced" to utilize treatment without being able to threaten the individual with re-hospitalization or some comparable incarceration. The authors, however, feel there is considerable interest by state governments in compulsory outpatient commitment, asserting that one-half of the states have enacted authorizing statutes and that the remaining half, with the exception of New York are "permissive" of such involuntary treatment. The authors, who possibly are lawyers, reveal their psychological naivite and serious biases about the mentally ill. In addition to referring to the patient as "allegedly mentally disordered", they talk about his being "adjudicated" and committed by a civil court to IOC. The individual so committed can achieve "early release from IOC by keeping appointments and complying with a treatment plan or can have IOC status **revoked for non-compliance**", which would presumably result in some form of loss of freedom.

Keilitz and Hall appear unaware of the hisotry of community-based mental health treatment prior to 1970. In New York, for example, persons leaving state psychiatric facilities were placed on "Convalescent Status" from which they were discharged only after demonstrating an ability to successfully manage their affairs, given the consequencs of their illness. This convalescent

status was very much like being on parole, with the aftercare therapist much like a parole officer who could order the patient back to the hospital or recommend "discharge". The authors unsuccessfully attempt to blend legal and psychosocial processes in order to validate IOC as a viable method for post hospital treatment of mentally ill persons. Such a blend is difficult, if at all possible, since psychosocial rehabilitation, which is important to sustained community living, is a voluntary activity requiring choice and personal, not court, commitment.

The second article on IOC is by Alexander D. Brooks, a law professor at Rutgers University. Professor Brooks has written extensively about legal issues in treatment of the mentally ill such as patient's rights, right to treatment, right to refuse treatment, and involuntary commitment. On these issues, Brooks appears to advocate for policies which insure individuals access to appropriate treatment. In his article, **Outpatient Commitment for the Chronically Mentally Ill: Law and Policy**, Brooks (1987) expresses concern about the potentially dangerous behavior of the mentally ill person in the community. In order to deal with such dangers, he puts aside clinical considerations of treatment goals, the availability of treatment facilities or resources and supports a proposal which emphasizes social control and neighborhood safety. Brooks cites medication "non-compliance" as an "offense" and repeated noncompliance is equated with criminal acts. Professor Brook's recommendations does not take into account the considerable agreement that voluntary post-hospital enrollment in case management and rehabilitation programs providing medication, structured time or work and stress reduction are the important

factors in avoiding relapse and enhancing community living. These require volunteerism for maximum success and are less likely to work in involuntary programs.

The final article reviewed is by John Parry (1986), a lawyer who tries to present fairly both sides in efforts to achieve balance in treatment of the mentally ill. In his article, **Civil Commitment: Three Proposals for Change,** Parry isolates and presents clearly the major elements in the disputes between clinicians and lawyers, between institutional and community-based treatment. He also recognizes the economic, social and political issues of the 1980's which led to the breakdown of coordinated efforts "to resolve conflicts and produce meaningful tools to relieve the tragic circumstances surrounding mental illness". Parry points out how "traditional prejudice and fear (is) unleashed against mentally disabled persons in a time of social and economic instability". He reminds us of the importance of understanding the socio-political climate in which we work. He repeatedly emphasizes achieving balance between advocating for due process while insuring that mentally ill persons receive the treatment and services they need to be stabilized and get better. His is a valuable contribution to the literature of involuntary hospitalization and treatment.

FOOTNOTES

1. New York State Mental Hygiene Law specifically prohibits such programs.

CHAPTER 4

RESEARCH METHODOLOGY

HOW THE STUDY WAS CONDUCTED

This study is intended to add to social workers' knowledge about the involuntary hospitalization and treatment of homeless and mentally ill appearing persons living on the street and three of the issues imbedded in such activity. The three issues investigated in this study are: (a) **WHO** ends up getting an involuntary trip to the hospital; (b) **WHY** the transported individuals are deemed to require such treatment; and **c) HOW** the process is carried out. In New York, such hospitalization is authorized under Section 9.37 of the State's Mental Hygiene Law. The study also addresses the Law's adequacy to assure services to all who need its protection and regulation.

The case study research method has been selected for this study as a good way to examine its **Who, Why** and **How** issues. Both Robert K. Yin (1989) and Michael Q. Patton (1990), who are leading writers on qualitative research, recommend the case study for such inquires. Yin points out that "How" and "Why" questions require explanatory responses which are likely to lead to the use of case studies or histories as preferred research strategies. According to both Yin and Patton, a more experimental strategy would be inappropriate for this study since the experimental method usually includes utilizing a control group as a variable from whom treatment would be withheld. For example,

in the experimental method, an individual being street-assessed by a Project H.E.L.P. team and found in need of in-hospital service, would be denied the service if he is part of the experimental control group. The effect of witholding such service would predictably lead to the individual's deterioration which would be unethical and unacceptable research.

A second type of research, such as a survey, deemed inappropriate for the study would be one only yielding data about the number of individuals involuntarily treated or the frequency with which selected persons are "designated". Such studies would generally not reveal the details of the underlying process, its nuances or how the process is applied.

Yin points out that the case study:

> ...is an empirical inquiry that investigates a contemporary phenomen within its real-life context when the boundaries between phenomenon are not clearly evident and in which multiple sources or evidence are used.

The contemporary phenomena being explored in this study are how homeless and mentally ill-appearing adults living in the streets are removed to hospitals involuntarily and how the statutes, public policies, practice skills and biases of outreach and hospital workers effect the use of such treatment.

Data sources for the study include: documentation, records, interviews, direct and participant observations. The data collection began in the fall of 1991 and was completed in the fall of 1992, a period of approximately 12 months. The direct and participant observation data was gathered during several visits to Project H.E.L.P. headquarters, three trips with Project H.E.L.P. teams, one visit to Project Reach-Out and one session of the State Supreme Court in Bellevue Hospital. It also included interviews with Executive Directors of

Project H.E.L.P. and Project Reach-Out, three Project H.E.L.P. psychiatrists, Project H.E.L.P. chief social worker and Project H.E.L.P. nurse and van drivers. Patton describes qualitative research and case study as important in evaluating human efforts. He outlines the qualitative method as:

> ...consisting of three kinds of data collection: (1) in-depth, open-ended interviews; (2) direct observation; and (3) written documents. The data from interviews consist of direct quotations from people about their experiences, opinions, feelings, and knowledge. The data from observations consist of detailed descriptions of people's activities, behaviors, actions and the full range of interpersonal interactions and organizational processes that are part of observable human experience, document analysis in qualitative inquiry yields excerpts, quotations, or entire passages from organizational, clinical, or program records, memoranda and correspondence, official publications and reports...
>
> The data for qualitative analysis typically come from field work. During field work the researcher spends time in the setting under study--a program, an organization, a community, or wherever situations of importance to a study can be observed and people interviewed. The researcher makes firsthand observations of activity and inter-actions, sometimes engaging personally in their activity as a "participant observer" ...Extensive field notes are collected through these observations, interviews and document reviews. The voluminous raw data in these field notes are organized into readable narrative description with major themes, categories, and illustrative case examples extracted through contact analysis. The findings, understandings, and insights that emerge from fieldwork and subsequent analysis are the fruit of qualitative inquiry.

The data also include information obtained from contemporary newspaper articles, agency literature and published reports, case records and agency service statistics.

According to the descriptions of qualitative case study strategies, this investigation can be characterized as descriptive and explanatory. As a descriptive and explanatory study "it examines contemporary events in which

relevent behaviors cannot be manipulated by the investigator" (Yin). The method is similar to the describing and explaining of a historical investigation but has the advantage of including direct observation and systematic interviewing. The study's data was collected during 1991 and 1992, ten years after Mayor Koch's first initiative and five years after his second major revision of policies and procedures effecting street-dwelling mentally ill. During the study period there were no important direct challenges to Section 9.37[1] but there was one case of a well-known homeless man on West 96th street who was reported to suffer substance-induced psychosis characterized by assaultive, dangerous behavior. The case of Larry Hogue as reported in the New York Times illustrated a problem with other sections of the State Mental Hygiene Law regarding involuntary hospitalization and treatment of substance abusers and led to public hearings in 1993 on revising the Law. The case also highlighted the conflict between New York City and New York State regarding responsibility for his long-term treatment. Throughout the weeks that the city, state and courts dealt with Mr. Hogue, police and others responsible for implementing Section 9.37 were not criticized. The media's description of public criticism was directed at the state for refusing to keep the individual out of the community.

Data collection for the study as indicated, included visits to outreach organizations, interviews with Executives, reading case records, and fieldwork. The interviews with Executives were each approximately one hour. Executives were asked to provide historical and descriptive information about their

programs, their experience with implementing Section 9.37 "designations"[2] and their opinions regarding its usefulness as a treatment strategy. Executives were also encouraged to discuss mental health services generally and their feelings about available programs. The interviews were somewhat open-ended which, according to Yin, "permits the investigator to ask key respondants for the facts of a matter as well as the respondant's opinions about events...the investigator may even ask the respondant to propose their own insights into occurances and may use such propositions as the basis for further inquiry."

The data obtained in interviews with key informants was recorded, for the most part, following each meeting rather than during interviews. With the exception of a few notes made during the meetings, this method required retrieving the major comments and thoughts of the respondants as soon after the interviews as possible. While most data was retrieved in this way, it is possible that some information was not.

Conversations with Project H.E.L.P. teams occurred primarily during trips as well as in separately scheduled interviews. These somewhat informal talks permitted staff to express their opinions, concerns, intests, and experiences as well as discuss the practice skills required by the work. The H.E.L.P. senior nurse, Helen G., was a key informant who was a most important person in this study. Her historical and current status are central to this investigation. She was able to provide historical information, tracing changes in policy and procedures for making street assessments. She also described changes over time involving police and the role of various Bellevue Hospital[3] units.

A selected sample of case records from among Project H.E.L.P.'s more

than two thousand cases were made available to the investigator. No claim is made in this study for the representativeness of the selected cases that were offered to the investigator to illustrate cases of substance abuse, self-neglect, anti-social behavior, the "revolving-door syndrome", lack of community-based resources and positive case management.

Service statistics of Project H.E.L.P. and Project Reach-Out were not made readily available and early requests for this information were not actively followed up by the investigator. Units of service when given, were approximate in both agencies which limits this study's utility as a resource for such information. It is the investigator's opinion that both outreach organizations have maintained information about their field activity and that a more sustained request for the data would have produced it. Any follow-up studies should have the data to provide a more complete view of outreach work in New York City.

Statutes were readily obtained from the Legal Departments of State Mental Health Departments of Illinois, Pennsylvania and New York. All three states, with some variations, provide for the involuntary admission of mentally ill persons on petition of physicians and hospital emergency room psychiatrists.

The Pennsylvania Statute (Appendix 1) states:

> Whenever a person is severely mentally disabled and in need of immediate treatment, he may be made subject to involuntary emergency examination and treatment. A person is severely mentally disabled when, as a result of mental illness, his capacity to exercise self control, judgment and discretion in the conduct of his affairs and social relations or to care for his own personal needs is so lessened that he poses a clear and present danger of harm to others or to himself.

The succeeding Statute sections describe "clear and present danger", involuntary examination and treatment ordered by a physician, 20 day extension of involuntary treatment certified by a Judge, and Court-ordered 90 day involuntary treatment.

The Illinois Statute (Appendix 2) states:

> When a person is asserted to be subject to involuntary admission and in such condition that immediate hospitalization is necessary for the protection of such person or others from physical harm, any person 18 years of age or older may present a petition to the facility director of a mental health facility in the county where the respondent resides or is present. The petition may be prepared by the facility director or the facility. Section 3-601.

The Statute further states that:

> The petition shall be accompanied by a certificate executed by a physician, qualified examiner, or clinical psychologist which states that the respondent is subject to involuntary admission and requires immediate hospitalization. The certificate shall indicate that the physician, qualified examiner or clinical psychologist personally examined the respondent not more than 72 hours prior to admission.

The New York Statutes (Appendix 3) state:

> (a) The director of a hospital, upon application by a director of community services or an examining physician duly designated by him, may receive and care for in such hospital as a patient any person who, in the opinion of the director of community services or his designee, has a mental illness for which immediate inpatient care and treatment in a hospital is appropriate and which is likely to result in serious harm to himself or others; "likelihood of serious harm" shall mean:
>
> 1. substantial risk of physical harm to himself as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that he is dangerous to himself, or

2. a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear or serious physical harm.

The need for immediate hospitalization shall be confirmed by a staff physician of the hospital prior to admission. Within seventy-two hours, excluding Sunday and holidays, after such admission, if such patient is to be retained for care and treatment beyond such time and he does not agree to remain in such hospital as a voluntary patient, the certificate of another examining physician who is a member of the psychiatric staff of the hospital that the patient is in need of involuntary care and treatment shall be filed with the hospital. From the time of his admission under this section the retention of such patient for care and treatment shall be subject to the provisions for notice, hearing, review, and judicial approval of continued retention or transfer and continued retention provided by this article for the admission and retention of involuntary patients, provided that, for the purposes of such provisions, the date of admission of the patient shall be deemed to be the date when the patient was first received in the hospital under this section.

(b) The application for admission of a patient pursuant to this section shall be based upon a personal examination by a director of community services or his designee. It shall be in writing and shall be filed with the director of such hospital at the time of the patient's reception, together with a statement in a form presecribed by the commissioner giving such information as he may deem appropriate.

While all three states authorize the involuntary hospitalization of certain mentally ill persons, there are significant differences among the states regarding who may initiate the hospitalization process, what is the role of the physician, and how do the courts support or oppose clinical judgment.

In addition to the three major research questions of **"Who, How and Why"**, the study was also intended to yield data within its limits of investigation about the following.

1. How are members of minority groups represented? Do minorities get hospitalized more frequently than others? Are minorities disproportionately represented in the "revolving door" population? Are minorities repeatedly hospitalized?

2. Who handles the really difficult cases requiring involuntary hospitalization? Are outreach workers, who are clinicians, expected to protect individuals or the community? How do police interact with clinicians in treatment of someone against his wishes?

3. Would hospitalzing street-dwelling mentally ill persons in acute-care settings reduce the number of mentally ill people on the streets?

As indicated earlier, the travels with outreach teams was the major source of the study's data and answers to questions.

According to Patton:

> Fieldwork is the central activity of qualitative inquiry. Going into the field means having direct and personal contact with people under study in their own environments.
>
> Qualitative approaches emphasize the importance of getting close to the people and situations being studied in order to personally understand the realities and minutiae of daily life, for example in a program. The evaluator gets close to the people under study through physical proximity for a period of time as well as through development of closeness in the social sense of shared experience and confidentiality.

The study's fieldwork and research data collection required a high degree of cooperation from Project H.E.L.P. and Project Reach-Out. Permission to accompany teams and to observe their work without restriction was essential to the study. Directors of both projects were generous in talking about their organizations, their mission, structure and proceedures. They were candid in discussing limitations and problems within the mental health system and in offering recommendations regarding improvements in policy, statutes and service planning.

Cooperation and access were perhaps more readily obtained in this

study because the investigator, a social worker, was known to the directors and staffs of Project Reach-Out and Project H.E.L.P. as a colleague and fellow service provider who would understand and be sympathetic to their work.[4] While such familiarity might color their responses it did also provide quicker access to participant observer possibilities and data. This cooperation and access made it possible to illustrate individual variations among teams in street assessment and involuntary hospitalization, which was important to the project.

The direct observations and participant-observations occurred during two daytime trips and one evening trip with Project H.E.L.P. teams which were arranged several weeks apart. The scheduling was done to fit the investigator's availability and to avoid over-burdening H.E.L.P. staff. The trips were followed by observing one day in the State Supreme Court which is in session one day a week at Bellevue Hospital. The Court observation was arranged by the Legal Department of the New York City Health and Hospital Corporation, parent organization of Project H.E.L.P.

Each of the three trips was with a different H.E.L.P. team. The purpose of this was to attempt representativeness in the study's participant observer activity. The activity, locale and purpose was different for each trip, illustrating a range of situations for the teams to handle. One of the three trips involved an involuntary hospitalization which called for police and Emergency Medical Service participation. Psychiatric assessments and decisions about hospitalization were involved in all of the trips. In addition to direct observation of the teams at work and the individuals with whom they were engaged, the investigator also became involved in participant observation.

Yin describes this opportunity as:

> The most distinctive opportunity is related to the investigator's ability to gain access to events or groups that are otherwise inaccessible to scientific investigation...For some topics there may be no other way of collecting evidence than through participant observation...It provides the ability to perceive reality from the viewpoint of someone "inside" the case study rather than external to it.

The use of the participant-observation research tool also confronts the investigator with negative effects. For example, in the case of the young man being assessed at the shelter, it is conceivable that the investigator's presence influenced the conduct of the assessment. It is possible that the psychiatrist felt observed and conducted her examination accordingly and that the young man being examined also responded in ways to impress the observer.

Yin also points out that participant-observation can lead to such research problems as: (1) reduced ability to remaining an external observer and become an advocate; (2) supporting the subject being studied; and (3) becoming distracted by the participant activity and losing the investigator role.

The three hazards to the participant-observer raised by Yin could easily have occurred during the activity of getting David hospitalized. He is a frail and medically as well as mentally ill man and one can readily empathize with his wish to remain independant. This observer recalls feeling relief when Emergency Medical Service personnel "finally" took him to the St. Luke's Hospital Emergency Room and admiration for his "spirit" when David walked unaided into the hospital.

Although not aware of being distracted by the participant activity, the investigator recognized that this may have occurred somewhat during the

"designation", with some loss of the investigator role.

The possible pitfalls of the case study method such as the reactivity of those being observed and of the effect of participation on the investigator raise questions about the validity and reliability of the study and its report.

In discussing **reliability**, Yin (pp. 45) states:

> Most people are probably already familiar with this final test, the objective is to be sure that, if a later investigator followed exactly the same procedures as described by an earlier investigator and conducted the same case study all over again, the later investigator should arrive at the same findings and conclusions (note the emphasis is on doing the same case over again, not on "replicating" the results of one case by doing another case study). The goal of reliability is to minimize the errors and biases in the study.

In assessing the reliability of this case study it is recognized that it will be difficult, if at all possible, for a future investigator to repeat the same observation made by this investigator during travels with Project H.E.L.P. teams. For example, it was a sunny Spring day when the team approached David Z. and when Dr. G. decided to hospitalize him involuntarily for medical treatment. It is possible that the process would have gone very differently had it been a cold winter day or a rainy day in any other season. On the sunny Spring day it mattered little that the team, the police and the Emergency Medical Service personnel were on the street a long time and were relaxed about getting David to the hospital. Those involved might very well have moved more quickly in rain or cold and David might have reacted differently on almost any day. In spite of all the conditions that could be different, effecting the activity, and make each action unique, certain parts of the activity and observation would be the same in each observation.

The data of the study do permit limited generalizability and are valid. Any investigator observing Project H.E.L.P. teams at work would, for example, see the extent to which practice skills and biases influence street assessments and involuntary hospital trips. Observers would similarly see that New York City's police have a major role to play in managing aggressive, assaultive mentally ill persons on their own as well as in assisting outreach teams with less difficult cases. In both instances, the investigator would observe that police lack training for their demanding work with such individuals.

The study's data has been analyzed in subjective and judgemental ways as well as with some objectivity. That is to say, the investigator has viewed the data against a backdrop of personal experience with chronic and homeless mentally ill persons and has made judgments about what was observed. It may be that the nature of the study makes subjective judgements inevitable, limiting its objectivity but not its validity and reliability.

FOOTNOTES

1. Section 9.37 of New York State Mental Hygiene Law which authorizes Commissioners of Community Mental Health or their designees to order involuntary hospitalization of those who are assessed as receiving immediate hospitalization.

2. The individual being taken involuntarily to a hospital is identified as designated by the psychiatrist for such a trip.

3. The special Project H.E.L.P. unit, Eighteen West, at Bellevue Hospital is described in a New York Times article on March 21, 1993 which is appended.

4. The investigator is Executive Director of The Bridge, Inc., a mental health and rehabilitation agency serving chronic and homeless mentally ill. The agency provides community residence as well as clinical and other comprehensive services. Project H.E.L.P. and Reach-Out refer patients to The Bridge.

CHAPTER 5

PUBLIC POLICY DEVELOPMENT

ROLE OF STATUTES, LEGISLATORS, ADVOCATES AND PUBLIC OFFICIALS

The involuntary hospitalization or civil commitment of mentally ill persons is regulated by state rather than federal or local law and varies from state to state. The laws of New York, Pennsylvania and Illinois, illustrate a range in the use of states' powers to assure involuntary clinical services to mentally disabled citizens while safeguarding society against acts of the mentally ill.

The statutes define who **can** have the authority to designate an individual for involuntary transportation to a hospital emergency room and who is authorized to order police or other peace officers to provide such transportation. They do not, however, identify who **must** remove mentally ill, self-endangering street-dwelling individuals to medical facilities for evaluation and treatment. The difference between who **can** and who **must** assist confused, disabled, inappropriate individuals to safety and care creates a large gap through which concievably many fall who could profit from early psychiatric attention and rehabilitation. This difference was noticeable to the investigator during a visit to Geneva, Switzerland in 1986 where he saw no obviously mentally ill people on the streets or in public places. In a meeting with a group of Swiss psychiatrists it was explained that in Geneva police are **required** to take such

persons to local precincts where they are showered, fed, given fresh clothing and escorted to rooming houses or the equivalent of single room occupancy buildings where they are housed for a time at city government expense. The local psychiatric hospital has an extensive community-based program of continuing day treatment, clinical and vocational services, and people picked up by police are referred for in-patient or community-based care. The professional group participating in the meeting seemed clear that being brought indoors came before consideration of loss of personal freedom. They felt it was important and proper to protect the individual from the elements, from hunger, from disease and life threatening situations. It seemed that in Geneva, police are required to serve a social as well as criminal justice function by removing mentally ill persons from the streets and providing shelter and care.

Public Policy

Pennsylvania's statutes are more detailed and elaborated than those of Illinois and New York. They contain considerable legal language which appears to criminalize the process of involuntary hospitalization. Under Pennsylvania laws the person for whom involuntary admission is being sought is "accused" of having mental illness and the condition must be proved before the person can be hospitalized. In contrast, the relaxed-seeming Illinois statute makes mental illness a condition in another person which anyone could identify and authorizes a variety of individuals to seek the person's hospitalization. The New York statutes rely on the "medical" model, placing important authority with the examining physician for the evaluation and hospitalization of a mentally

ill person. The Parens Patriae powers of all states to involuntarily hospitalize individuals underwent extensive review and revision in the 1960's and 1970's providing greater individual protection against unwarrented detention. Under pressure from civil libertarians in most states, police and Parens Patriae powers were restricted by legislatures which voted mental hygiene laws establishing standards for involuntary treatment. One state, Washington, adopted restrictive statutes in 1973 and six years later, in 1979, changed course, adopting a more liberal policy and law which moved away from "dangerousness" as the basis for hospitalization.

> Prior to 1973, Washington's Civil Commitment Law was fairly typical in its criteria for determining who could be subject to involuntary hospitalization. Under the 1959 Law, a peace officer or chief medical officer of a licensed hospital could, in an emergency, apprehend or detain for 12 hours a person believed to be mentally ill and dangerous to himself, others or property. Within 12 hours of detention, examination by a licensed physician was required. If the examining physician found him to be mentally ill, the individual could be confined and treated in a hospital for up to 72 hours.

In 1973 Washington revised its statutes using the "legal" model, including concepts of dangerousness" and "grave disability" as bases for involuntary hospitalization. The changes obliged the State to demonstrate that an individual required hospitalization "as a result of mental disorder that presents a likelihood of serious harm to others or themselves or were gravely disabled". The terms "likelihood of serious harm", "danger" to others and "gravely disabled" were in turn defined in the statute which also provided that, "The State was not to commit individuals involuntarily if they could live independently or with the assistance of family or friends". The 1973 Washington statute revisions reflected a nationwide trend toward narrowing commitment

criteria, signaling a victory for civil libertarians over clinicians and families who were less effective in keeping statutes more permissive for easier hospitalization. In 1979, following more successful political action by those favoring less restrictiveness in involuntary commitment, Washington again revised its laws. Its 1979 Involuntary Treatment Act created a "wider net" for involuntary commitment by expanding the definition of "gravely disabled" and the state's Parens Patriae power.

Washington's statute changes provided unique research opportunities. Mary L. Durham and John Q. LeFond (1985), conducted an extensive review of hospitalizations before and after the statute change. They report serious disruption of the State's mental health and psychiatric hospital systems following the 1979 changes. A large increase in involuntary commitments, though expected, was not budgeted by the state with the result that existing facilities quickly became overcrowded.

> While the revised statute made it easier to commit more people to state mental facilities, expansion of mental health resources did not match the expansion of authority to detain patients involuntarily. Staffing and bed space did not expand apace to accommodate the growing number of patients in the system.

The heavy influx of new and old involuntarily commited patients rapidly excluded those seeking voluntary hospital admission which hospitals attempted to remedy by a formula capping admissions. The overuse of nonexpanded facilities, according to Durham and LeFond, meant that "Washington's public mental health system provided inadequate treatment for most patients and provided virtually no treatment for many patients who voluntarily sought institutional care for mental illness".

While the Washington state study has not been repeated elsewhere, several smaller studies report that there is a surge in hospital admissions immediately following new policies or statutes which loosen restrictions, after which the number of admissions returns to previous levels. This has been interpreted as a function of the admission of the backlog of patients not admitable earlier and a leveling off after they are accomodated.

Several states have enacted laws based on recommendations of the American Psychiatric Association which expand the power of the state to commit those persons not commitable under their previous statutes. Experience in these states has not yet been reported but the Washington experience should be a valuable guide to any state considering revising statutes to expand the reach of its involuntary civil commitment system. Durham and LeFond conclude that:

> The fierce debate over involuntary civil commitment will undoubtedly continue. It is an area of the law especially influenced by the ebb and flow of public sentiment about the appropriate role of the state in pursuing the collectivist goal of preserving community security and the humanitarian goal of providing care for individuals who may need psychiatric treatment.

In 1991, in New York State, one body of the Legislature, the Senate passed a Bill expanding the definition of necessity for involuntary care for mental illness to state:

> A person who has a mental illness and because of their mental illness is not capable of surviving in freedom or is helpless to avoid the hazards of freedom through his/her own efforts or with help of willing family or friends, even without recent overt conduct evidencing substantial and present risk of serious physical harm.

The legislation is opposed by, among others, the Executive Director

of the Westchester Mental Health Association, Michael Friedman and by Dr. Sam Tsemberis of Project H.E.L.P. As experienced professionals working with homeless mentally ill street-dwellers in large urban and suburban centers, they feel existing statutes are adequate to insure that all those who need involuntary trips to hospitals are receiving such care, especially when the statutes are interpreted liberally. They point to the Washington experience as empirical evidence that broadening statutory criteria leading to increased hospitalizations could seriously disrupt the state's mental health systems. This is especially true in New York where the Office of Mental Health policy, under its current leadership, calls for the reduction of its inpatient capacity at state psychiatric centers by 150 beds a month. New York State's psychiatric hospital census is at an alltime low and will be reduced to even lower levels in coming years, making an increase in involuntary commitments to state facilities a serious problem for a system which is shrinking and not likely to readily increase its capacity.

New York State developed large asylums for the mentally ill during the 19th century when it, by statute, relieved local government of the expense of caring for their psychiatric patients. These laws created a historical, legal basis for long-term care of psychiatric patients which lasted until the 1960's when state policy has steadily shifted responsibilities onto local and federal government. The State Office of Mental Health budget allocates large sums to the maintenance of state facilities caring for fewer patients. The Office of Mental Health, libertarians, families and advocates have favored closing specific hospitals with savings reallocated to more highly valued

community-based programs. Such changes require action by the Legislature which, in New York State alone has the legal authority to close a state facility. Legislators have been reluctant to close facilities which are important employers in their districts and have pressed for plans to convert facilities to other uses which will sustain employment.

The New York experience is cited here to illustrate what can happen as legislators' self-interest influences legislation needed to implement departmental policy which could benefit homeless mentally ill.

Current statutes in New York, Illinois and Pennsylvania generally provide adequately for hospitalization of those individual's requiring such care against their wishes and **only** for those who need such treatment.

Mental Hygiene Statutes of New York, Illinois and Pennsylvania covering involuntary trips to psychiatric emergency rooms are appended as Appendix numbers 1, 2, 3.

FOOTNOTES

1. Under the Willard Act of 1865, New York State assumed the cost and administration of care for the state's mentally ill. The State Care Act of 1890 established a centralized state system of care of the mentally ill.

CHAPTER 5

PUBLIC POLICY DEVELOPMENT

THE STATUTES

INVOLUNTARY ADMISSION TO HOSPITALS AND PSYCHIATRIC EMERGENCY ROOMS

Who May Involuntarily Hospitalize A Mentally Ill Person

New York	Pennsylvania	Illinois
Director of Community Services or an examining physician duly desginated by Director of Community Services	A physician, a responsible person, county administrator or peace officer	Any person over 18 with certificate by physician, qualified examiner or clinical psychologist, courts or peace officer

Who Can Be Hospitalized Involuntarily

New York	Pennsylvania	Illinois
Any person whose mental illness is likely to result in serious harm to self or others	A person whose mental disability poses a clear and present danger to harm others or self	Persons requiring immediate hospitalization to protect such persons and others from physical harm

How Many Certificates Are Required For Involuntary Hospitalization

New York	Pennsylvania	Illinois
Applicant Physician and hospital staff physician	Physician or responsible person	Applicant plus physician, qualified exam? or clinical psychologist; applicant only when physician, Q.E. or Ph.D. unavailable

How Long Can Persons Be "Detained" For Treatment

New York	Pennsylvania	Illinois
32 hours subject to judicial approval	Must be examined at psychiatric hospital within 2 (two) hours - not to exceed 72 hours	24 hours pending certification by hospital physician

PUBLIC POLICY DEVELOPMENT

STATUTES

Exceptions To The Rule of Physician Examination and Application

New York	Pennsylvania	Illinois
In communities of fewer than 200,000 population and absence of Section 9.39 hospital, certified social worker or clinical psychologist can make application	Not specified	Petition alone pending obtaining physician, Q.E. or Ph.D. certification

Who May Order a "Designated" Person Transported To a Hospital

New York	Pennsylvania	Illinois
A Physician who has been designated by a local community services Director		Peace officer, qualified expert, physician

Severely Mentally Disabled Defined

New York	Pennsylvania	Illinois
Mental illness for which immediate inpatient care and treatment in a hospital is appropriate and which is likely to result in serious harm to self or others	As a result of mental illness his capacity to exercise self-control, judgement and discretion in the conduct of his affairs and social relations or to care for his own personal needs is so designed that he poses a clear and present danger of harm to others or to himself	Subject to involuntary admission and in need of immediate hospitalization to protect such person or others from physical harm

CHAPTER 6

THE NEW YORK EXPERIENCE

LOCAL OUTREACH PROGRAMS

HOMELESS EMERGENCY LIAISON PROJECT

Few civil environmental issues reveal our ambivalence as much as our responses to encountering disheveled, unclean, isolated, disaffiliated men and women sleeping on hot air vents, huddled in doorways and panhandling on the streets. Many of these are mentally ill, confused, disoriented streetbound people who act bizarrely, and are often physically ill. We often resent, fear and avoid them, but also, feed, clothe and give them money. According to Dr. Sam Tsemberis of Project H.E.L.P., the homeless population in New York City equals the total population of such cities as Ann Arbor or Miami Beach. Dr. Neal Cohen estimated in 1981 there were 31,000 homeless in New York City, most of whom had mental illness. While we recognize the rights of these people to be in the parks, subways, terminals and on the streets, we also prefer to have them removed to safe, out-of-sight places where they can be cared for, thereby posing less threat to themselves or others. State and local legislation and funding have enabled many homeless mentally ill persons to be helped to "come indoors" voluntarily or involuntarily, to utilize shelters, food programs, residential and clinical services and to be restored to more satisfying community living.

In New York and elsewhere, state governments have recognized their role earlier in adding to the homelessness of the mentally ill by sending them out of psychiatric facilities and not allowing them back in. Since the late 1970's and during the 1980's they have supported local programs to bring services to mentally ill in the streets. These new programs are reaching out to men and women who are either uninformed about available assistance or are unwilling or unable to become clients of traditional social agencies and hospitals. Many of those living in the streets are presumed to be the dysfunctional men and women who left psychiatric facilities unprepared for the unsupported, depressing life in single room occupancy hotels or other low-quality housing without services and who spilled into the streets when their money, judgment and life skills ran out.

By 1980 it was apparent, especially in large cities, there were many thousands of street-dwelling mentally ill who were at serious risk of becoming sick and perishing if unaided. Programs that were developed to offer various services to the identified mentally ill on the streets are being heavily utilized, but there remain large numbers who either reject services or accept only limited engagement and who remain at the greatest risk. For those who did not voluntarily accept medical, psychiatric and social services, it became clear that such services would have to be provided against the person's wishes. The use of involuntary hospitalization and treatment became an important component of outreach services in the 1980's, bringing with it controversy and the need for changes in statutes.

Paul S. Appelbaum states (1984) states:

> Systems for treating mentally ill people have always been premised on the assumption that coercive treatment may be needed, either because many mentally ill persons are incapable of making competent decisions about their need for care, or because they present serious threats to their own well-being or the well-being of others.

In New York State, Article 9 of the Mental Hygiene Law governs the involuntary commitment of mentally ill persons. Section 9.01 of the Law states, "Involuntary care and treatment means that a person has a mental illness for which care and treatment as a patient in a hospital is essential to such person's welfare and whose judgment is so impaired that he is unable to understand the need for such care and treatment". Section 9.37 of the Law authorizes involuntary admission of a mentally ill person upon certificate of a Director of Community Services or his designee. In New York City, the Commissioner of the Department of Mental Health, Mental Retardation and Alcoholism Services is such a "Director of a Community Service" and since October, 1982, has authorized Project H.E.L.P. as his designee to have homeless mentally ill persons transported to Bellevue Hospital Emergency Room for psychiatric evaluation. While physicians, judges, Emergency Medical Service, peace officers and others can also petition hospitals for emergency psychiatric admissions, Project H.E.L.P.'s mobile outreach activity today accounts for most of these admissions in New York City. As such, the Program is the major service provider in this case study.

Project H.E.L.P. teams "conduct psychiatric assessments of homeless mentally ill people who live on the streets, in parks, in transportation terminals and in other unorthodox places". The teams which consist of social worker,

nurse and psychiatrist are in the field at work days and evenings, every day of the year.

The program is a quasi-autonomous project of the New York City Health and Hospital Corporation and occupies a section of the 12th floor of Gouvorneur Hospital. The hospital is a Diagnostic and Treatment facility without inpatient beds. Patients needing to be hospitalized must be admitted to Bellevue Hospital. The program's space consists of an office for the Project Director, several small offices, a clerical area and one large open floor area filled with desks, files, refrigerators and equipment. It is a busy place with phones ringing and staff moving around preparing for the day's "action". The room resembles what one would imagine of a command post.

Project H.E.L.P. was developed to implement Mayor Koch's first initiative aimed at correcting conditions which, in January, 1982, led to the death of a woman living on the street in a cardboard box. Its teams operate out of radio equipped vans, enabling them to locate and evaluate individuals referred to them as well as others who seem unable to care for themselves. Since its inception, thousands of assessments are conducted every year, only 10% of which result in hospitalization. During its seventh year, from January 1 to December 31, 1989, teams conducted over 5,000 assessments on 918 patients, 716 of which were new cases. Of these, 261 or about 5 percent of the total contacts were hospitalized involuntarily and 70 were brought to Bellevue Hospital voluntarily. Project teams will often visit a patient several times a week or even daily, if needed, to assess the person's ability to remain where they are or whether they require a trip to the hospital. The 918 patients

recorded in 1989 were contacted about five or six times each on average with about one-third combined old and new cases being hospitalized.

Project H.E.L.P.'s patients are generally self-neglecting individuals with psychiatric and medical problems who do not use clinics, shelters, soup lines or entitlements. In their Journal article, Jane Putnam, Neal L. Cohen and Ann M. Sullivan (1986), the original staff of the project wrote, "most project patients have been homeless for an extended period and have lengthy psychiatric histories, which mean that the project serves the most chronic, treatment-resistent, difficult-to-engage patients". They offer the following description of the "typical" project patient:

> An older, white male who is readily identifiable on sight. He is bizzarely dressed, frequently inappropriately clad for the weather, usually wearing various layers of mismatched, tattered, and dirty clothing or wrapped in blankets. His hair and body are filthy. He is disheveled and often lice infested... In addition to his appearance, his bizzare behavior identifies him as a proper subject for Project H.E.L..P. services. He is always isolated, often withdrawn and uncommunicative. He displays strange gestures and mannerisms.

Project H.E.L.P.'s patients sound very much like those individuals who would have been lifetime "asylum" residents before the emptying of psychiatric hospitals and the policy of non-institutionalization. They are too dysfunctional to voluntarily utilize benefits and programs and often too confused to leave the streets and come indoors. Many would perish if left unaided. Those who are assessed by teams to have psychiatric impairment but "able to function on the streets" are not immediately taken to hospitals but are monitored closely to develop a treatment strategy.

In keeping with their non-traditional organization, structure and mission, Project H.E.L.P. operates in an informal work environment. Personnel dress

casually and one has to read a person's ID badge or ask to learn individual disciplines and function. Staff, who must rely on each other in the field, seem to know each other well and are accustomed to being in action together. Teams are either two or three professionals and a driver who, at times, has more experience in the field than the social workers or psychiatrists.

Project H.E.L.P. is assigned responsiblity for Manhattan and Downtown Brooklyn. The teams actually mostly cover lower and mid-Manhattan, seldom being called upon above 125th Street. Their activity takes them to areas having the highest concentration of homeless at risk persons who congregate in transportation terminals, shelters, and heavily traficked areas such as Times Square and parks. The teams respond to telephoned referrals or requests for assistance from other outreach programs, social agencies or individuals who have located and identified a person they feel is ill or behaving strangely. When the day or evening team has reason to believe the referred person will require hospital treatment, a psychiatrist goes along to "designate" the person for police transportation to the hospital. At other times, the team may include the psychiatrist because individuals who were being observed regularly might be ready for a trip to the hospital and will require "designation". If no designation seems indicated, the team may go out without a psychiatrist.

The work of Project H.E.L.P. was greatly aided by the development of special units at Bellevue Hospital for the admission and treatment of their patients. In 1987, a second initiative by Mayor Koch, created a 28-bed unit known as the Bellevue Homeless Psychiatric Unit. The hospital also opened a men's shelter which provide Intensive Case Management and Continuing

Treatment Programs. In addition, a temporary 50-bed Intensive Placement Unit operated for a time at Creedmor Psychiatric Center for intermediate or long-term psychiatric care while patients awaited placement in community residential programs. Steven Katz, et. al. (1993) write, "it should be noted that although 60% of Bellevue Hospital Center's 389 psychiatric patients are homeless, only those brought to the hospital under the aegis of Project H.E.L.P. become part of this specialized program". The Bellevue Homeless Psychiatric Unit derives directly from Project H.E.L.P.'s realization that getting the patient to the hospital is the beginning of a process, and not an end.

Mayor Koch, in a forward to the new book, **Intensive Treatment of the Homeless Mentally Ill** writes:

> On October 28, 1987, using my authority as Mayor of the City of New York, I started a program designed to assist homeless people in need of psychiatric assistance, including a 28-bed unit at Bellevue Hospital Center set aside for them. It was one of the ten best things I did in my 12 years of service as Mayor.

Project H.E.L.P.'s Director felt that existing statutes combined with the special unit at Bellevue Hospital and liberal intrepretation of policies at the hospital made it possible to get every individual who needs hospital treatment to the hospital. He felt, however, that there were too few places for those individuals to go after the hospital and that this lack of resources constituted the greatest problem of the care system.

LOCAL EFFORT - NEW YORK CITY'S OUTREACH PROGRAMS

PROJECT REACH-OUT

The need to locate and deliver services to New York City's growing number of mentally ill who were living in the streets in the late 1970's and in other non-traditional places contributed greatly to the development of mobile outreach programs. There was mounting evidence that many of those who had spilled into the streets were spending days wandering aimlessly, much to the concern and displeasure of citizens of towns like Long Beach on Long Island or Broadway in Upper Manhattan. Citizen protest and professional planning led to federally supported, state and local Community Support Services which included provision for serving streetbound mentally ill. The early prototype program was designed to identify and track those mentally ill persons in a geographic area who were avoiding or unaware of conventional mental health services available to them and to encourage their use. There were large concentrations of prospective clients on New York's West Side, an area bounded by 59th Street, 110th Street, Hudson River and included Central Park. New York City's first mobile outreach team was developed by Goddard-Riverside Neighborhood Center and called **Project Reach-Out**. The Center, located at 87th Street and Columbus Avenue is a long-established multi-service community center with strong ties to the community, which enabled it to gain the support it needed to fulfill its new mission.

Outreach programs have the dual task of gaining the trust of the individuals they locate as well as of the citizens of the community they serve. They typically offer food, clothing, showers, temporary shelter, information about benefits, health and clinical services. The food, such as sandwiches and juice, are usually offered first as an "engagement tool"[1] and it may be some time before the isolated, disaffiliated person they have met is able to accept more or to talk to the outreach worker. These new, unique outreach programs provide rapid response to referrals and calls to assist persons who appear disoriented and mentally ill who might be lying in the street, wandering, taking shelter in dangerous abandoned buildings or in parks or subways. In addition to responding to telephone calls and other referrals, the outreach teams typically also conduct their own daytime and evening tours of their sectors to check on the condition of homeless persons they already know and monitor and to locate and assist those who may be new to the area. One finding of work with street-dwelling mentally ill is that they are highly "territorial" and will remain in or return to what they perceive as their territory. This makes keeping track of people somewhat simpler.

An important feature of most outreach programs, including Project Reach-Out, is the necessary reliance of getting their clients to voluntarily utilize services, especially hospitalization. This has required the development of special practice skills and training to teach these skills. The Project Reach-Out success was followed by the addition of a mid-town mobile team fielded by Manhattan Bowery Corporation, a multi-service program with a long experience working with substance abusing mentally ill on "The Bowery"[2]

and by Lenox Hill Neighborhood Association located on East 71st Street which covered Manhattan's Upper East Side.

The Goddard-Riverside, Lenox Hill and Manhattan Bowery Outreach Programs have retained their identities as providers of voluntary services only. They have not been designated to act for the New York City Commissioner of Mental Health in effecting involuntary hospitalization of street-bound individuals they assess. Their outreach teams have not included the physicians (psychiatrists) who could petition for hospital admission and they do not seem to be moving in such a direction. The one outreach program in New York City that has been authorized by the Commissioner to effect involuntary hospitalization is **Homeless Emergency Liaison Project** (H.E.L.P.). It employs psychiatrists who make street assessments and is able to order police to transport an individual to an emergency room, even if against the individual's wishes. Project Reach-Out, Lenox Hill and Manhattan Bowery call upon Project H.E.L.P. for assistance in situations in which they feel an individual needs to be removed from the street.

The outreach program included in this study to illustrate a local effort to cope with the build-up of unserved or underserved mentally ill living on the street is **Project Reach-Out** of Goddard-Riverside Neighborhood Center. The Program was initiated in 1979 as a contract agency of the New York City Department of Mental Health as one of its newly instituted, state financed, Community Support Services. With few existing models to follow, Project Reach-Out had to create its own policies and procedures as well as defining its mission and setting up an agency.

The Project began its operations using a parked Winebago camper as a mobile office. The camper was quickly identified for what it was as it appeared in various locations on Manhattan's West Side and people either approached it for food or help, or avoided it in order to remain disaffiliated. The Winebago was, over time, replaced by a small fleet of less identifiable vans, as well as a combination office and drop-in center and an additional church basement used by its day program.

Susan Barrow (1989) describes Project Reach-Out in her report on the effectiveness of five outreach programs for the homeless mentally ill as follows:

> Project Reach-Out was the first program to find and engage homeless mentally ill clients and offer services responding to both emergency and long-term needs. Project Reach-Out uses its offices in the basement of a public housing project as an informal drop-in site where clients find respite from the streets and as a base for case management services.

Project Reach-Out is a mental health and social service component of Goddard-Riverside Neighborhood Center. Its basement headquarters is within several blocks of Goddard-Riverside's main facility. It is, according to its brochure (Appendix #11), "A mobile outreach program providing services to the mentally ill homeless on Manhattan's Upper West Side from 59th to 110th Streets, including Central Park." The area includes Riverside Park as well as Central Park and Broadway's Mall benches which have always attracted the homeless and the bizarre who mingle with the elderly and other regular bench occupants. It is in a section of the city where for many years mentally ill released from hospitals lived in plentiful single room occupancy buildings which were sprinkled among more affluent cooperatives and condominiums. The area

has a long history of social and political activity and it is not surprising that the community through its leaders sought and supported the city's first mobile outreach project.

Since 1979, Project Reach-Out has served several thousand undomiciled men and women. Among these are clients they have known and worked with for months and years as well as those who they have seen once and never again. It is supported by contracts with the New York City Department of Mental Health and is licensed by the New York State Office of Mental Health.

The Director of Project Reach-Out is Diane Sonde, a social worker who has been Director for seven of the agency's twelve years. In an interview with this investigator, she spoke about her experience at the agency as exciting and rewarding, as well as frustrating and tiring. For the past several years, the program has had contact with between 500-600 persons a month in winter months and about 1,000 a month in the summer. The great majority of these are clients the program has been following and to whom they have been providing case management services. A small number of new cases seem to appear regularly and they are quickly assigned for assessment and case management.

Within its boundaries, Project Reach-Out regularly responds to referrals from social agencies, concerned individuals, police, families and others who have identified someone who appears streetbound and needing help. In addition to responding to these referrals, Project Reach-Out mobile teams seek out mentally ill people to identify and assist. The teams are out twice daily to contact and "gain the trust of mentally ill persons living in the streets." This is done by providing the individual essentials, such as food, clothing and blankets. The Project Reach-Out teams utilize the standard "engagement tool" of a brown

paper bag containing sandwiches, juice and desert offered to the confused, hungry, frightened and often suspicious homeless person they are approaching for the first time or someone with whom they have an ongoing relationship. According to Diane Sondes, the twice daily van trips account for the major part of the program's new case finding as well as enabling staff to keep in touch with their ongoing clients.

Project Reach-Out has a staff of twenty, including social workers, nurses and paraprofessionals. Its mobile outreach teams are made up of combinations of social workers, nurses and others. Project Reach-Out also has several volunteering part-time psychiatrists who provide patient assessment, medication supervision, and consultation. They do not participate on outreach teams. From its beginning days, Project Reach-Out has emphasized its work of encouraging street-dwelling mentally ill to "come indoors" and to accept first emergency and then ongoing services. All of Project Reach-Out's services require voluntary agreement of the client which challenges staff's ability to engage such individuals. For many reasons, these are among the most help-rejecting, resisting individuals who often will accept clean clothing, showers, food and help with benefits long before they will consider accepting psychological services. Project Reach-Out has increasingly assumed responsibility for stabilizing those they first encounter in a subway station, park or on the street. They have arranged for mentally ill clients with health problems to be treated at no cost by the Hillman Center of Health Care for the Homeless on West 40th Street. Some clients are offered temporary housing in single room occupancy rooms controlled by Project Reach-Out or its parent

agency, Goddard-Riverside Neighborhood Center. The agency is committed to providing ongoing services as individuals become able to accept them and has become the primary agency providing services to a large number of clients. Such programatic expansion has been characteristic of outreach programs which, after having gained clients' trust, find referral and transfer difficult to achieve. Susan Barrow points out that the clients remain with the outreach program which adds services and becomes more comprehensive[3].

According to Project Reach-Out's Director, Diane Sonde, most but not all of the agency's activity is with approachable, self-neglecting, at-risk individuals. From time to time, teams encounter hostile, difficult individuals who may be having substance-induced aggressive episodes and the agency has had to develop policies and practices to deal with those who could not be engaged through their usual procedures and present a danger to others. In the years immediately after 1979 until 1982, Project Reach-Out relied on precinct police for assistance with what is now called an "Emotionally Disturbed Person"[4] or with a person so deteriorated that they needed to be taken to a hospital. Precinct police response, is described by Sondes as unpredictable and unreliable. They are said to have had too limited training or understanding of mentally ill persons to enable them to collaborate effectively. Project Reach-Out has not been designated by the Commissioner to order police to transport people and police have increasingly been sensitive to violations of peoples' rights. While police assistance is still required to deal with problems in Reach-Out offices and programs, assistance with assessing individuals for trips to hospitals is requested from Project H.E.L.P.

In 1982, Project H.E.L.P. was established and designated by the Commissioner to make street assessments of mentally ill persons and to order police to voluntarily or otherwise transport those who were deemed to need care in a hospital. Reach-Out has, since then, called upon Project H.E.L.P. when encountering a new client who needs to be hospitalized or when an ongoing client has decompensated or become too ill to remain on the street. When police assistance is required by Project Reach-Out teams with an Emotionally Disturbed Person they are called for through the "911" emergency system rather than from a precinct.

Project Reach-Out is housed in the basement of a high rise building and is approached through an alley where one small sign identifies its existence. Staff have done what they could to enliven the space with bright colors, lounge furniture, coffee machines and water fountain. Several offices are located off the reception area and have glass partitions, which provide openess and visability but little privacy. It is evident the activity in this place is different from traditional social agencies. The investigator saw few people arriving with appointments and many who "dropped in". The nurse was busy preparing patients' medications in one area while a patient in another corner seemed to be sleeping off the effects of some substance. Clients drop in for coffee and to talk with staff who seem busy but available. The drop-in space is very limited and the available chairs seemed to be filled during the investigator's visit. This space limit contrasted with the number of clients who wish to spend time at Reach-Out is given by the Director as the reason for renting space in a nearby church basement for a day program utilizing a drop-in format. This space and program are known as **"The Other Place".**

Project Reach-Out now provides day program for forty clients at "The Other Place". It also offers its clients temporary or transitional housing, benefits assistance, clinical services, counseling, health care, advocacy, job training and some Activities of Daily Living skills training. This growth of services into a comprehensive organization was found by Susan Barrow to characterize each of the five agencies she studied. According to Diane Sonde, these programatic expansions developed because other agencies rejected Reach-Out referrals and the agency had to create their own services to meet client needs. It would be interesting to research how effective inter-agency linkages are in providing continuums of care. It was obvious to this investigator that Reach-Out was working with a very difficult patient population. Several of the clients observed were actively psychotic, hallucinating, delusional, apathetic and restless. They appeared very much like Project H.E.L.P. clients and would probably be in hospitals if not attended and sustained by Project Reach-Out. In response to request for information about clients observed in the office and waiting room, Sonde stated they were all ongoing Project Reach-Out patients who stopped at the office on their way to "The Other Place" to spend the day and that they would be going to various shelters for the night. No information was given as to whether these clients had been unsuccessfully referred to other agencies.

The current policies and practices of Project Reach-Out have evolved from the original mission of locating and bringing emergency services to homeless mentally ill men and women existing in parks, on the street and other space. It is now a multi-service organization sheltering and "treating" a large,

stable case load. The agency has not sought authority to hospitalize patients involuntarily and actually sees such authority as counter to its mission. According to Diane Sonde, it is important in gaining patients' trust not to be identified as the agency that orders involuntary hospitalization or treatment. She finds hospitalization occasionally necessary and prefers to refer such individuals to Project H.E.L.P. or the Psychiatric Department of New York City Human Resources Administration, both of which have designation authority under Section 9.37 of the Mental Hygiene Law.

Project Reach-Out provides a welcoming, nurturing humane setting to very disabled homeless mentally ill people who, according to Sonde, generally do not become clients of more traditional agencies and who may in fact, have been rejected by such agencies. Its outreach activity is an important part of the overall effort to locate and serve the most isolated, dysfunctional of the mentally ill who have spilled into the streets from single room occupancy buildings and other inexpensive housing. Their clients are among the most persistently ill, revolving door cases who are locked out of hospitals and require long-term assistance to live in the community.

The Project's ability for rapid response to calls for assistance to homeless mentally ill has helped to identify large numbers of such persons in their sector. Once identification is made and the individual is encouraged to "come indoors", there are, according to Reach-Out's Director, insufficient resources to which the person can be referred for the help necessary to be mentally restored and live in the community.

The following flow-chart illustrates Reach-Out's activity and the

need for places homeless people can go.

FOOTNOTE

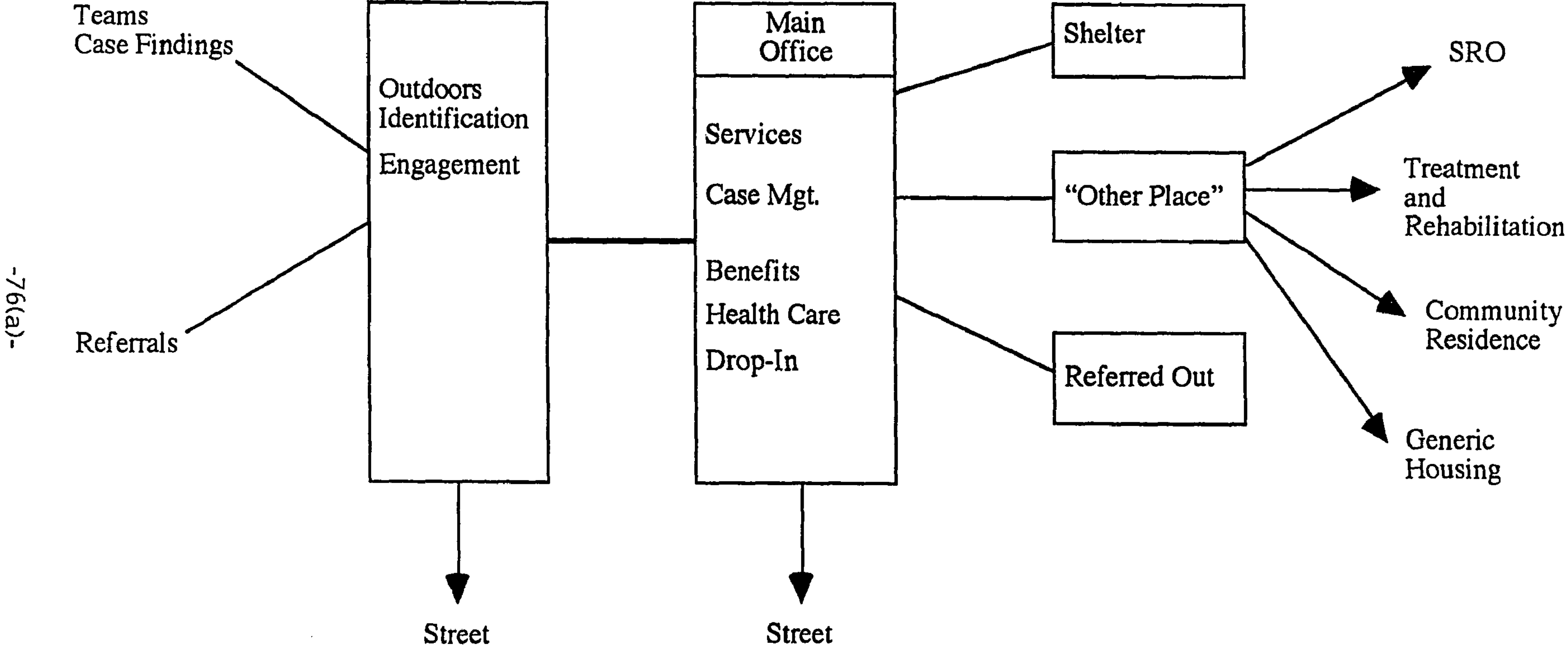
1. The mentally ill who have survived in the streets are generally difficult to approach or engage, the offer of food to one who is often hungry has proven to be a successful tool in initial contacts or engagements.

2. The Bowery refers to New York City's skid row area on and adjacent to Third Avenue, and Bowery, between Houston Street and Canal Street. The area includes a number of lodging houses or "flop houses" where nightly beds can be bought cheaply.

3. Susan Barrow (1989) points out in her study of five New York City outreach programs that comparisons were difficult because all five programs rapidly expanded their service provision to become more than outreach organizations.

4. An "Emotionally Disturbed Person" is usually a mentally ill person who is delusional, paranoid and belligerent, who will require restraints. Such physical engagement is avoided by outreach teams and remains a police function.

PROJECT REACH OUT ACTIVITY



FLOW CHART OF PROJECT REACH-OUT ACTIVITY

CHAPTER 7

TRAVELLING WITH THE PROJECT H.E.L.P. TEAMS

PARTICIPATANT OBSERVER DATA COLLECTION

FIELD TRIP - JUNE 4, 1992

As indicated in Chapter 4, the major research method of this case study is the observation of a social agency's staff at work who have "designation authority" under the State's statutes to order involuntary trips of homeless mentally ill people to a hospital. New York City's Project H.E.L.P. was selected as the agency to observe. The observations and data collection were achieved by traveling with the agency's teams as they responded to requests for assistance and also made their regular tours to observe and monitor people they know and who were considered at risk if they remained on the streets.

In preparation for traveling with the H.E.L.P. teams several meetings were held with the project's Director, Dr. Sam Tsemberis, a Clinical Psychologist. Dr. Tsemberis has been very generous in talking about the program and allowing this study to focus on its activity. At Dr. Tsemberis' invitation, several visits were made to the agency's offices at which times case records and staff were made available. As a result of these visits, it was possible for this investigator to become a somewhat familiar person in the agency which helped in the conduct of the study.

Project H.E.L.P. daytime teams work from 9:00 a.m. to 5:00 p.m. and evening teams work from 4:00 p.m. to midnight. The work schedule includes a 4:00 p.m. daily "round-up" meeting at which "day" and "evening" staffs meet together to exchange information. This is especially important as a way for the day team to alert the evening team to carry-over situations needing same-day attention. The meetings also provide staff with critical social and operational supports as well as producing important morale building. At the May 7th round-up meeting, Dr. Tsemberis began by introducing the study's investigator and described the study. He explained the significance of the project and let the staff know that in order to gather information about involuntary hospitalizations, the investigator would be traveling with them. Staff seemed interested in the project and welcomed being observed at their work. It seemed that staff were accustomed to such observation and also welcomed the possibility of having their work publicized. One psychiatrist who works with Bellevue Hospital and Project H.E.L.P. offered a pre-publication copy of a chapter he recently contributed to a book on Intensive Treatment of Homeless Mentally Ill.

The investigator's initial trip with a team was scheduled for Thursday, June 4, 1992. As suggested, the investigator arrived at Project H.E.L.P.'s office at Gouverneur Hospital at 10:30 a.m. to accompany that day's team on its tour. The investigator, whose name was on the blackboard as scheduled to accompany the team was welcomed by staff who were busy setting up the team's activity for the day. The blackboard also indicated that Jacob, a Danish documentary TV producer, was also going out with the team to observe today.

The large staff room was busy this morning with mobile team members taking telephone referrals, arranging the day's stops and going over details with support staff. The atmosphere is friendly, slightly "charged" with the anticipation of starting the day's action. By 11:00 a.m. it was decided by the team nurse and psychiatrist that the day's team would first go on a "designation"[1], which is H.E.L.P. parlance for responding to a referral which would likely involve the involuntary hospitalization of a street-bound individual who was refusing to accept psychiatric and medical services voluntarily.

This morning's 3-member team would be Helen G., Nurse Superviser; Dr. H. G. - Chief Psychiatrist; and the van driver. The person to be located and assessed was David Z. someone known to H.E.L.P. Helen and Dr. G. had several previous contacts with David Z., an 80 year old white man who is "homeless" and spends his time in and around Columbia University. Today staff of a social agency which is connected with Columbia University and works with homeless persons, had called saying that David appeared more than usually frail and a danger to himself by neglecting medical conditions that required attention. Efforts by staff of the referring agency to get him to seek medical care voluntarily had been rebuffed. Dr. G. explained that Project H.E.L.P. was called to assist because a psychiatrist was essential if David needed to be transported to a hospital involuntarily. Such an action could be ordered only by a physician. On trips where it is not likely there will be a "designation", the psychiatrist does not always accompany the team.

Dr. G. remembered David Z., recalling that he "designated" him one and a half years earlier for treatment of a cancerous tumor on the right side of his head. The patient then required radical, life-saving surgery, which

included loss of the right ear and considerable facial disfigurement. The referral today indicated the man was having a problem at the site of that earlier surgery, as well as problems he was having with both legs. David had been seen by a staff member of the referring agency sitting on a bench at 111th Street and Broadway. He often sits on these mall benches and would probably be at 111th Street or nearby when we arrived.

Two other referrals were received before setting out to find and contact David, which might also have become "designations". One was a Project Reach-Out referral of a man at Broadway and 98th Street and the other an elderly, disoriented woman referred by Lenox Hill Neighborhood Association's outreach team. Dr. G. had decided to contact David Z. first and Helen informed the other two callers that the team would try to respond to their requests for assistance if there was time after attending to David Z.

The team of Helen and Dr. G. plus Jacob and the investigator started on this tour at 11:30 a.m. On the way to the van Helen collected two large brown bags of lunches (similar to the "engagement" tool described by Project Reach-Out) and cellular telephones with which to communicate with the van, the office, police and others[2]. The lunches were to be given to David, the other two referrals if contacted, or to others known to H.E.L.P., who might be encountered. Offering lunches is a way of sustaining relationship and checking on the condition of known mentally ill being monitored[3].

En route to 111th Street, which is just north of Project Reach-Out's boundary, Dr. G. talked about what he recalled of David Z.'s fixed delusion that a lawyer or lawyers were withholding his inheritence from his deceased

father. David repeatedly maintained in the past that he needed legal help to get this money with which he would get housing, medical attention and everything else he needs. It seemed that David Z. had, according to Dr. G., been a Columbia University student as a young man and that he knew his way around the campus and was rumored to be actually living in one of the buildings.

As the van approached the West Side, Helen learned by carphone that the elderly woman referred by Lenox Hill had left their meal program and was unavailable. She was expected to return the next day when she could be contacted.

When the van arrived at Broadway and 111th Street at noon, David was easily located dozing on a bench at Broadway and 112th Street. The day was sunny and mild and David was wearing a shirt, tie, bright red sweater and tweed jacket. He is a white-haired, not very clean, frail man of 80, carrying one bag of groceries and a large brown envelope filled with papers.

When the van was parked at 111th Street, Dr. G. was first to exit and begin the contact. He slowly but directly approached David, calling him by name when close to him, and offering a brown bag of lunch. Helen then left the van and also approached David remaining slightly off to one side. Dr. G. and Helen demonstrated their way of approaching a mentally ill person in the streets and one recognizes that the manner in which the approach is made and how the space around the person is dealt with are very important. Helen has had much experience with approaching street-dwellers and has written a guide for new workers on conducting street interviews and assessments. (Appendix 12)

Two men who shared the bench with David left quietly when they saw Helen and Dr. G. approach. Jacob and I also left the van but did not approach David, remaining a short distance away[4]. David responded to Dr. G. and Helen, remembering and referring to them by name. He refused the lunch that was offered and became uneasy while Dr. G., who was now quite close, talked with him about his health and especailly problems with his legs and oozing from the earlier surgical wound on the side of his head. David denied any health problems and after five minutes he got up from the bench, moved away from Dr. G., waved goodbye and crossed from the center island to the sidewalk close to where I was standing. Dr. G. followed slowly. He had seen enough of the condition at David's ear and made the decision that David needed medical care. He then asked Helen to call for police assistance in order to transport David to the hospital.

Once on the sidewalk, David began walking north slowly. It was at this point that I became a participant observer as well as an observer. It was necessary to maintain visual contact with David while Dr. G. arranged for police and so I kept pace with David, maintaining a distance of about 8 feet. David's path was north on Broadway from 112th to 115th Street which is lined with booksellers' tables. David moved very slowly, stopping at each bookseller's table to read titles and thumb through books, which made it easy to stay close to him. David is known to the booksellers, all of whom seem concerned about him and appear to look after him in some way. David's slow pace may in part have been due to his diseased, swollen legs and ankles but it seemed that he also moved slowly because he knew the team was keeping pace with him and

that it would be useless to try to evade the team. It apperared David also knew that he was going to the hospital just as surely as the team knew it.

The documentary producer, Jacob, left at about this time when it became apparent the patient would be hospitalized.

As Dr. G. and I walked along slowly, following David and waiting for police to arrive, Dr. G. talked about his dislike for this part of his work that involved ordering police to transport someone to a hospital against their wishes. He felt it was better though, that he who disliked it, was on this "designation" rather than one of the Project H.E.L.P.'s psychiatrists whose bias was for getting more people removed from the streets by having them transported by police. This was one of several comments made to the investigator by staff about the range in H.E.L.P.'s psychiatrists' attitudes about involuntary admission. Such comments by H.E.L.P. staff provide a glimpse of the extent to which the interpretation of Section 9.37 is personalized and governs who gets a trip to the hospital.

It becomes evident in this observation that the handling of cases in the field is determined by the bias, attitude, experience and skill of the psychiatrist and other team members who have wide latitude in making their decisions. Dr. G. had made his street assessment of a previously known person quickly and ruled out efforts to get David to get medical attention voluntarily. Another physician might have spent more time assessing the patient's condition and might have tried more strongly to escort David to medical care on his own before bringing in police and utilizing the 9.37 hospitalization procedure. Other physicians might have seen the situation differently and called for Emergency

Medical Service rather than police. Dr. G. later pointed out, David's reluctance to agree to voluntary medical care was probably related to his recollection of the earlier surgery and long hospitalization. He felt that perhaps a different approach might have avoided the involuntary trip, but that David's life-threatening condition required greater certainty that he would get treatment.

Dr. G. is Chief Psychiatrist of Project H.E.L.P. He is a white haired, mature man who has practiced psychiatry for many years. He works at H.E.L.P. three days a week and is one of a number of the program's part-time psychiatrists. Several of the other physicians divide their work time between H.E.L.P. and Bellevue Hospital where they work with seriously and persistently mentally ill patients in emergency room or in-patient units. Prior to joining H.E.L.P. three years ago, Dr. G. worked with a similar Westchester County outreach project. In observing Dr. G.'s practice skill, it was apparant he had experience with outreach methods and work with patients in the street rather than in the office. When asked to describe how he worked, he explained that once he made the assessment that a patient was to be "designated", time was on his side and it did not matter how long it took to achieve it. Dr. G. proceeded with the work of getting the person to the hospital hospital at a slow, deliberate pace. He avoided getting the patient agitated, did not rush the process but was firm and reassuring. At one point when David turned from looking at books to confront him, Dr. G. re-engaged David in conversation. David repeated his deluded conviction about his withheld inheritance, insisting that what he needed was legal help which he asked Dr. G. to arrange for him. He rumaged

among his papers and gave Dr. G. the name and address of the attorney who was handling his late father's estate. Dr. G., who seemed genuinely interested in finding out if there was any reality to David's story, said he would contact the law firm. This exchange seemed to create for the first time something of a working alliance between the two men, although it was not strong enough to overcome David's reluctance to go to a hospital.

The small group that had been walking up Broadway came to a halt at about 115th Street at which point David again tried to dismiss Dr. G. who repeated to David that he was going to the hospital for medical care and that police assistance was on its way to get him to the hospital. David had a physical reaction, became slightly alarmed, then recovered, remained passive, repeating that he felt well and only needed legal help. At this time, it was evident David knew there were several people gathered around him and that although not being physically constrained, he was being detained, and he did not walk any further.

At 12:35 p.m., about one half hour after police assistance had been requested, two young white, male police officers of the Manhattan North Task Force arrived by van from their headquarters on Ward's Island. The arrival of officers from a special police unit rather than a precinct seemed unusual and when questioned, Helen explained that when a H.E.L.P. team needs police assistance, it now requested it from the Manhattan North Task Force rather than from the precinct or "911"[5]. This arrangement with the Task Force was worked out recently after many years of strained and difficult relations between H.E.L.P. and the Police Department. The arrangement with the Task Force

is more effective because it does not ask precincts to interrupt patrol schedules or other planned local activities and does not tax local emergency response systems. Police assigned to the Manhattan North Task Force carry out special assignments, including assisting in a "9.37" process. The officers who arrived did not, however, know how personnel are selected for the Task Force and were not familiar with the full range of assignments they might get. The Task Force did not seem to have specialized units for rescue or work with emotionally disturbed persons.

The two officers who arrived had not previously assisted in a "designation" and in fact had not known about Project H.E.L.P. before today. Dr. G. briefly explained to the police officers that as a physician he had determined that David needed treatment in a hospital and that their assistance was required in getting him to the hospital. He requested the police ask David to accompany them to the hospital for a check-up. They did this very calmly and in a sensitive, non-threatening way while positioning themselves close to David to prevent his possible sudden movement to leave. Although these officers said they were not specifically trained to work with mentally ill people, they somehow understood the importance of the patient's "space" and the use of their authority. David remained in place, but refused to go to the hospital and repeated his need for legal assistance. He added that the police had no right to detain him, that he had committed no crime and asked the police to leave.

With the arrival of the police there were now five people and David in a group. Curious passersby stopped briefly to watch what was happening or walked around the group to avoid the activity. The activity was occurring

on the sidewalk of Columbia University which is an atypical neighborhood and possibly accounted for the limited curiosity of those hurrying by. One bookseller approached and spoke to David, encouraging him to go with police to the hospital. David refused this suggestion and it became apparent that this defiant, frail, elderly man would in some way have to be physically placed in a vehicle to be transported to a medical facility. It was equally apparent that H.E.L.P. staff and the police were uneasy and not going to do anything physical with this man. The two officers had put on heavy gloves, however, as part of new universal precautions against AIDS, in the event physical contact had become necessary.

After ten minutes (which seemed much longer) the officers, having been unable to get David into their van, and seeming stumped, decided to call their supervisor for further instructions. On their car phone they were told by their supervisor to call in an E.M.S. team and ambulance because of the medical aspects of the case.

While waiting for the Emergency Medical Service team to arrive, a subtle change occurred in which responsibility for David and getting him hospitalized, shifted more to the police and away from the Project H.E.L.P. team. Almost all sporadic conversation that now occurred was between the police and David with the police gently but clearly keeping David from leaving. One officer explained to him that physical contact would occur only if he made moves to leave and so David remained quite still. Dr. G., Helen and I stood together talking several feet away from David and the police and for about ten minutes everyone seemed to be just waiting for the next step in the process.

At 12:55 p.m., the Emergency Medical Service team arrived as did the Manhattan North Task Force sergeant, his driver and two police of the local precinct who were driving by, saw the crowd and stopped to offer assistance. The sergeant, like his officers, was unfamiliar with Project H.E.L.P. and with the 9.37 process. He was curious about the procedure, and after talking with Dr. G., talked to his officers who he instructed to continue their handling of the situation. The two precinct police who had arrived were also uninformed about 9.37 procedures were and curious about it. Unlike everyone else who had been very gentle with David, the one female officer from the precinct tried to get "tough" with him, telling him he had to get in the ambulance, "or else" David responded by telling the officer she had no right to arrest him, at which the officer retreated.

After several minutes of unsuccessfully talking to David to get him to enter the ambulance, the Emergency Medical Service team produced a folding canvas chair which they placed behind David. With one gentle shove, David sat into the chair, was strapped into it by the very efficient Emergency Medical Service team and carried the short distance to the ambulance. By 1:05 p.m., 65 minutes after first locating and contacting him, David was on his way to an involuntary trip to the hospital. The elapsed time seemed a lot longer than one hour and five minutes, revealing the tension this process is capable of producing.

At this point, Dr. G. again became the "authority" and directed the next phase of the activity. He was to be the petitioner ordering the trip to the hospital and asked the Emergency Medical Service crew who now had David,

to transport him to Bellevue Hospital where Project H.E.L.P. has access to accelerated admitting to units reserved for their "designated" persons. Dr. G. especially wanted David admitted to Bellevue Hospital's combined psychiatric and medical unit for treatment of his medical problem. The Emergency Medical Service team, however, did not want to go from 115th Street and Broadway to Bellevue Hospital at 33rd Street and First Avenue and said they would take David to St. Luke's Hospital which was one block away at 114th Street. The Emergency Medical Service team appear to have authority for the final word on which hospital to go to and this time it was to be St. Luke's. Hearing this, David asked to be allowed to walk one block to the hospital voluntarily. This raised for the investigator the question as to why a walk to the hospital was not proposed earlier and whether the involuntary trip could have been avoided.

David was already strapped into the Emergency Medical Service chair in the ambulance and he was not freed to walk to the hospital. He was taken to St. Luke's emergency room in the ambulance, followed by the police and Project H.E.L.P. vans (an impressive motorcade). Once at the St. Luke's emergency room, David was allowed to walk from the ambulance into the hospital where he gave the admitting clerk required information. David was now quite relaxed in what seemed a familiar setting.

Dr. G. went off to meet with the Psychiatric Emergency Room Director and to complete all the necessary forms for David's admission. Helen and I took up a position with the police officers near the entrance where David could be observed. The time waiting for David to be evaluated by the emergency room psychiatrist who had to concur with Dr. G.'s assessment in order for

admission, provided an opportunity to chat with the officers. By 2:00 p.m., David was seen by the emergency room psychiatrist. This was followed by another long wait while Dr. G. negotiated David's admission. The work of trying to get David admitted to St. Luke's Hospital took longer than the entire process of locating David and getting him to the hospital. He was ultimately not admitted to St. Luke's Hospital but was later taken to Bellevue, lengthening the process to almost 12 hours.

Helen has considerable experience with these trips and she explained that had we gone to Bellevue Hospital, David would have been admitted quickly and the police and the H.E.L.P. team could have left to return to their headquarters. Since the activity was at St. Luke's, where David was not being immediately admitted, the police were required to remain with David until admitted at St. Luke's or elsewhere. The officers said they were quite content to remain at St. Luke's Hospital and be responsible for David since this would take them beyond their regular shift and would be overtime work for them.

Helen, when asked, agreed that David had actually walked into the hospital and now seemed to be voluntarily presenting himself as a local resident seeking medical attention. She agreed that a "designation" might have been avoided if David had agreed earlier to be accompanied to St. Luke's Hospital but that this was deceptive. She pointed out that like many other patients, he had become cooperative only after he knew he would be taken to the hospital against his wishes.

At about 3:00 p.m., Dr. G. emerged from his meeting with the Emergency Room Director. St. Luke's Hospital did not want to admit him and

David was to remain there in a holding area for now until arrangements were made about where he would be treated. It seemed likely that since he was known at Bellevue Hospital he would be transported there for treatment. It was evident that David was not in a psychiatric emergency and did not require immediate psychiatric treatment. There was nothing further for the H.E.L.P. team to do and the team left St. Luke's Hospital at 3:15 p.m. leaving the police officers to continue their responsiblity for David.

In talking with the officers, it was learned they were both college graduates who were recently appointed to the Police Department. They each felt positively about police work, including today's assignment, which was a learning experience for them. They felt, however, they had insufficient training at the Police Academy in working with psychiatric or homeless persons and that they should have been familiarized with programs like Project H.E.L.P. These two officers viewed their police work as primarily helping citizens with a variety of problems rather than pursuing criminals.

On the trip back to H.E.L.P.'s offices, it was learned in car telephone conversation with the hospital that David was to be transferred from St. Luke's Hospital to Bellevue Hospital as soon as transportation (Emergency Medical Service) was available. He was actually transferred later that evening. On July 20th seven weeks later, it was learned that David was still at Bellevue Hospital where plans were being made to find him supervised housing and a day program. It was said that David was eager to be housed near Columbia University and had refused several possible placements in other parts of the city.

This "designation" may have been essential to provide a life saving service. Its cost in police, Emergency Medical Service and Project H.E.L.P. time can raise a question as to its cost effectiveness and whether half the time and expense could have been saved if the Emergency Medical Service driver had been called earlier or if he had been obliged to transport David to Bellevue as requested by Dr. G. The policy and practice of who has authority to decide which hospital to use should be clarified and possibly changed. The lack of police officers' familiarity with programs and policies for assisting mentally ill homeless, if true for all or most police, also points to the need for clarification and changes in policy regarding police training. Police were involved this time without incident in taking a frail, elderly passive man to a hospital against his wishes. How does this compare to the experience of getting a younger, more aggressive or even combative person to an emergency room if the person is uncooperative and determined not to go? Over the years H.E.L.P. has encountered many such difficult individuals and has relied on police being more active than in today's experience including placing a person in restraints. Dr. G. and Helen stated that when a person is identified as an "Emotionally Disturbed Person", the person is totally a police responsibility with such cases handled very differently than a 9.37 case. Several such cases have made newspaper headlines recently when the individual to be restrained or police, or both, are injured or killed.

HOW IT WORKS - WHO GETS HELPED

TRAVELLING WITH THE TEAM

FIELD TRIP - JUNE 16, 1992

On June 16th, a bright, sunny day, twelve days after the first trip with a Project H.E.L.P. team, a second tour was arranged with another daytime team. In contrast to previous visits when the office was busy and bustling, there were few staff and very little activity in the office when the investigator arrived at 10:45. Helen, with whom this second observation had been arranged stated there were no "emergencies" for the team this morning and introduced Dr. Diane L., who would be available, if needed, as today's team psychiatrist. There had been several non-emergent calls requesting Project H.E.L.P. assistance, the most urgent being a repeat request to evaluate and possible "designate" a mentally ill homeless man, "Freddy", who regularly sits long hours in front of a super market at Broadway and 98th Street. The refering agency, Project Reach-Out, thought the man who they have known for some time, was ill and needed to be hospitalized. Helen, in planning the team's work schedule, said the team would look for the man and since there was a possibility this might be a "designation", Dr. L. prepared to go along. As the observer and third team member, I volunteered to bring the lunches.

Dr. L. is Project H.E.L.P.'s one full-time psychiatrist and divides her

time between going out on the van and working at H.E.L.P.'s two drop-in centers. She is a young woman who recently completed psychiatric training, during which she worked for several years with homeless and chronic mentally ill. Today she is wearing a "T" shirt and jeans and would hardly be recognized as a traditional physician. Helen too is dressed very casually.

The team boarded the "day van" shortly after 11:00 a.m. to head uptown to locate "Freddy" at Broadway and 98th Street. The driver today was Roberto who has been with the project since its inception, having transferred from Emergency Medical Service. Roberto is the regular driver and is much more part of the team than the young driver on June 4th. Helen and Diane seem to rely on Roberto to be a male presence when approaching an individual which Roberto seems to sense and he seems to enjoy being the team's man. Unlike other drivers met during this study, Roberto leaves the van and accompanies Helen and Dr. L. when they approach the person being assessed, making him a more intergral part of the team.

From the time the team left the project office, there seemed to be an apprehensiveness in the team which was not present during the previous trip two weeks earlier. Helen talked about "Freddy", the man to be evaluated, as being well known to Project Reach-Out. The referring agency had suggested that he be hospitalized because they felt that he had become thinner, dirtier, sleeping more and neglecting himself. Helen emphasized in talking about Freddy that he was ill and a danger to himself, not to others. The issue of dangerousness was raised repeatedly as the van drove to the West Side. Helen and Dr. L. told stories about incidents in which people being contacted had turned on staff

and of times when staff were threatened or even assaulted. The talk turned to learning where to stand and how close to be when talking to a street person, whether to wake someone who was asleep and when to call for police assistance. Helen has developed the appended manual for new staff, describing ways to approach someone, how to use the lunch as an "engagement" tool and how to recognize an emotionally disturbed person who should be handled by police. Generally, Helen felt it was "safer" working with H.E.L.P. streetbound people than working in the confinement of an inpatient ward. Here on the street the person being approached, if angered or paranoid, can walk away and doesn't have to strike out since the person is not in any way restrained.

En route to the West Side, a call came in on the car telephone requesting that H.E.L.P. assist a seemingly disorganized woman walking barefoot north on First Avenue at around 87th Street. The caller, a staff person at Lenox Hill Neighborhood Center[6], could not be certain whether this unidentified person was intoxicated, under the influence of drugs or psychotic. Helen, who was clearly in charge of this trip, told the caller the team would respond and asked Roberto to head for the location.

The team did not locate this person but the Lenox Hill outreach worker who had called waited in the area and met the H.E.L.P. van at 87th Street. He explained that he had observed that after the woman's many unsuccessful attempts to get a cab to stop for her, one cab did and she "escaped" by taxi. This woman was not known to the Lenox Hill team or H.E.L.P., raising the question of how many such cases there were in which people appear and disappear without being contacted.

The trip to find and evaluate "Freddy" continued and at 11:50 a.m. he was located sitting on the ground asleep, in front of a supermarket at Broadway between 97th and 98th Streets. Since he was asleep, and it was not known whether he might be hostile, Dr. L. wanted Project Reach-Out staff to come from their office ten blocks away to positively identify the sleeping person as "Freddy". Project Reach-Out staff knew "Freddy" and Dr. L. felt they would be helpful in deciding how to approach him.

Helen contacted Project Reach-Out by the car phone and they agreed to meet the team. While waiting for them, Helen explained that Project Reach-Out teams preferred not to be seen together with Project H.E.L.P. teams in order to avoid their being identified as an agency that hospitalizes people against their wishes. This was consistent with statements by Diane Sonde, Project Reach-Out Director, about the perceived need to gain clients' trust of them as the protecting and sheltering agency. Casting Project H.E.L.P. as the "bad guy" may have created some tensions between the two organizations. Helen felt the Project Reach-Out team had agreed to meet the H.E.L.P. team this day and to make the identification only because they were very eager to have Freddy "designated" and taken to a hospital for medical attention. Project Reach-Out staff felt he was seriously ill, possibly showing signs of advanced HIV illness or AIDS. Freddy had refused Project Reach-Out's offers of their medical services and refused to go to a hospital voluntarily with Project Reach-Out staff. Under the evolved system of services on the West Side Reach-Out's call to H.E.L.P. was the next step in the process of aiding a mentally ill person needing immediate treatment who was unable to seek services unaided.

The Project Reach-Out team arrived in an unmarked van and quickly confirmed that the man in front of the supermarket was "Freddy", the man about whom they were very concerned. The Project Reach-Out team said they were pleased that H.E.L.P. "finally" responded to requests for assistance with Freddy. The Reach-Out team of nurse and African-American paraprofessional were eager to leave before Freddy woke. Before leaving they assured Helen and Dr. L. that Freddy would not be hostile or flee but would probably resist leaving his "spot" to go to a hospital voluntarily. The Reach-Out staff said that from their experience with him he would need to be transported by police.

While waiting for the Project Reach-Out team it was observed that several people approached Freddy, both as he slept and after he awoke and left him packages of food and money. One person who left a bag of food was another street-dweller whose possessions were piled up on the sidewalk nearby next to a table where he was selling used books and other salvaged things. He stayed close to Freddy, and without speaking or asking questions seemed interested in the team and its activity. There seemed to be a connection and communication between Freddy and this man, even though no words were spoken.

Shortly after the Project Reach-Out team confirmed "Freddy's" identity, Dr. L. and Helen approached him, one on each side and stopping several feet from him. He was now awake, in a sitting position, appearing docile and not very alert. Several people hurrying by called to him by name and a few gave him money. Freddy nodded to those who called to him. He was dressed in a very dirty down type jacket and dark pants. His hair was matted, he looked very much in need of a bath and clean clothing. His sneakers, once white, were

worn and lived in. Several front teeth are missing, giving Freddy a toothless grin and adding to his sickly appearance.

While Dr. L. began talking to him, Helen offered Freddy lunch although by this time he had considerable food piled in front of him. The team driver took a position about eight to ten feet to the right side of Freddy, while Helen and Dr. L. were now together on Freddy's left. The observer was ten feet away, between the team and the van where what was happening could be seen and heard without being intrusive[7].

Freddy seemed friendly, responded easily to the team's questions, saying he felt fine and was O.K. where he was. He selected and ate from among the food and drink before him as he talked. The used book seller who was a white man, asked the team for a lunch and then a younger African-American man appeared and also asked for a lunch. This young man, who had several knives in his belt and looked beligerant, seemed to come from nowhere to check on what was happening to Freddy or around him and incidentally, to get something for himself. While he seemed potentially troublesome, the young man did not cause problems, leaving as quietly as he had arrived after checking out the situation and getting a brown bag lunch. Dr. L. and Helen did not react to the young man who could have been trouble. The quiet, efficient way other street people appeared at Freddy's side made it seem as though these people had done this many times before and that they were part of some kind of "society" or community. The larger community's reaction to Freddy seemed generally accepting and friendly.

Freddy had chosen a busy place to sit where there is heavy pedestrian

traffic and many curious passers-by. One passer-by, a man in his sixties approached the observer wanting to know what was being done with Freddy. When I explained Project H.E.L.P.'s interest in Freddy's health the man felt the organization was wasting its time. He said Freddy had been at this spot for two years and got $40.-$50. a day panhandling at this location and that he did not look any worse today than he always looks. The man thought the agency should be spending its time and money looking after other people who needed and would make better use of its help. He, for example, could use the agency's help. He recently had by-pass heart surgery which he said was poorly done, leaving him disabled and worried. He wanted to know if we could help him get St. Luke's Hospital where his surgery was performed, to re-evaluate his condition and help him feel better. He went on about how the Civil Liberties Union protected and encouraged people like Freddy to panhandle rather than getting them off the street. The man did not know where Freddy went when he left his "spot" or where he slept. He also did not know what Freddy did with the money people gave him. The neighborhood reactions to Freddy are quite varied, ranging from wanting him removed to supporting him and looking after him.

Dr. L. and Helen talked with Freddy for about fifteen minutes and Dr. L. decided he was not a candidate for an involuntary trip to the hospital. She had not previously seen Freddy and so had no basis for judging any deterioration in his condition such as reported by Reach-Out staff who felt he was physically ill and needed the medical care he was refusing. Dr. L.'s assessment was based solely on psychiatric mental status criteria and was not

responsive to Reach-Out's request for assistance in hospitalizing Freddy. She felt that he was alert, oriented, not psychotic and not presenting a danger to himself or others. Freddy refused Dr. L.'s offer to get him medical help but said he would go with the team "tomorrow" for a shower and clean clothing. Freddy looked and sounded more childlike as the team prepared to leave and it was the observer's impression that if this wasn't the day Freddy was to be involuntarily hospitalized, that day would inevitably come, probably sooner than later.

At his present location Freddy seems to be part of a sub-culture in which he is looked after and held onto by other street dwellers. He seems to be their panhandler and they in turn seem to feed him, possibly also providing him a nighttime place for safety and sleeping.

What to do about Freddy was entirely the physician's decision and a judgment call which Helen did not seem to try to influence. After leaving Freddy, the conversation turned to which of H.E.L.P.'s psychiatrists would have "designated" Freddy today and which, like Dr. L., would wait for more concrete medical or psychiatric signs of dangerous self-neglect. There was also talk about Project Reach-Out's reliance on H.E.L.P. to be the "bad guy" by transporting someone like Freddy for medical or psychiatric assistance. Helen said she did not like being the "911" for Project Reach-Out and implied there had been inter-agency problems over the years. Sharing views about biases of other staff as well as tensions with another outreach program may demonstrate feeling comfortable with the investigator but is also somewhat indiscreet. It also asks that the investigator side with them and lose objectivity.

The team took a lunch break after leaving Freddy. This provided an opportunity to give Dr. L. and Helen a tour of the observer's agency, The Bridge. Dr. L. and Helen planned to look in on clients at the transit terminals where they would distribute the remaining lunches. The observer did not accompany this part of the day tour.

This field trip again highlighted the degree of subjectivity involved in deciding who will be given an involuntary trip to a hospital emergency room. The dangerousness standards are to be interpreted by the team physician who is responsible in the field for carrying out organizational policy. The physician on today's team avoided interpreting "9.37" aggressively and seemed just as content to have decided not to designate "Freddy".

Whether another physician would have arrived at a different assessment is unknown. It is equally unknown whether Dr. L. would have been influenced in her decision if Helen had differed with Freddy's request to remain on the streets.

HOW IT WORKS - WHO GETS HELP

TRAVELLING WITH THE TEAM

FIELD TRIP - JULY 20, 1992

For the third field trip with Project H.E.L.P. the observer arranged to travel with an evening team on Monday, July 20, 1992 and arrived early to read additional cases before accompanying the team. The charts requested were those of people who had earlier been served by Project H.E.L.P. and having gone on to be enrolled as patients of The Bridge, Inc., were now living in Bridge rehabilitative housing. The charts and a desk were very graciously made available and charts were read until the day and evening teams gathered for their daily 4:00 p.m. "round-up" meeting.

The day team on this date had been Helen G. and Jenny R., a social worker. The team had not included a psychiatrist. They arrived first and were followed by Marty H. and Dr. Shari B. who would be the evening team. Dr. Tsemberis opened the meeting and invited the observer to join the staff, which added to feeling part of this activity and added to facilitating the observation process.

The meeting format consisted of a prepared, though brief, staff member presentation on a topic of general interest followed by individual activity reports and matters of day team activity which would be of interest and concern to the evening team.

Today's presenter was Marty who began the meeting by saying he wanted to talk about the "thinning out" of homeless and mentally ill people at Grand Central Terminal. According to Marty there are now only eight "hard core cases" at the terminal. Marty is the Chief Social Worker at H.E.L.P. and is very highly regarded by his co-workers for his fund of information, his special sensitiveness and skill in approaching street-bound mentally ill. He did not today indicate whether agency policy or his own concern led to his interest in developing strategies for assisting these remaining people to leave the terminal. This discussion occurred around the time of the Democratic National Convention when the mid-town area was the focus for removing homeless and others. Several of the remaining homeless mentally ill had been "designated" one or more times and had, after each hospital trip, returned to their "spot" in the terminal. It was clear that staff did not wish to lose these people by "shoving" them out of the terminal, but rather offering them an acceptible alternate place to be. The plan that was evolving during the discussion centered around enlisting the help of the two specially trained police officers who work in the Grand Central Terminal and in Metropolitan Transit Authority systems and know the mentally ill individuals. The plan called for the remaining eight hard-core people to be individually escorted by the police to H.E.L.P.'s 44th Street drop-in center or to the local police precinct. At the drop-in center or precinct, H.E.L.P. staff and staffs of other cooperating agencies would work with these individuals to encourage them to enter programs and to accept transitional housing. The H.E.L.P. staff were reluctant to "9.37" these last eight people and seemed comfortable that working with the two special police

officers would effectively implement this strategy. The two police officers, working in and out of uniform, had specialized in recognizing and assisting homeless people who gravitated to terminals. Unlike police encountered on earlier travels with teams, these police are described as knowing about assisting the mentally ill and working collaboratively with out-reach programs and social agencies. Information was not provided on how or where these two officers were trained but they are highly regarded by H.E.L.P. staff. It was also not reported how many people had been involuntarily hospitalized to achieve the "thinning out" of Grand Central Terminal. The work of contacting the police officials and implementing the plan to assist the remaining Grand Central Terminal "eight" was to be initiated by a day team in the next several days.

Following Marty's presentation, the day team reported on its activity. In the absence of any "designation" today, the team traveled to locations where known clients were likely to be and could be visited. On this day the team also had contact with two new cases. Locating and identifying new cases is an important H.E.L.P. activity which accounts for several hundred of its cases each year.

One new case contact occurred at Staten Island Ferry Terminal where a young, African-American male came to the van asking for help. He said he was homeless and reported multiple psychiatric hospitalizations. He told the team he was now having panic attacks, was fearful and hearing voices. In describing the brief contact with the young man, Helen reported that the team had gone out without a psychiatrist who could have made a street assessment and if need be, order transportation to a hospital. Helen told the group she

did not feel the young man needed immediate hospital treatment. She observed that he was well dressed, neat, clean, well nourished and appropriate. He was depressed and knew quite well how to ask for help. Approaching the van for help made him somewhat unusual in comparison to other H.E.L.P. cases. Helen and Jenny had decided he needed a place to stay and gone with him to the John Heuss House case manager located in the terminal and asked that the young man be allowed to go to their Beaver Street shelter for a while where a H.E.L.P. team, including a psychiatrist, would see him later that evening. John Heuss House is a private, free-standing program which provides homeless persons with case management, counselling, drop-in, food, referral, clinical, brief shelter and health services. It is located in the downtown financial district. It is contracted by New York City to care for homeless people, including mentally ill who spend their days at the lower end of Manhattan. The agency receives psychiatric consultation and clinical back-up from Federation Employment and Guidance Service. Helen's action involving Heuss House illustrates good coordination of services and collaboration between agencies.

The contact with this new client revealed a H.E.L.P. operational policy, namely, that as a rule, anyone who approaches the van asking for assistance is considered able to seek voluntary services, including hospitalization and, therefor, is ineligible for "designation". The H.E.L.P. team procedure is to enroll the person as a client and provide referral and other services but will not order a trip to the hospital. The team today felt very uncertain about the young man's story, especially about the "voices" and considered the possibility of his being a malingerer. They felt it would be essential, as promised to John

Heuss staff, to have him observed by the H.E.L.P. psychiatrist who would be part of this evening's team which would visit him at the shelter.

Following this report, the day team social worker, Jenny, reported on the team's second contact of the day which was with a young, African-American man with whom she had one prior contact. She described this contact as an outdoor "therapy" session in Thomas Paine Park but it seemed uncertain whether this contact was an agreed upon "appointment" time for therapy or whether it was a verbal therapy session which occurred spontaneously as part of the team's work this day. The social worker's report demonstrated an additional H.E.L.P. service which is not yet part of its mission statement but perhaps should be. The discussion of the worker's session with the client revealed something about Project H.E.L.P.'s leadership style and agency practice. The young social worker's report of her activity and the client's responses, made it evident that the client had become agitated and suspicious, probably as a result of his sexualizing the interaction. As discussion of the session went on, the meeting process became essentially peer group supervision sensitively conducted and led by Dr. Tsemberis. He attempted, in a non-confronting way, to have the social worker see the need to define and structure her meetings with the young man. The staff meeting illustrated ways in which staff had to develop practice skills to match the services being offered. Dr. Tsemberis recommended definition and structure without referring to the need to "defuse" and "de-sexualize" the "sessions". Marty assured Jenny that if the "sessions" became too "probing" or uncomfortable, the young man would break off the relationship simply by not appearing in his usual places and that

there was little likelihood he would do anything to harm the worker. Helen pointed out that she and the van driver are close by during "sessions" and that it was quite safe. No one was critical of Jenny's work or her interest in attempting psychotherapy or counseling with this homeless mentally ill young man who seemed able to manage on the streets and was not going to be transported to a hospital, voluntarily or otherwise.

The case illustrated that ongoing individual psychotherapy or counselling are not fully developed services within the H.E.L.P. mission but that some staff are interested in trying this modality. Project teams do monitor clients over lengthy periods which provides opportunities for a special kind of individual casework but it is questionable whether psychotherapy is an appropriate method during the street-dwelling phase. The social worker was not stopped from continuing her efforts to work with the client individually but was gently urged to exercise caution and to be much clearer with the client about the nature and purpose of the "sessions". One suggested focus for the "sessions" would be to encourage the client to accept referral to an outreach program which included temporary and transitional housing. The staff bring a variety of training experiences to their work at H.E.L.P. They are not expected to be skilled in ongoing psychotherapy and do not receive supervision in doing therapy. The discussion of this contact provided a view of ways in which staff seem divided about their outreach role. Most staff clearly see providing emergency services and getting street-bound people to safe places as most important. The two drop-in centers which H.E.L.P. recently added to its program as described, seem to concentrate on providing immediate, basic

needs rather than more traditional therapeutic objectives of self-understanding, insight and independent function. It emphasized the unconventional role as "rescuer" which Project H.E.L.P. has developed in the community.

This evening's team was Marty H., Dr. Sari B. and the observer. Marty is the Social Work Supervisor of Project H.E.L.P. and has been an important part of the organization for more than five years. He works with evening and weekend teams in addition to being a full-time social worker on an in-patient service of South Beach Psychiatric Center. He has had vast experience with persons with serious, long-standing mental illness which provides him with treatment skills and knowledge from which he has developed a personal style for engagement and communication on the streets. While such in-patient experience as Marty has is not required for employment at H.E.L.P., it certainly seems highly desireable. His empathy with the mentally ill is balanced with understanding, caution and therapeutic intent. When he approaches someone in the streets his purpose is not likely to be misunderstood, even by a person who is not in good touch with reality. Marty seems to have the task at Project H.E.L.P. of working with and teaching new staff, such as Dr. B.

Prior to this evening's tour, Dr. B. had worked one day a week for the past three weeks as a Project H.E.L.P. psychiatrist. She recently completed psychiatric residency training and is a Fellow in Community Psychiatry at Columbia University. Her three days-a-week fellowship work-sites are the drop-in and intake centers of the Volunteers of America located at Bellevue Hospital. Dr. B. did her psychiatric residency training at Bellevue Hospital where she experienced and learned about the problems and capabilities of

seriously mentally ill, including the homeless and substance abusing mentally ill.

Dr. B. wore the "T" shirt and jeans which H.E.L.P. psychiatrists seem to favor and Marty was equally casually dressed, including a colorful baseball cap.

The team left directly after the staff meeting, taking several bags of "lunches" with it. The driver for this trip, Jose G., was waiting for the team which set out for Heuss House at 5:25. Mr. G. was on temporary assignment with Project H.E.L.P., filling in for a regular driver on leave. He hoped to be regularly assigned to the project because he preferred the work's variety and mission to his regular hospital driving assignment.

Marty was clearly in charge of the tour this evening. He very skillfully encouraged Dr. B. to plan the assessment approach to the person waiting for the team at Heuss House and he also invited this observer to help evaluate the young man. He wanted to tailor this evening's work to the observer's background and interest and was seeking ways to fit the experience to the dissertation. He suggested that Dr. B. lead the interview, that the observer take "second seat" and that he would be in the "back row".

After leaving Gouverneur Hospital at 5:25 p.m. and a brief stop to pick up coffee, the team arrived at John Heuss House at 5:40 p.m. The shelter is in an anonymous looking building in the financial district. (A description of the shelter's program is appended.) It occupies basement space one flight down, which is not handicap accessible. A very friendly young man at the entrace reception desk admitted the team into a large, brightly lit area filled

with chairs occupied by about forty men and two or three women. In addition to the main lounge a smaller, TV area was off to one side and a large administrative area with several offices occupied the remainng space. The Heuss House is a day program and "sit-up" overnight shelter where a new "guest" can spend the night on chairs. When an individual becomes better known to staff, a bed in a church shelter, or occasionally, one of the few beds at Heuss House, is made available. Such overnight arrangements require evidence at Heuss House of cooperativeness, socialized behavior and commitment to self-rehabilitation.

On the evening the team arrived to assess the referred individual, Joan, who is a nurse, was in charge of the shelter. Additional staff included one other woman who supervised social services, a young man whose responsibility included dispensing medications and two or three young men who handled the reception desk and seemed to provide security. The Social Service Supervisor and other staff were not introduced and the team did not talk with them. Dinner had been served and cleaned up shortly before we arrived and people in the lounge and T.V. room seemed to be relaxing and socializing.

Marty introduced Dr. B. and the observer to Joan who he has known for a long time and with whom he has a friendly relationship. After the brief introductions, Joan arranged an office for the team and brought Mr. M., the client to be assessed, for the interview. Mr. M. is a slight young man, quiet and carrying a clean, filled back pack. He very politely shook hands as he joined the team in the small office that had been made available.

Dr. B. conducted a skillful 45-minute, in depth, psychiatric mental

status interview with Mr. M. while Marty and the observer listened. The office door had been left open to provide Mr. M. some comfort and avoid his feeling locked in even though noises from the outer spaces made it noisy. He sat calmly and composed through the examination, appearing familiar with the process and having answered questions about himself many times before.

In response to Dr. B.'s questions, Mr. M. revealed the following:

He recalled approaching H.E.L.P.'s van at the ferry terminal earlier in the day, repeating he did so to get assistance with the voices he was hearing which he recognized from the past as symptoms of psychiatric problem. Mr. M. is 37 years old, single and has been undomiciled since January (7 months). His last housing was an S.R.O. room during November and December, 1991 when he worked as a relief bell ringer at Volunteer of America Santa Claus stations during the Christmas season. He has not worked since last Christmas and offers no information about how he has supported himself or where he has lived. He was not pressed for such information.

Mr. M. is neatly groomed, clean, wearing new, or carefully cared for clothes, carrying a small back pack. He definitely seems organized to "travel light". He reported a first psychiatric hospitalization at Rockland Psychiatric Center as a 15 year old adolescent 22 years ago, resulting from his behavior problems within a family situation he describes as "bad". He has had several additional hospital stays, none as lengthy as the first. Information is given in response to questions rather than volunteered. In response to Dr. B.'s questions, Mr. M. denies drug use beyond occasional snorted heroin and marijuana. He strongly denies "crack" use and says marijuana makes him feel

too mixed-up and so he does not use it regularly. He acknowledges using alcohol, at times heavily, and says he has participated once in a while in Alcoholics Annonymous.

Mr. M. now finds himself feeling funny among "crowds" which seems to contradict his spending time at busy terminals such as the Staten Island Ferry. He has a good vocabulary and in response to the observer's question says he has been through high school and that he continues to read several newspapers a day in addition to books he finds. Mr. M. has in the past had food stamps, welfare, and other benefits which he talks about to explain how he manages without regular employment. He sticks to his life story very well with good internal consistency. His mental status is clear and sensorium is intact with no apparent thinking disorders or signs of organic problems. There are large gaps in his chronology but it is evident that this slightly built, timid, African-American man has had limited successes and many hard times in his young life. He is depressed and whether he actually heard voices, which are vaguely described, or not, Mr. M. now needed outside, institutional help. Dr. B.'s "here and now" approach to this examination had made it very clear that Mr. M. was not a danger to himself or others and that he did not require a trip, voluntary or involuntary, to a psychiatric emergency room. The team suggested that he spend the night at John Heuss House and go to the Bellevue Hospital Walk-In Clinic next day to be evaluated for psychotropic medication and anti-depressants for his depression, "uneasiness" and voices. Mr. M. knew where Bellevue Hospital was and felt he could get there either escorted or on his own. He had enjoyed the chicken dinner served earlier, liked being at Heuss House,

and felt he could spend the night at the shelter even though it was a new place to him and he did not know anyone.

Following the interview with Mr. M., the team met with Joan to share its assessment and recommendations. The response from Joan was a stream of surprising hostility aimed at Gouverneur Hospital for discontinuing regular psychiatric services and at Federation Employment and Guidance Services for promising but not providing contracted clinical services. Joan said she too realized that Mr. M. did not require a trip to the hospital and that her anger was not directed at H.E.L.P., especially since it made good on its agreement to come to the shelter this evening. She acknowledged the value of the coordinated service which occurred earlier in the day when Mr. M. was directed to Heuss House. She also recognized Mr. M. required a program, medication, a place to stay rather than a hospital and said that if he had, on his own, come to Heuss House she would have worked with him and avoided referring him to H.E.L.P. for possible "designation". Joan recited a long list of disappointments with the system which she felt was not working well for clients or for Heuss House. The agency is contractually responsible for shelter services for homeless persons who were attracted to the area south of Chambers Street and Joan preferred that clinical services needed to serve the mentally ill in this population be provided within the catchment area, specifically by Gouverneur Hospital. She felt getting such services from outside the area, from Federation Employment and Guidance Services did not work and predicted Mr. M. would not be accepted at Bellevue Hospital since Heuss House is not in its catchment area. She related, however, surprisingly, that Bellevue Hospital staff visited

the Heuss House program several days earlier to discuss expedited referrals from the shelter to its new in-patient and out-patient services. Joan repeated her doubts about it happening. From Joan's comments it seemed Heuss House felt it was doing its job while others were not. It also sounded as though Joan was making a case for Heuss House to expand its contract with New York City to add its own on-site clinical services which might be a useful arrangement. She was also expressing the often repeated frustration of emergency and outreach service providers with the lack of services to which patients could be referred from the shelter for long-term planning and program. This lack of referral resources creates the revolving door experienced by shelters, outreach programs and acute care hospitals.

During the 45 minutes the team met with Mr. M. and while the team talked with Joan, it was observed that a staff person was dispensing medications to individuals. When Joan was asked about this, she explained that medications that had been prescribed for individuals staying at the shelter by private psychiatrists or other facilities were stored for safety at Heuss House. Individuals are essentially self-medicating but obviously observed by staff who give them their medication in labeled envelopes. Individuals took medication from their envelopes, which then were returned and put back in the locked desk. This very simple process revealed an important service and the trust individuals have for Heuss House staff which is important for sustaining helping relationships with clients who had been isolated and living on the street.

Joan assured the team that Mr. M. could stay at Heuss House and that every effort would be made to get him to the Bellevue Hospital walk-in clinic

next day. Joan seemed more relaxed and friendlier after talking with the team. The team again met briefly with Mr. M. to whom all this was conveyed and then left at 6:55 p.m. As the team left, Mr. M. offered his thanks for its help. There was still daylight as the team returned to the van and Marty decided to go to Battery Park and Staten Island Ferry Terminal to check on old clients and to see if there were any more contacts to be made on this tour.

When the team returned to the van, Marty had a message from the driver that the Director of a men's shelter in Brooklyn had called for H.E.L.P.'s assistance. Marty returned the call on the van's car phone and the team learned that a highly disturbed man who had been barred was outside the shelter throwing things at the building and menacing shelter residents. He was well known to the shelter staff who had kept him out for assaulting others. The man was described as so disturbed that on one occasion when staff were trying to get him out of the building, he jumped through a closed glass window. Marty explained that the person being described was more correctly an "Emotionally Disturbed Person" to be handled by police and suggested the Director call "911" for assistance.

This incident illustrated how policy and practice are defined in the field. Marty, as a senior H.E.L.P. staffer, was very clear that H.E.L.P. does not try to work with those who are so out of control that they will need restraint and that such cases call for police action. The Police Department Emergency Service Unit has specially trained and equipped personnel who would be dispatched by "911" to handle the Emotionally Disturbed Person. This message about exercising caution, avoiding injury and getting appropriate police

management of assaultive or dangerous people was heard from all H.E.L.P. staff. Marty's experience and the agency policy is clearly that H.E.L.P. was best able to assist those who were confused, self-neglecting, non-assaultive and "environmentally" inappropriate. In response to the observer's question of how H.E.L.P. staff could quickly and accurately determine who was appropriate for them and who should be left to police, Marty illustrated how a person wearing too much clothing on hot days or too little in the cold were the kind of people they served best. He talked about weather being an important factor in determining H.E.L.P. activity. In his experience, extremes of heat or cold often decided when a person being observed could no longer adapt to street living and should be "designated". The incident at the Brooklyn shelter again informed that clinicians decide how best to serve an individual including involving police to manage those persons who need to be restrained in order to protect the person and society. A large number of mentally ill persons who are assaultive or commit crimes are dealt with by police and are served in forensic units of psychiatric hospitals, but many are known to remain in the criminal justice system and spend time in jails and prisons.

Marty had let Joan know that when the team left Heuss House it would be going to Battery Park and the Ferry Terminal. She told Marty about Jack, a "man in a green jacket", a shelter client who spent time in the park and about whom she was concerned because he had not come to the shelter recently. Marty said the team would look for him and check on his condition. Shortly after arriving at Battery Park Joan's "man in a green jacket" was located riding a swing in the children's section. He is an irregular user of Heuss House who

is said to spend long hours on a park swing which keeps him "calm and content". Marty approached the man, using the man's name, "Jack", which Joan had given. Dr. B. walked slightly behind Marty and the observer was off to one side. A low fence separated the team from the man in the green jacket. Marty spoke to the man who readily accepted a lunch. He said he was O.K., that there still were noises in his head and that he did sometimes go to Heuss House. He was clean, answered questions slowly, simply with no elaboration and with a rather blank, vacant expression. Marty said to the man he hoped he would let people at Heuss House know if he needed help and we left. It was the observer's impression from the man's posture and movements that he might have been a professional prizefighter who had too many blows to the head, sustaining brain injuries. He was not in an emergent condition, seemed to be sustaining himself in the community and was far from needing to be immediately hospitalized. Again, the brief conversation with the homeless man was very much "here and now" with no attempt to find out anything about him beyond his immediate and current functioning. Marty and Dr. B. were satisfied he was not self-neglecting or a danger to himself or others. From the brief conversation with "Jack", it was not possible to learn whether anyone was providing him case management services or whether anyone was able to compare current function to previous condition or future needs. Marty's comment to the man about letting the staff of the shelter know when he needed help seemed directed at responding to Joan's concern about Jack and illustrated inter-agency collaboration by Project H.E.L.P. doing some outreach for Heuss House.

A short distance from the children's swings where Marty had talked

with the man in the green jacket the team met a bearded young man Marty knew from previous contacts. He accepted a lunch from Marty and seemed eager to talk with the team. He told about noises in his head and asked if the team could tell him what caused them or whether other people had similar noises in their heads. He also wanted to know whether he looked "like a bum". His matted hair and beard surely needed attention and he could have used a shower and clean clothes. He accepted suggestions about how to avoid looking like a "bum" but in answer to the observer's question, became vague about where he would go for a shower, clothing and barber. Instead he returned to the noises in his head while he vehementaly denied he was having a psychiatric problem. He said that he had been treated many years earlier at Long Island Jewish Hospital for similar complaints. He claimed that he can't return to that hospital because he no longer has insurance and would not go there anyhow because they sent him to the psychiatrist. He knows he is not a psychiatric patient and would "kill" himself if he were. He repeated this several times, again asking if others had similar complaints, which he doubted.

Marty suggested to the young man that he should have a doctor examine him and in response the man asked if the team knew a doctor. When Dr. B. identified herself as a doctor the man wanted to know what she thought. Dr. B. said she or any doctor would need to examine him and do tests to explain his noises and said this would best be done in the hospital. Did he want to go to the hospital? He said no and changed the subject to ask again how he looked. To a question of where he thought he could go to clean up, he said, "the fountain".

It seemed that this homeless, confused, psychotic man was close to meeting criteria for "designation" but Marty and Dr. B. felt he wasn't ready enough to be admitted to the hospital. He still seemed somewhat oriented, able to get wherever he sets out to go and able to provide for himself. The noises and pain in his head could indicate an organic problem. Shortly after the man and the team parted, he was seen again, eating the food he had been given and hallucinating as he walked among the trees.

The team did not encounter other people known to H.E.L.P. in the park. An unknown man sitting huddled in a corner against a wall trying to play a trumpet was seen along the path. He waved the team off when Marty offered him food.

When the team left the ferry terminal it headed up to the East Side to tour along First Avenue. All along First Avenue Marty identified people (almost all men) with whom he had previous contact, including arranging hospital trips. It seemed Marty knew everyone on the streets and their stories.

At about 8:00 in the evening, as it was getting dark, the observer left the team as it headed downtown for dinner and a tour of Grand Central Terminal and Times Square.

This tour, in contrast to the June 4th and June 16th was more active, including an inter-agency contact which had political overtones. The three client contacts of this third field trip further illustrated Project H.E.L.P.'s policies and practices. In the first situation, the team had to decide whether a self-referred client, temporarily lodged with a collaborating social agency should be transported to Bellevue Hospital Psychiatric Emergency Room. The

H.E.L.P. psychiatrist and social worker acted together very smoothly in this, their third evening of working together. During the first contact, they maintained focus on the patient while recognizing the shelter Directors concerns. The second contact, Jack, the man in the green jacket on the swing, required a quick assessment after brief conversation. Again, the decision was not to "designate" him but to open a case at H.E.L.P. so that he would be regularly observed. He showed no evidence of danger to himself or others and was not neglecting himself. He obviously had chronic mental illness of some sort but did not require a trip to the hospital which would have deprived him of personal freedom.

The third contact, the bearded man complaining of noises in his head, presented a possible "designation". The decision not to hospitalize him was essentially Marty's. He knew the man from previous observations and felt he was not very different than he had seemed before. Dr. B. went along with the decision and offered him help in getting out-patient clinic and social services. This young man, like others, will ultimately need to be hospitalized for evaluation and treatment to aleviate his pain. For now, he is able to manage on the street, in parks and terminals. Project H.E.L.P. will monitor him and be available when the time is "right" for an involuntary trip to the hospital.

FOOTNOTES

1. The team psychiatrist is responsible for completing a petition for pysician certification of a person designated as requiring immediate psychiatric hospitalization.

2. The van radios and cellular phones demonstrate the use of available technology.

3. Food generally undercuts rage and learning how to offer it to street-dwelling people is an important practice skill.

4. The investigator uses "I" as a convenience to describe the participant-observation during this field trip.

5. "911" is the telephone number used for reported incidents and requesting emergency services including police and ambulance.

6. Lenox Hill Neighborhood Center's Mobile Outreach Program is responsible for serving homeless mentally ill persons within the area from 59th to 96th Streets, Central Park to the East River, roughly the boundaries of Community Board #8.

7. "I" is again used to identify the investigator.

CHAPTER 8

WHO HAS BEEN SERVED

CASE RECORD DOCUMENTATION

The files of New York City's two longest established outreach programs, Project Reach-Out and Project H.E.L.P., contain thousands of stories of the men and women they have assisted during the years since they began taking services to mentally ill people living on the streets. Project Reach-Out, established in 1979, provides services to several hundred new clients a year and in its fourteen years has assisted thousands of individuals.

Project H.E.L.P. has opened more than two thousand case records of people it has contacted, observed, followed and "designated" since it began operations in 1982. It maintains all cases as "open" cases since, in their experience, many people they have contacted regularly re-appear in terminals and on the street, even after successful referral for services including residential placement. Project H.E.L.P. appears to add 200 new people each year to its growing list of known street-dwelling mentally ill in Manhattan. Of these 200 new cases each year many will be "designated" for involuntary trips to hospitals, others will be helped to get voluntary psychiatric or medical care, and still others referred to shelters or day programs. The largest number will be followed and observed by staff teams for months or in some cases, years. Hospitalizations

occur when it becomes evident that individuals are unable to manage on the streets and unable to make and carry out plans for "going indoors" or to continue caring for themselves. Some of Project Reach-Out's cases are also cases that have been referred to Project H.E.L.P., creating some duplication in the case count of homeless mentally ill the city.

Seven H.E.L.P. charts were read in this study. These were a non-representative sample of their 2,000 cases. This small sample does provide important information about how the mobile teams work in making street assessments as they respond to referrals or conduct their own tours in non-traditional settings. The charts are very much "here and now" documents which describe the person and his or her current circumstance, using short, descriptive terms, omitting history and focused on diagnostic impressions for ready communication to anyone reading the chart. Each contact by a team is documented by a brief chart note which, over time and in a continuum, paint a graphic picture of an individual's deteriorating physical and psychological condition, leading to hospital trips. The cases read by the investigator tell the stories of three men and four women suffering chronic, serious mental illness who have been "designated" and hospitalized at least once. One man is classified as an "Emotionally Disturbed Person", one a mentally ill chemical abuser, and the third a help-rejecting, defiant, though system-dependent young man. The four women all had longstanding mental illness and had been spending their days in transportation terminals or on the street for long periods. All were diagnosed as schizophrenic, three were transferred from Bellevue Hospital to a special program at Creedmor Psychiatric Center from which they were

admitted to a Bridge, Inc. community residence.

Following are brief summaries of the seven charts.

CASE #1

An African-American male in his early 30's who was contacted in January, 1988 by a H.E.L.P. team in Grand Central terminal to which they were summoned by police. The young man had been seen previously by H.E..L.P. teams in the neighborhood around 47th Street and 2nd Avenue where local residents had called H.E.L.P. for assistance. The case illustrates ways in whcih H.E.L.P. fulfills a community service role as well as coordinating services among police and public agencies. The contact made with the client in Grand Central terminal was brief and the team did not record its assessment. This contact was followed by a second one in the terminal during a regular team tour in March, 1988. The chart note for the second contact states he "looked about the same" but the psychiatrist's diagnosis now recorded is "undifferentiated schizophrenia with alcohol abuse". No details are offered about how the diagnosis was made, but a psychiatrist must have had conversation with the man to lead to the diagnosis and the decision not to hospitalize him. It may have been the alcohol-abuse assessment that prevented getting him hospitalized since persons with substance-induced conditions are generally not hospitalizable. From March, 1988 until February, 1989 the client was observed periodically but not contacted back in his old neighborhood around 2nd Avenue near 47th Street. By February 26, 1989 when people in the 47th Street area again called H.E.L.P. he showed marked deterioration and the H.E.L.P. psychiatrist ordered police to involuntarily transport him to the Homeless Psychiatric Unit at

Bellevue Hospital. The psychiatrist's petition indicated the man was a danger to himself and at substantial risk of doing harm to himself because of self-neglect.

The chart does not reveal what occurred in this man's treatment at Bellevue Hospital nor for how long he was hospitalized. He is reported to have reappeared in his favorite neighborhood on 2nd Avenue between 44th and 45th Streets late in 1989 where concerned local residents again called H.E.L.P. to get him treated for what was described as his "failing health". On December 30, 1989 when contacted by a team, he was less communicative, less approachable and was "deteriorating". The team psychiatrist felt he was a danger to himself and "designated" him for a second involuntary trip to the hospital within a ten-month period.

There does not seem to have been follow-up when the patient was hospitalized. The chart again provides no information about the man's experience at Bellevue Hospital. Nine months after his second hospitalization, in August, 1990 he was observed in his old "territory". He is described as being "in good shape", approachable, communicative but lacking any plan for himself beyond a day-to-day existence. Another nine months later, in May, 1991, the chart note indicates a team making a street assessment felt he looked ill, less well cared for and requiring more regular observations. Subsequent notes record the man's progressive deterioration until, on December 19, 1991, when for the third time, a team psychiatrist ordered him transported to Bellevue Hospital. A chart-note records that in this hospitalization he required serious medical attention, including toe amputations as a result of cellulitis or gangrene which

are common conditions among neglected homeless people. During this hospitalization he was transferred to the psychiatric/medical service on 18N at Bellevue Hospital.

Project H.E.L.P. was active with this young man for about four years, from January, 1988 to December, 1991, during which he was involuntarily hospitalized three times under Section 9.37 of the New York Mental Hygiene Law. His need for psychiatric evaluation, hospitalization, medical and clinical treatment was obvious during these years. Project H.E.L.P. repeatedly brought this young man to psychiatric, medical and social service care systems which resulted in only brief hospitalizations and treatments. He is among the large number of "revolving door" cases one reads about who are system-dependent and need sustained case management, medical care and long-term treatment but are not getting it. Under new admission procedures, they are locked out of state psychiatric facilities and do not seem able to access ongoing, comprehensive community-based services which are scarce and may be unprepared to work with this population. Like many others, this mentally ill man has been treated and released from an acute care hospital several times with no place to go except back to his old street haunts where he becomes no-one's patient until re-hospitalized.

CASE #2

This is the case story of a male Caucasian in his early 40's who was known to Project H.E.L.P. from July 27, 1988 until March 19, 1992. During this time he was repeatedly described as "floridly psychotic", non-compliant and help rejecting". He was "designated" seven times in this period. On July

27, 1988 he was observed by H.E.L.P. teams in Battery Park, adjacent to the Staten Island ferry terminal, behaving "inappropriately". The team psychiatrist made a street assessment, diagnosed him as "paranoid schizophrenic" and ordered him transported by police to Bellevue Hospital. The patient was familiar with the "72 hour" procedure under which he could request his release from the hospital and after three days he was released by order of a Supreme Court Judge sitting in Bellevue Hospital courtroom. While this procedure gained the patient his freedom, it also appears to have deprived him of treatment he needed and which subsequent events revealed he should have had.

Six months after the first hospitalization on February 1, 1989, the patient was again referred to H.E.L.P. which carried out its street assessment and again hospitalized him voluntarily at Bellevue. The patient's chart indicates that during this hospitalization a hospital psychiatrist's request to have him remain in the hospital against his wishes was, this time, ordered by the Court. While the Court ordered his continued hospitalization, it did not authorize involuntary treatment, presumably because the patient rejected medication so vigorously. Based upon the Court ordered extended hospitalization, the patient was transferred to a long-term unit at New York State's Creedmor Psychiatric Center where an Intensive Case Manager was assigned to assist him in developing a "life plan". Before any of this important work could be accomplished, however, this help-rejecting patient left the Psychiatric Center without consent and was not returned. On April 3, 1989, two months after his last trip to Bellevue he was seen by H.E.L.P. teams, back on the streets. In this case, H.E.L.P., Bellevue Hospital, the Court, New York State Office of

Mental Health, all worked to designate, hospitalize, retain and treat a client who did not want any of it and who frustrated those who tried to help him.

On July 15, 1989 the patient was "designated" a third time and again taken involuntarily to Bellevue Hospital. There is no follow-up in the chart of this designation and the chart does not provide information about what occurred during this hospitalization. It is not known how long he received treatment but he was again observed on the street in January, 1990 at which time he appears to have been taken to the hospital again. His fourth or fifth recorded involuntary hospitalization occurred April 1, 1990. During this hospitalization he was treated medically against his desires. The patient was suffering gangrene, a condition which required amputation of several toes and for which it was necessary to have a court order. After the surgery, he almost immediately eloped from the hospital, remaining on the streets briefly, only to be re-hospitalized again one month later, on May 9, 1990. After a short hospital stay, he was on the streets for longer periods and was transported to Bellevue again on March 27, 1991 and once more a year later on March 19, 1992.

This "gravely disabled" patient who is obviously a "danger to himself", is self-neglecting and seriously mentally ill. The systems which have imposed his repeated hospitalizations seemed to have kept him alive and functioning. He is well known to Project H.E.L.P., but accepts limited assistance and goes from system-to-system, so that very little is known about him. Project H.E.L.P. teams have had no difficulty getting him to the hospital in spite of his otherwise non-compliance and it may well be that he has come to rely on Project H.E.L.P. to do for him what he does not do for himself, that is, seek emergency medical

treatment and respite. His "revolving door" story is outstanding. The patient appears, on some level, to have evolved a way of utilizing the psychiatric, medical and social service systems in an ideocyncratic manner which is oppositional to what doctors, judges and social workers prescribe for him. In another era he would have been a life-time state hospital resident and one wonders how long he will be able to function outside an institution.

CASE #3

Case #3 is a 46-year old African-American male labeled an "Emotionally Disturbed Person" because of his aggressive, anti-social behavior observed by police who have encountered him several times in transportation terminals. He is in a category of street-dwellers not usually served by Project H.E.L.P. but was for some time "informally" known to H.E.L.P. teams. Project H.E.L.P. did, at the request of police, send teams to evaluate this person several times in Pennsylvania Station even though they were to play only a limited role. The man was known to spend his time at several transportation terminals where he menaced women, made sexual gestures and refused police orders to modify his behavior. On November 30, 1989 Long Island Railroad police requested a Project H.E.L.P. psychiatrist to assist in getting the man hospitalized. The H.E.L.P. psychiatrist did an on-site assessment on the basis of which he found the man to be psychotic and a danger to others. This statement by the psychiatrist made it possible for police to take him involuntarily to Bellevue Hospital. The chart reveals that this scene at Pennsylvania Station was repeated many times in the following two and a half years, with the most recent hospital trip on March 20, 1992. The H.E.L.P. record

informs that this man was hospitalized many times but says little about who this man is or what attempts, if any, have been made by the medical, social service systems to treat or rehabilitate him. Since he repeatedly interferes with others, such as passers-by in a terminal, he has probably been arrested often and perhaps even convicted of criminal acts and spent time in jail or prison. There is some reason from the chart to believe that this man's behavior may be alcohol or substance related. This situation is similar to the story of a man named Larry Hogue, who is described in recent newspaper accounts as suffering substance induced episodes of assaultive, paranoid psychotic behavior. Hospitalization seems to serve a detoxification purpose, after which such individuals do not seem mentally ill and leave the hospital in another revolving door pattern. [1]

The man in Case #3 and Larry Hogue get diagnosed as mentally ill when their anti-social or criminal behaviors lead to street or hospital psychiatric examination. Neither has derived demonstrable or lasting benefit of psychiatric hospitalizations which seem more to only temporarily interrupt them and allow society to relax briefly. The criminal justice system is not able to remove Larry Hogue from his "turf" permanently and the courts have not commited either man to long-term psychiatric treatment in secure psychiatric facilities. Such cases raise questions about the policy on non-admission to hospitals and the benefits of long-term hospital treatment.

The man in Case #3 and Larry Hogue behave in ways that make them subject to arrest, even though they suffer a form of mental illness. The Case #3 record indicates that following his March 20, 1992 hospitalization, it was

decided that the criminal justice rather than the psychiatric hospital system should more appropriately attempt to modify his behavior through a prison term and the District Attorney was preparing a case for criminal prosecution. The policy of keeping mentally ill people out of psychiatric hospitals is resulting in rising numbers of mentally ill people in jails and prisons.

CASE #4

A 33-year old Caucasian woman who has had numerous psychiatric hospitalizations at both Bellevue and Beth Israel Hospitals in the past five years. She has been diagnosed by H.E.L.P. and hospital psychiatrists as having a serious mental illness. The chart indicates that she also is known to abuse substances and has a history of setting small fires, usually in transit terminals. She is referred to in the record as a mentally ill, chemical abusing patient (M.I.C.A.) and as such represents a large and growing group of Project H.E.L.P. cases.

This young woman was first referred to H.E.L.P. on October 29, 1989. Her disturbed mental status and over-all physical condition appeared serious enough to the examining psychiatrist who "designated" her for involuntary hospitalization. It was explained by Dr. Tsemberis that it is unusual for the team to order hospitalization in a first contact but might do so when the team was uncertain whether the individual would be seen again. The chart indicates she was admitted to a combined psychiatric and medical unit (18 West) at Bellevue Hospital, implying that she was physically ill. It is not known how long she remained hospitalized and the chart does not indicate what treatment she received.

The patient was next referred to H.E.L.P. seven months later, on June

5, 1990. This time the team did not find her a danger to herself or others and it was decided that teams would periodically check on her condition. The record notes indicate that the patient was seen frequently near the John Heuss Shelter in the Wall Street area. It also indicated that on several occasions during the next five months, until November, she set small fires. H.E.L.P. psychiatrists, who talked with her several times did not order hospitalization.

On November 15, 1990 H.E.L.P. responded to a telephone call referral and this time the team found the patient hospitalizable. She was taken by police to Bellevue Hospital where she was admitted and remained twelve days, leaving on November 27, 1990. There is no reference in the record of a discharge plan and the next entry in the H.E.L.P. chart is dated eighteen months later when, on March 19, 1992 the young woman was again referred to H.E.L.P. and taken by police to Bellevue Hospital where she remained for some time. On April 16, 1992 a H.E.L.P. team member visited her at Bellevue Hospital and noted she was still hospitalized.

Although "designated" and briefly hospitalized several times in two and a half years, this homeless young woman is essentially able to manage for long periods in the streets and in shelters. The record indicates she appears knowledgable about benefits, food stamps, shelters, social agencies, showers, clothing, and medical/psychiatric services. Her underlying psychiatric condition is not so debilitating as to render her unable generally to care for herself. It appears, however, from the chart that when she abuses alcohol or other substances, she becomes a danger to herself through self-neglect and a danger to others by fire-setting. Psychiatric treatment alone seems to have been

ineffective for this woman. She has not sought help for her substance abuse problem which, in combination with her mental illness, will almost surely be lethal.

As with other cases, Project H.E.L.P. has removed her from the streets periodically, bringing her to the place where treatment and rehabilitation services would be available. The available services have not held this patient who becomes part of the revolving door population and remains part of a serious systemic problem.

The first four reported cases illustrate the regularity with which mentally ill people in the streets are identified and, when appropriate, taken to psychiatric emergency rooms. In many cases, through a combination of patients' resistence, hospital crowding, reduction in state-run long-term beds, and shortage of community residences these patients did not move on to a system of care which would keep them off the streets and on a path toward rehabilitation.

The following three cases are women who, unlike the first four patients, did utilize involuntary hospitalization as the entry into systems which provide ongoing comprehensive treatment programs. It is important to note that the three women were "designated" by H.E.L.P. at a time when the New York State Office of Mental Health was establishing a unit at Creedmor Psychiatric Center to provide long-term care to a limited number of stabilized patients in Bellevue Hospital's homeless psychiatric unit. The three women in this group transferred voluntarily from Bellevue Hospital to Creedmor where Intensive Case Managers were assigned to them who were able to effectively refer and advocate for

admission of these patients to community-based programs and housing. The three women whose cases are reported were fortunate in being in the group that went from Bellevue Hospital to Creedmor. Once in this special unit they were referred to The Bridge, Inc., a mental health and rehabilitation agency. After a wait of several months, while the Communiity Residence was completed, they were admitted to Old Broadway House, a Bridge supervised community residence. The Creedmor unit operated for about two years and was successful in getting its residents placed in community programs. It was was closed when all those who were referable were transferred. The project was not institutionalized or made continuously available to additional patients. The successful collaboration between city, state and voluntary agencies in this project was a good illustration of the kind of effort required to interupt the revolving door.

CASE #5

The first of the three cases is a fifty-year old African-American woman who had been a long-time client of Project Reach-Out on Manhattan's Upper West Side. The record indicates she had taken up residence in a boarded-up, abandoned, vacant building at Columbus Avenue and 87th Street, one block from Goddard Riverside Neighborhood Center and Project Reach-Out. Her ability to care for herself, as observed by Project Reach-Out, diminished over time and when Project Reach-Out could not get her to a hospital voluntarily they called upon H.E.L.P. to assist in hospitalizing the patient. The woman was evaluated by the H.E.L.P psychiatrist on July 20, 1988 and diagnosed as delusional, psychotic, self-neglecting and in danger of harming herself. She

was involuntarily hospitalized at Bellevue Hospital. The H.E.L.P. chart does not indicate where in Bellevue she was treated or how long she was there. Several weeks later, on August 11, 1989 the patient was observed by H.E.L.P. team back in her old neighborhood.[2] On that date, a H.E.L.P. psychiatrist "designated" her for a second involuntary trip to Bellevue Hospital. This time she appears to have been admitted to the Homeless Psychiatric Unit from which she was shortly thereafter transferred to Creedmor. The patient remained at Creedmor until admitted to Old Broadway House of The Bridge in early 1990 where she has remained in a rehabilitation program.

CASE #6

The second case tells the story of a 50-year old, Latvian born, Caucasian woman who spent days in Grand Central Station, the Port Authority bus terminal and the Staten Island ferry terminal. These sites put her where there was heavy pedestrian traffic, public bathrooms, police, continuous lights and the opportunity to be observed and assisted. The H.E.L.P. record indicates there was a first brief contact by a team in early September, 1988. On the 15th of September, in a second contact the patient spoke to H.E.L.P. staff, saying she wanted to go to a shelter. She refused, however, to be transported by the team to the nearby Moravian drop-in center and shelter facility. There was, presumably no additional service provided during this contact and H.E.L.P. staff continued to "monitor" her regularly, at times as often as once a week. For almost a year, from September 19, 1988 until August 7, 1989, there were thirty-one reported H.E.L.P. contacts with the patient. On August 7, 1989 she was taken by Emergency Medical Service ambulance and not by H.E.L.P.

from Grand Central Station to Bellevue Hospital for treatment of an unspecified medical condition.

The patient was out of the hospital four days later and seen by H.E.L.P. teams at Grand Central Station on August 11th. She was subsequently seen by teams at the Staten Island ferry terminal and at Grand Central Station and was described in team reports as looking disheveled, and in failing health. There is a chart note indicating that the patient had around this time received treatment for cellulitis, presumably as a voluntary patient at a hospital.

Through repeated contacts, the patient is described as becoming increasingly communicative with H.E.L.P. staff although she remained opposed to voluntary psychiatric treatment. On November 6, 1989 she was "designated" by a H.E.L.P. psychiatrist and admitted to Bellevue Hospital Homeless Psychiatric Unit. She became one of a group of patients voluntarily transferred from Bellevue to a special unit at Creedmor Hospital from which she was in turn referred to The Bridge, Inc.'s new residential program at Old Broadway House. She was admitted to Old Broadway House on November 1, 1990 where she has remained in residence and in program. Work with this patient covered twenty-six months from the time she was identified until her admission to a comprehensive rehabilitation program which included supervised housing. In this case, city, state and voluntary agencies worked collaboratively for two years, which seems to be how long it takes for the client to develop trust, agree to be a patient and utilize an available service.

CASE #7

A third person, who also became a resident of Old Broadway House,

after being involuntarily hospitalized by Project H.E.L.P., is an African-American woman in her forties. The H.E.L.P. chart gives little historical information about this person who was first referred to the agency on June 15, 1988. She was not "designated" in this first contact but two weeks later, was given an involuntary trip to Bellevue Hospital on June 28th. She is described as inappropriately dressed, which probably means wearing layers of heavy clothing on a warm summer day. She is also said to have been mute, uncommunicative, and unclean.

This patient remained at Bellevue Hospital, did not seek release and became part of the group that voluntarily transferred to Creedmor Hospital for extended hospital care and treatment. She was at Creedmor until May 3, 1989, almost a year after her first "designation". On May 3rd while waiting to move to the community residence, she left Creedmoor without consent. Two months later on July 10, 1989 the outreach team of Lenox Hill Neighborhood Association had contact with her on the East Side and referred her again to Project H.E.L.P. who arranged her return to Bellevue Hospital. She was able also to return to Creedmoor Hospital from Bellevue and some months later was admitted to Old Broadway House.

The patient was known to Project H.E.L.P. for just over one year during which she was involuntarily hospitalized twice. The case record provides limited information about the patient, providing limited description of her behavior or her diagnosis. The patient appears to have been compliant when being transported to the hospital, and she utilized the assistance which is provided by Section 9.37 of the Mental Hygiene Law to be stabilized and helped to plan for her future.

The three patients who were ultimately admitted to Old Broadway House of The Bridge were able to profit from a co-ordinated system of care which offered thoughtful, concerned, professional services beginning at Project H.E.L.P. and its Bellevue Hospital Homeless Psychiatric Unit, a 28-bed specially staffed acute care program, and proceeding to the 50-bed long-term program at Creedmoor and then to a supervised community residence. These patients received, and were able to accept, much more attention and service than is seen in the typical emergency room admission and a brief hospital stay. They responded well to the activity and special attention they received. It is apparent that such services should be the norm and not "special" in order to move more mentally ill from the streets to restored lives and more independant function in the community.

The Project H.E.L.P. case records cover more than ten years of their activity with street-bound mentally ill in New York City. The records offer limited historical information about each person with whom they have worked but clearly demonstrate that it is relatively easy to hospitalize an obviously ill person and that the real difficulty is in providing appropriate services after the hospitalization. The records also demonstrate trends in the type of client seen over the years and, other changes in the homeless population. Of especial importance has been the rise in substance abuse and its effects on underlying psychotic conditions.

FOOTNOTES

1. The Larry Hogue case is discussed in New York Times articles as Appendix 13, 14, 15, 16 and 21.

2. This patient illustrates the regularity with which homeless people return to their adopted "places" making monitoring more possible.

CHAPTER 9

THE ROLE OF THE COURTS

There are, as we have seen, many issues of law become involved when the involuntary hospitalization and treatment of a person are ordered by an authorized physician or peace officer. Because there are legal issues, it is inevitable that courts of law and judges will become involved in determining when statutes and policy have been followed and when the hospitalized person has either had the benefit of "due process" or when it has been denied.

In New York State courts have been established in psychiatric facilities where judges decide on such matters as requests by patients to be released, requests by physicians (psychiatrists) and hospitals to have patients remain hospitalized and requests by physicians and hospitals to carry out specific treatments when they are against the patient's wishes. The law requires that requests by patients or hospitals be made within strict time limits, that patients be represented, either by their own attorney or by an attorney from Mental Health Legal Services, a part of New York State Office of Court Administration, that the hospital have its case presented by an attorney and that the proceeding follow regular rules of evidence. The proceedings are civil but they do not include a jury and generally exclude audiences in order to maintain confidentiality.

At Bellevue Hospital, a municipal hospital that is part of the New York City Health and Hospital Corporation, the State Supreme Court sits in

a Courtroom on the 19th floor of the new psychiatric hospital. It is a well-lit, attractive room filled with new pew-like benches, raised seats for the Judge, Court Clerk and witnesses. A court stenographer records the proceedings. The court calendar is arranged by a senior Bellevue Hospital nurse who administers the program. On the day the Court was observed, the judge was to hear cases from Bellevue and other Manhattan hospitals. The judge that day was State Supreme Court Justice Bruce Wright who had, some years earlier, been nicknamed in the press as "Turn 'em Loose Bruce" because of a reputation he had for releasing accused and indicted persons on little or no bail. The observer was checked out by a court officer before court began and was directed to a seat alone and toward the rear of the courtroom.

Case No. 1 of four of the matters before the Court the day of observation, November 2, 1992, was a petition by Lenox Hill Hospital, a voluntary, not-for-profit general hospital on Manhattan's Upper East Side requesting a court order to involuntarily retain and use specific medications in treating a patient. The request was presented by a hospital psychiatrist who read from the patient's hospital chart, describing the patient, his behavior, history, diagnosis, course of treatment and condition. The chart was accepted as evidence by the Court with the agreement of the patient's attorney that it was accurate and a "true record". The patient was represented by a Mental Health Services attorney who later questioned the psychiatrist primarily about the patient's dangerousness. The patient was also "sworn" and had a brief dialogue with the Judge.

The patient was a 35-40 year old, frail African-American homeless

man wrapped in a blanket who claimed he could not walk and who actually needed assistance into the courtroom and into his seat. There was no wheelchair available. The patient had gone to the Lenox Hill Hospital emergency room on October 4, 1992 complaining of severe leg and lower body pain. He was examined in the emergency room and admitted as a medical patient. In three weeks on a medical-surgical service, doctors found no physical reasons for his symptoms. The doctor described that during these weeks there was some improvement in the patient's over-all physical condition but at the same time an increase in his psychiatric symptomotology. The patient on the ward began to make claims that he was the President of Liberia. He would not eat hospital food and resumed his physical complaints and refused to walk. A psychiatric consult was ordered and he was diagnosed as "paranoid schizophrenic". The examining psychiatrist prescribed anti-psychotic medication. On the basis of the psychiatrist's assessment the patient was transferred to the hospital's psychiatric unit on October 29th. The patient objected to being in the Psychiatric Unit and refused to take medication. In order to retain the patient in the hospital and treat him with medication, it was necessary to request the Court order. The request to the Court was made on November 2nd, within the 72-hour legal requirement, (excluding weekends) for such requests ordering involuntary retention and treatment.

The patient's lawyer's questions of the hospital psychiatrist established that the patient had a history of psychiatric hospitalizations and treatment with medications to which he had what were said to be adverse reactions. The Court was informed that the patient was a homeless person known to Lenox

Hill Neighborhood Association Out-Reach Program. The attorney described him as not threatening or menacing. She stated he is harming only himself by refusing hospital food and that he insists he is medically ill. The lawyer informed the Judge that the patient wished to remain at the hospital but on a medical service and not in the Psychiatric Unit.

After hearing from the psychiatrist and from the patient's attorney, the judge questioned the psychiatrist about the medications the hospital wanted to use. It had been established that the patient had adverse reactions to Haldol and Cogentin. When the psychiatrist said patient would be given Prolyxin, there was a brief discussion between judge, doctor and lawyer about risks and benefits of various medications, including Prolyxin.

The patient who had heard all that was being said became slightly agitated and was eager to address the judge. Before addressing the judge, the patient called the psychiatrist a "liar" and then told the judge he wanted to get well in the hospital so that he could return to the Presidency of Liberia. When the judge asked him about "Charles Taylor", rebel leader in wartorn Liberia, the patient said he didn't know Mr. Taylor and had not heard of him. This seemed to conclude the discussion and Judge Wright, having made his decision, explained to the patient he was returning him to Lenox Hill Hospital psychiatric division where he was to remain and follow the recommended treatment. The judge granted the hospital's request and ordered the involuntary stay and treatment.

During the 30 minute hearing, the patient's attorney covered the issues of "dangerousness", the patient's experience with medication side-effects and

the patient's demonstrated ability to function in the community. Beyond covering these point, the attorney did not press for the release of the patient or object to his receiving treatment. The judge was very sensitive to the issues and his questions were useful in further demonstrating the patient's delusional and other symptoms of active mental illness. In this case it seemed that everyone was in agreement, including the lawyer that the patient needed additional in-hospital treatment and that the "common sense" rule prevailed.

Case No. 2 heard was a Bellevue Hospital patient's 72-hour application for release from the Section 9.39 facility. The patient was a Hispanic woman in her mid-thirties who was admitted to the psychiatric unit from the hospital emergency room where she had gone because of "rectal bleeding after being sodomized by a stick". She was admitted to the hospital psychiatric unit on October 26th and, on November 2nd was within the limits of the 72-hour provision under which to request her release.

The patient was represented by a Mental Health Legal Services attorney and the hospital was represented by a per-diem outside lawyer who usually handles Queens cases at the Creedmoor Psychiatric Center Courtroom. A staff psychiatrist presented the hospital's case for opposing the patient's request and introduced as reasons the following from the patient's chart:

The patient was acutely psychotic when admitted from the emergency room. She was described as having been homeless and decompensating since being sent away several weeks earlier from a shelter in Brooklyn where she had lived and where she had been working with an Intensive Case Manager. Although living in Brooklyn, she was known to the Bellevue Walk-In Clinic where

she received monthly intra-muscular Prolyxin treatment. She had prior admissions to Bellevue in 1989 and 1990. The earlier admissions had been voluntary due to "inability to function day-to-day" and reported suicidal ideas. The patient had been diagnosed as suffering a "schizo-affective disorder". She was also said to be a paranoid schizophrenic and having a thought disorder. The Bellevue psychiatrist requested the Court to deny the patient's request for release and order her retained for further treatment.

When the patient was sworn by the Court Clerk, she spoke in a heavy Spanish accent and asked to be referred to the hospital social worker. She said she needed help with a place to live and "social service". The patient appeared confused and when asked by the judge if she would remain in the hospital while community living arrangements were made for her she changed from asking for release to consenting to a 15-day stay in the hospital. The Judge ordered the extension and the patient's attorney did not question the decision. This case was completed in twenty minutes and again, "common sense" seemed to prevail.

Case No. 3 was a combined patient's application for release from a private psychiatric hospital and simultaneous application by the hospital for an order to retain the patient and provide medication treatment against her wishes. Gracie Square Hospital, the petitioner, had admitted the patient, a woman in her mid-fifties, on October 16, 1992 on a two physician certification that she required hospitalization and treatment.

The patient was diagnosed as suffering bi-polar disorder and in the manic phase of her psychosis. She was said to have threatened her husband

with a knife which she also is said to have threatened to use to harm herself. The Gracie Square Hospital psychiatrist reported that she had a lengthy history of psychiatric treatment.

Her story was presented by the hospital psychiatrist who described at length the hospital staffs' unsuccessful efforts to get patient to cooperate with prescribed anti-psychotic medications. The patient's Court supplied attorney questioned the psychiatrist about the recommended medicines, their side effects and benefits. When she questioned whether the patient presented a danger to herself or others, the psychiatrist further described the patient's hallucinations and her need for supervision and medication.

The patient, whose husband was not in court, was "sworn" and presented her story to the judge. Patient said she had a long career as a company executive, a good marriage and comfortable life. She acknowledged refusing medication which she related to being a "vegetarian", a believer in "holistic medicine". She said she had taken pills prescribed by her own psychiatrist who was now on vacation and had become agitated, leading to her hospitalization. Patient said she practiced yoga and meditation and that the knife with which she is said to have threatened her husband was "knives of the mind" only. She denied trying to harm herself or her husband.

This white, middle-class woman was not floridly psychotic but obviously confused. She seemed to be losing her grip on reality and was in serious emotional trouble.

The Judge asked the psychiatrist about what medicines were recommended and the Court was told the hospital wished to try the patient

on Lithium and one or two other medicines. The psychiatrist felt the patient required a maintenance medication regimen. The Judge spoke to the patient, urging her to cooperate with hospital staff and signed an order for 30-day hospitalization and involuntary medication if needed.

Case No. 4 was another Gracie Square Hospital patient requesting release after 72 hours in the hospital, which the hospital opposed. The patient, a 30-year old Middle-Eastern man had been admitted to Gracie Square on October 29th. It was not clear whether the admission was voluntary or otherwise. He is reported to have been a psychiatric patient since 1987 and according to the hospital psychiatrist had a history of bi-polar disorder including periods of "grandiosity", persecutory delusions and that he was now in a manic phase. The psychiatrist had seen patient privately several days earlier at which time he prescribed medication. Patient was then briefly hospitalized at another private suburban hospital, after which his wealthy family brought him back to the psychiatrist and then to Gracie Square Hospital. The patient had been subjected to considerable activity in a brief period when he was unstable and the hospital psychiatrist made the point that the patient needed to be stabilized in the hospital.

This case was different than the previous cases in that the patient is employed in the family's successful travel business, lives on Park Avenue, and can afford private psychiatric care and private hospitals. The court provided lawyer asked the psychiatrist the usual questions about the patient's danger to self or others which allowed the psychiatrist to put into the court record that the patient directed abusive language and physical threats at him. The

patient's lawyer established that he had actually recently used Lithium which had been prescribed by another psychiatrist. She requested the patient's release, pointing out that if released, the patient had a home and job, that he would see the psychiatrist and resume Lithium therapy.

The Judge then asked the patient's wife to address the court and express her preference. The wife described the patient as abusive to her, insisting he needed a different woman every night and disrupting their lives. She recounted how he was tipping doormen and cab drivers with $100. bills. She wished her husband continued in the hospital and her negative response seemed to indicate she preferred that he be hospitalized for a long time, or permanently. Her cousin, a physician, asked to be allowed to describe what he observed about the patient, but was not allowed by the judge.

The judge then wanted to hear from the patient who was "sworn" and sounded quite reasonable. He denied threatening anyone, could not understand why his wife was "against" him and saw himself being treated unfairly. He said he was eager to resume treatment with his regular psychiatrist and return to his "lovely home" and work. He did acknowledge recently giving doormen and waiters $100. bills as tips but said he knew this was "wrong" and would not again do so.

The judge, who heard the case for thirty minutes, spoke to the patient about his need for additional treatment and urged him to be cooperative with the hospital staff. He signed an order for three weeks of hospitalization. As the patient was being led from the courtroom, he cursed the judge and threatened to "get" the psychiatrist.

These four cases may or may not be typical of a day in court. They do illustrate, however, that a range of persons appear in court and although needing psychiatric care and treatment had seen themselves as being detained rather than helped. Patients are said to use the court to gain freedom at times but seem more often to find themselves ordered to remain in hospitals for treatment. On the day of this observation, the patients, whether poor and homeless or priveleged and educated, received very similar attention in the court. The Mental Health Services attorney represented each case in very much the same way and seemed sympathetic to each person's need for additional therapy. The judge seemed sensitive to individual situations and demonstrated knowledge about clinical issues. He ruled in favor of continued hospitalization in each case, stressing each person's need for treatment even though this meant loss of freedom. The Judge did not seem overly concerned with each patient's danger to others and did not stress whether each patient was a danger to his or herself according to Cleveland, Mulvey and Appelbaum (1989).

> Data from several studies suggest that an important reason for the negative findings is that the dangerousness-based statutes, once thought to be restrictive and precise, allow a good deal of discretion in application. Moreover, statutory standards seem to be ignored when both clinical and judicial decision makers believe that hospitalization is necessary on some "common sense" basis.

The four patients observed in court all needed further in-hospital treatment and follow-up community-based services and the Court, in a "common sense" manner ordered such. The clinicians, lawyers and Judge all seemed to interpret the standards according to what was "good for the patient". The three hospitals, and the psychiatrists representing them, chose to retain and treat

uncooperative, threatening patients they could have, under the statutes, released. Their assuming such responsibility adds weight to the Court's siding with clinicians as happened in these cases. McLeod and Milstein conclude in their study of hospitalization at Bellevue Hospital "over all the Homeless Initiative demonstrated that the legal system is not an obstacle in providing treatment for the most neglected of our patients".

It seems clear that judges who hear cases in the courtrooms of psychiatric hospitals have considerable discretion in how they view involuntary hospitalization, treatment and commitment. These judges can have varied knowledge and understanding of mental illness and have biases which become part of their decision to grant or deny requests for release or remand. Their function seems most clearly to be the safeguarding of the principle that those who need treatment, and **only those** get it, even when against the patient's wishes.

CHAPTER 10

MAJOR FINDINGS

This case study explores the experiences of a number of homeless mentally ill persons who spend their time in sections of Manhattan, in New York City. They have been clients or patients of outreach programs, received services in hospitals and social agencies. Many of these people have been street-assessed, transported to psychiatric emergency rooms, hospitalized and treated against their wishes. There is no "official" count of how many mentally ill live among the larger number of street-dwelling, or "homeless" in New York City. It is generally agreed that there are perhaps 10,000 mentally ill homeless in the city and that they constitute about one-third of all those who survive either on the streets, in transportation terminals and other "unorthodox" places. It is also commonly agreed that the homelessness of many mentally ill is an unanticipated by-product of the combined emptying of psychiatric hospitals and the insufficient preparation and capacity of community-based mental health and social services organizations to provide necessary shelter and care to released mentally ill, system-dependent patients.

In 1979, New York City funded its first outreach program under the newly organized Community Support Services program to locate, identify and contact mentally ill persons living on the streets. That year, Goddard-Riverside Community Center sponsored Project Reach-Out to find and serve undomiciled mentally ill who were spending their time in the area bounded by 59th and 110th

Streets, from Central Park to the Hudson River. Three years later, in 1982, Project H.E.L.P., the first of Mayor Edward Koch's two homeless initiatives, was set up to both respond to referrals from agencies and individuals about streetbound, ill people needing help and also to themselves seek out such persons in the downtown, mid-town and Upper East and West Side areas of Manhattan. From 1982 until Mayor Koch's second initiative in 1987, Project H.E.L.P. provided services to many thousands of individuals, including transporting many hundreds to Bellevue Hospital. In 1987 the Bellevue Hospital Homeless Psychiatric Unit was established which provided expedited admission to the hospital and ongoing psychiatric care. With the availability of set-aside beds at Bellevue, H.E.L.P. has transported a higher proportion than earlier of its patients to the hospital. Those involuntary trips to the hospital were authorized under Section 9.37 of the State Mental Hygiene Law, and is a subject of this case study. The following are major findings of the study:

I. Who Has Been Served By Outreach Programs

The files at Project Reach-Out and Project H.E.L.P. contain many thousands of cases of men and women who were identified and have received services since 1979. Project Reach-Out, which began its work in a Winebago camper from which workers went out to locate the undomiciled mentally ill in its area, has great community recognition and acceptance and over the years added substantially to its services. The project has grown to include day program, clinical, health counselling, advocacy, temporary housing, vocational planning, work readiness and referral services. The project has demonstrated

its ability to work with very resistive, help-rejecting individuals who over time do frequently come indoors and utilize services. The homeless mentally ill tend to spend their time in a few favorite places and predictably return to their "turf" after absences. This has enabled Project Reach-Out to monitor the known cases and to rapidly identify new cases within the boundaries of Community Board #7. The Winebago has been replaced by radio equipped vans that patrol the area days and evenings. Staff still rely on bags of sandwiches and drinks as engagement tools in contacting their clients. The teams make 500-600 contacts a month in winter and 1,000 a month in summer. Of these, 75% are contacts with known persons and 25% are fresh cases. Among the known cases are those who have survived in the streets without accepting any indoor services or residences as well as those who have left the streets for a time either by being hospitalized, jailed, lived in a residence or S.R.O. and returned to the streets. The "typical" Reach-Out patient has been homeless four to five years, and has been diagnosed suffering either schizophrenia, affective disorder or head injury.

In November, 1986, Diane Sonde, Director of Project Reach-Out reported in a New York Times Article by Daniel Goleman

> Project Reach-Out has recently averaged each month 479 street people it is in contact with regularly--people who day after day, unless they wander elsewhere for a time, are on a bench or sidewalk, or perched on a rock in the park. An additional 120 or so people are approached just once, never to be seen again. And, in any given month, about 25 percent of the street clients will accept the invitation to come into the project office where they receive anything from a cup of coffee and a shower to a room, financial aid and psychiatric care.

On a larger geographic scale, Project H.E.L.P. is in contact with many

more hundreds of patients each month, the great majority of whom are men and women the Project has known and is following. Project H.E.L.P., like Reach-Out, sees many people once only and frequently "designates" individuals in the single contact who need assistance and when a team feels the person will not stay in a regular spot at which to be monitored.

Project Reach-Out on the Upper West Side and Project H.E.L.P. in most of Lower Manhattan have identified, approached and served many thousands of homeless mentally ill. Like Project Reach-Out, H.E.L.P. teams spend more time with cases they are monitoring than with new cases and they report fewer new cases annually for several years. A H.E.L.P. team leader reported at a recent meeting that there were only eight old "hard core cases" remaining in Grand Central Station and no reported new cases in that terminal. An outreach program on Manhattan's Upper East Side, Lenox Hill Neighborhood Association, has been identifying the seriously mentally ill homeless for more than five years. This project seems so familiar with each case in its sector that it called H.E.L.P. for assistance when an unidentified barefoot woman who might need to go to a hospital was wandering in their area.

All three outreach programs report working primarily with confused, isolated, disaffiliated men and women whose judgment has failed and who seem stuck in an existance out of which they need to be coaxed or involuntarily removed. All report that people need to be contacted repeatedly and that work usually goes on with an individual for several years. None report getting homeless mentally ill people "unstuck" quickly and their clients are frequently the "revolving door" person who gets hospitalized many times.

II. The Increase In Substance-Induced Psychiatric Disorders Complicates Getting Services For Some Individuals

Recently a case on the Upper West Side of a known mentally ill man who became assaultive, abusive and paranoid when using street drugs has called attention to the rise among homeless mentally ill of substance-induced psychotic states. Discussions with Project Reach-Out and Project H.E.L.P. staff confirm that the incidence of alcohol abuse and other substance-induced behaviors has been increasing among known and new patients. This is not surprising given the greater availability of street drugs and the vulnerability of the homeless mentally ill. The incidence of substance-induced psychosis needs to be documented and consideration given to modifying mental health statutes to provide appropriate involuntary care when indicated.

Projects Reach-Out and H.E.L.P. offer patients referral for detoxification programs and provide other, limited substance-abuse services. According to Commissioner Marcos (letter of November 9, 1992 in Appendix 25), "The current Mental Hygiene Law expressly excludes substance abuse from its definition of mental illness and separates the provision of care to the mentally ill from provision of care to substance abusers. Specifically, it excludes emergency involuntary treatment for substance abusers." In light of the increase of such cases, Commissioner Marcos has proposed amending the Mental Hygiene Law to add substance-induced disorders as requiring emergency admissions for immediate observation, care and treatment.

III. New York's Statutes Do Allow For The Involuntary Hospitalization and Treatment Of All The Homeless Who Need It

The statutes provide for involuntarily hospitalizing and treating those

whose psychiatric disability and lack of judgment makes them a danger to themselves or others. These laws protect individuals from capricious, unwarranted detention and also protect society by defining who is a danger and authorizing the removal of people who should be hospitalized and treated. Appelbaum and others note that recent studies indicate that those needing involuntary treatment, and **only** those requiring it are being accomodated under the usual "dangerousness" standards. Applebaum is a psychiatrist who is knowledgeable and writes about the law. In his work he seeks a balance between threatening to harm self or others and clinical judgement as the basis for involuntary hospitalization.

At Project H.E.L.P. it is felt that statutes under which it operates are adequate to assure appropriate treatment for their patients. The agency and its Director, Dr. Sam Tsemberis, in public hearings, have not supported efforts to substitute criteria of "gravely disabled" for "dangerous" in order to liberalize the basis for involuntary trips to the hospital. Recent studies support this position, indicating that individuals needing involuntary treatment were not denied it by the statute. In those instances when hospitalization was indicated but did not occur, it is more likely the result of the interpretation of the statute by the psychiatrist making the street assessment or by the psychiatric resident in the hospital emergency room. The statute, Section 9.37 of the Mental Hygiene Law, is subject to wide interpretation. Outreach workers and hospital psychiatrists become known in the field for how they interpret the law. At Project H.E.L.P. the story is told of how years ago staff would take patients to Bellevue Hospital on days they knew certain emergency room

psychiatrists were on duty and avoided "designations" when other doctors were on duty.

IV. The Rule of "Common Sense" Often Prevails In Court Proceedings More Than Statutes

Appelbaum, a leading psychiatrist and researcher in legal issues in psychiatric treatment, makes the point that regardless of concern about individual's rights and due process, frequently everyone involved in a case agrees that the individual's self-neglecting, confused, behavior warrants a trip to the emergency room for treatment. He refers to this as the rule of "common sense". At Project H.E.L.P. the experience has been that about one-third of the patients they designate each year are in the common sense rule category. Such patients advance readily from street assessment to hospital admission and court ordered retention and treatment. They seem able to get people working together to assist them and it would appear that a floridly psychotic person is recognizable to professionals, non-professionals, magistrates and the citizen making the telephone referral. There are cases in which there is little controversy, and others in which the hospital physician may disagree with the street psychiatrist about the need for admission or instances in which the judge may disagree with the hospital and order a patient released.

The four cases observed in State Supreme Court at Bellevue resulted in court ordered extended hospitalization and treatment with specific medications in each case. All patients were represented by the same Mental Health Legal Services attorney who made minimal points opposing retention and treatment but who appeared to recognize that the conditions of these patients required further treatment. It is conceivable that another lawyer might

have represented the patients differently or that another judge could have decided the cases differently. Further observations in the court would be useful in establishing patterns for ways in which cases are handled and adjudicated. In these cases it seemed to make good "common sense" for the Court to order treatment. Project H.E.L.P. estimates that after five years of experience with the 9.37 process the Court now sides with clinicians and hospitals in about 90 percent of its cases. This increase in the "common sense" approach to involuntary treatment is one reason Project H.E.L.P. feels existing statutes are adequate and do not require more liberal language.

V. Practice Skills, Attitude And Judgment Of Outreach Teams Determine Who Is "Designated" Under Section 9.37

The statute defines that persons needing "immediate hospitalization" are to be transported by police on petition of a physician authorized to order it. The need for "immediate hospitalization" is then left to the decision of the outreach team psychiatrist making the street assessment. Observation of this process of assessing street-dwelling persons, together with information from Project H.E.L.P. staff indicates that there are substantial differences in performance among team psychiatrists, social workers and nurses which are based on their experience, skill and attitude.

In the case of David, an elderly white male who was taken involuntarily to the hospital for the medical care he himself was not seeking, it is possible that a different team could have handled the case very differently. David did, in the end, walk into the St. Luke's Hospital emergency room when the Emergency Medical Service team declined to transport him to the Bellevue Hospital emergency room. David's designation was ordered by an experienced

psychiatrist who had prior contact with the patient. The psychiatrist determined that David needed life-saving medical attention and became focused on bringing David to the special unit at Bellevue Hospital. There never was discussion with David about voluntarily walking a few blocks to St. Luke's Hospital. A different team, possibly led by someone like H.E.L.P.'s Chief Social Worker, Marty, might have recognized this possibility and avoided the lengthy and costly "designation". As it developed, David was held in the St. Luke's Hospital emergency room and transferred to Bellevue Hospital where he voluntarily remained for several months.

The experience, skill and attitude of the team psychiatrist in making decisions about hospitalization was evident in two other observed cases. In the case of Freddy, the young African-American man panhandling in front of a supermarket, the physician who made the assessment seemed ill-at-ease, uncertain and she was easily put off by the patient's help-rejecting behavior. She did not seem to seriously evaluate the information given by the local outreach agency who knew the patient and were monitoring him. The outreach staff had reported his deterioration and need for hospitalization in requesting H.E.L.P.'s assistance. The physician decided that the patient was not psychotic, that his mental status was intact and that basically he needed to be showered, cleaned up and given clean clothing. The team nurse, an experienced professional did not question the physician's decision, agreeing that he should be encouraged to seek medical care. While the patient could be said to be making an adaptation of sorts to living on the street, he did seem physically ill and self-neglecting. He could have qualified on that day as a person needing

hospital care and it seemed evident that if he remained in his usual space another team would soon be arranging his removal to the hospital for medical care.

In the third case, the assessment of the young man who approached the H.E.L.P. van asking for help was made by a psychiatrist new to the organization and its practices. She conducted a thorough examination of the patient and then shared the decision about designation with the more experienced social worker who recommended out-patient treatment and referral. The psychiatrist seemed comfortable in agreeing with this recommendation.

VI. Distinguishing Between An "Emotionally Disturbed Person" And Self-Neglecting Streetbound Mentally Ill Is Important In Arranging Street Assessment

Outreach teams that respond to calls to help with mentally and physically ill people living in the street must be able to rapidly determine whether the individual will become violent or need to be subdued and restrained. From time to time there are reports of injuries or deaths occurring when police or others approach an out of control, crazed individual. Outreach teams are not trained or equipped to deal with such persons. These difficult cases quickly become police responsibilities when public safety is an issue. The Police Department has provided limited training in dealing with "Emotionally Disturbed Persons" and has developed special equipment for approaching "Emotionally Disturbed Persons" who might be armed or combative. In 1989 the New York City Police Department demonstrated a video equipped robot tht could be sent into a room to "see" and send back pictures of events in the room to police outside. Other equipment included motorized shields from behind which police could safely negotiate with an "Emotionally Disburbed Person".

Project H.E.L..P. and Project Reach-Out staffs rely on police to take full responsiblity for detaining and managing menacing, beligerant, armed and dangerous mentally ill persons. They rely on police primarily to assist them with confused, oppositional people like David. Staff of the two outreach programs report that their experiences with police have often been negative, principally because police who are sent to assist them are not well trained for the task and do not have required skills. The outreach staffs need to feel physically safe as they do their work among the mentally ill. Project H.E.L.P. has developed a guide for staff which teaches how to safely approach patients in the street and how to carry out street assessments. The cases observed in this case study involved patients who did not pose physical threats and when teams were asked how they would respond to an agressive, paranoid patient, the answer was that they wouldn't approach such a person but would advise the referring person to call for police.

VII. Police Training For Assisting With A 9.37 Designation Needs Improvement

Staffs of both Project H.E.L.P. and Reach-Out tell of no longer calling police precincts for assistance because the response was often slow, uncertain, overly forceful or not firm enough. Precinct officers seemed to resent interrupting their own activity to respond to calls to help in getting a mentally ill person to the hospital. The officers who responded often did not know about the law defining involuntary trips and refused to take someone against their will. Project Reach-Out staff have found getting police help through the "911" emergency system more satisfactory when a patient who is in their offices or day program becomes difficult to manage and needs to be removed. Police

in the "911" system know they may be called to help in such an emergency and are said to arrive more prepared.

Project H.E.L.P. has a special relationship with the Police Department Manhattan North Task Force which permits them to by-pass the precinct and "911". The arrangement provides a more prompt response although no assurance that the officers who arrive have been trained or are aware of techniques for interacting with mentally ill people.

VIII. The Training, Biases And Skill Of Hospital Psychiatrists Often Determine Who Gets Hospitalized.

The psychiatrist's street assessment leading to an involuntary trip to the emergency room has to be redone by the hospital psychiatrist and the examiners must agree before the patient is admitted. This "gatekeeper" has the latitude to readily agree, or be uncertain, or to disagree. The resident may not wish to commit a bed during a busy time or may prefer to have the medical/surgical staff admit the patient or may simply be too new and inexperienced to recognize the severity of patient's pathology. In the first years of Project H.E.L.P.'s activity, most people brought to the emergency room were "treated and released", or given medication and returned to the streets. With the development of the Homeless Psychiatric Unit at Bellevue Hospital, almost all those brought are admitted. Recently, many of the Bellevue psychiatrists have worked part-time at Project H.E.L.P. where they have had training and experience in working with street-dwelling mentally ill. This seems to have increased the rate of agreement needed for hospital admission.

IX. Those Who Become 9.37 Designees Are Among The Most Dysfunctional And Difficult Patients To Refer For Ongoing Services And Rehabilitation

The continuous work of New York City outreach programs has had the effect of creating the wide end of a funnel, through which large numbers of mentally ill are brought to the hospital. Once treated they must later emerge from the hospital through the much narrower end of the funnel in order to be referred to residential, day, or clinical programs. Many of those brought to hospitals, voluntarily or, more often against their wishes, have been isolated, disaffiliated, and disorganized for a long time. They have become distrustful and refractory to traditional treatments and require more extended contacts with helpers in preparation for program utilization. The usual referral process, with its timed, sequential steps, must be adjusted to accommodate those who have hidden away from people and avoided being known. Those mentally ill homeless who are the most disabled have obliterated their histories and previous lives and must be systematically assisted in restoring order and structure to their present and their future. This requires more steps in the process while the patient is in a stable environment.

The promise by various governmental agencies of programs and housing with services in the community has gone unfulfilled for many years. As a result there are not nearly enough places for people to go from the hospital. Those programs even willing to consider accepting the homeless mentally ill become "silted up" in short order, causing back-up throughout the system. The complicated, unattractive or difficult patient seems to be left behind, especially if he or she has not readily embraced the idea of living in an orderly, supervised arrangement.

X. The "Revolving-Door" Phenomenon Reflects The Lack Of Post-Hospital Programs More Than The Limitation Of The Mental Hygiene Statutes Which Are Effected By It

The files of New York City's outreach programs tell the stories of thousands of men and women living on the streets and suffering the consequences of mental illness who require long-term clinical, rehabilitative and residential services. Many have been repeatedly hospitalized under Section 9.37 or other statutes but return to the streets when there is no place else to go on leaving the hospital. The statute permitting their hospitalization is well intended and broad enough to insure that a person at serious risk be readily hospitalized and briefly treated. The acute-care hospital, however, cannot be the locus of long-term care.

There have been very positive results when New York City and State have collaborabed on a policy to provide a stable treatment environment for patients awaiting referral to community residences at Creedmor Psychiatric Center following an acute-care hospitalization at Bellevue Hospital. The continuum from Bellevue's Homeless Psychiatric Unit to a special intermediate care unit at Creedmor demonstrated that when patients are not sent back to shelters or the streets after brief hospital stays, but can be treated for longer periods, they utilize community placement more effectively. When the Creedmor unit was closed, after approximately two years, Bellevue Hospital created a hospital based Transitional Living Center which replaced it, providing ongoing treatment and "holding" patients awaiting long-term community placement.

The "revolving-door" as it is known and the numbers of people caught in it are clearly determined by the availability of suitable post-hospital community-based services and not by hospitals' willingness to admit patients.

XI. Outreach, In-Patient And Other Organizations Are Developing Comprehensive "Shelter and Care" Services To Meet Patient Needs

The Community Mental Health Centers Act of 1963 envisioned the creation of comprehensive community-based programs to care for patients exiting the down-sizing psychiatric hospitals. This change in locus of treatment from huge asylums to small, community-based services rarely happened, however, except in some rural areas. The few community mental health centers developed in large urban areas, such as New York City, were quickly overburdened by the large numbers of former psychiatric hospital patients swarming to the cities seeking needed clinical and basic supports and services. The 1960's and 1970's found that unprepared communities were hosting large clusters of unwelcome, unfamiliar people who had nowhere to go and little to do. By the 1980's, state and local support programs had developed to engage many of these patients in day or evening programs as well as providing supervised housing. In the 1980's outreach programs were created in New York City to locate, identify and secure services for those who were uninformed about services or were reluctant to request assistance. The experiences of outreach programs in the 1980's and early 1990's seem to indicate that usual referral systems did not provide sufficient services to their clients because of the scarcity of programs and the special problems their clients present. As a consequence, these outreach programs have added their own services, such

as temporary and transitional housing, day programs, drop-in centers, vocational and job counseling, clinical and health services. The agencies have found that "linkage" does not sufficiently produce the results in day programs or housing which they seek for their clients.

While these expanded programs undoubtedly provide important services to otherwise unserved men and women, there seems to be an unasked question as to what will be their work in the future when homelessness among the mentally ill may not be the problem it is today.

XII. The Mentally Ill Among The Homeless Truly Reflect The Policies Of De-Institutionalization and Non-Institutionalization

The fact that many mentally ill are today denied admission to state psychiatric facilities is periodically highlighted when we learn that horrible crimes have been committed by a person who has made repeated visits to psychiatric emergency rooms only to be sent away with three days of anti-psychotic medication and an out-patient clinic appointment, or hospitalized briefly and sent back to the streets. In New York City it is clear that the network of community-based services, while it has grown and expanded, has not been sufficiently supported to develop the necessary capacity to absorb all those released from or turned away from state psychiatric facilities.

Some of the policy questions inbedded in non-institutionalization include civil liberties, the value of clinical judgment, fiscal conservatism, political expediency and attitude toward disability. It is well known that relapse in mental illness can be delayed and avoided by (1) proper medication, (2) work, or structured, productive time, (3) stress reduction. The individual given a

trip from the streets to an emergency room is at that moment at least a candidate for help in reconstituting, stabilizing and avoiding relapse. The non-availability of the long-term psychiatric hospital option means he or she will have to improve quickly and stay better to avoid the "revolving door". The community-based services which have assumed responsibility for many, perhaps most, of those who left hospitals for insecure, unsafe, cheap housing and then spilled into the streets, have not yet developed the capacity to care for all who need help.

FOOTNOTES

1. The case of a man identified as Larry Hogue has been followed and written about by the New York Times. Several of the articles are appended.

2. The Project H.E.L.P. Guide is Appendix 12.

CHAPTER 11

COMMENTS

The investigator's bias and assumption when beginning this case study was that not enough was being done by organizations responsible for removing the large number of obviously mentally ill people still living on New York City streets. Why were more people not being assisted to safer, helping environments and rehabilitation? These people were suffering and projecting their pain and anguish onto those who were more fortunate and who allow themselves to notice their condition. It seemed that they should be taken more regularly, involuntarily if need be, to hospitals for emergency treatment, stabilization and preparation for rehabilitation activities which would lead to re-built lives. It seemed that the following four major issues were contributing to the "revolving door" process and the continued presence of homeless, mentally ill living on the streets of New York City.

The annual combined budgets of the four outreach programs in New York City during the period of this case study (1991-92) were reported by the New York City Department of Mental Health, Mental Retardation to be more than ten million dollars. When the costs for police and Emergency Medical Service are added to this, the cost each time a mentally ill homeless person is served on the street or transported to a hospital may exceed several thousand dollars. There has never been a way to provide mental health services cheaply

and those fiscal conservatives who saw large savings by closing psychiatric hospitals have probably learned by now that care in the community is also costly. It should also be clear that providing no services early is, in the long run, even more costly. Such total cost information does not seem to be collected anywhere and is not published. It would appear that the expense of serving an individual as an emergency who appears and re-appears on the street will exceed the cost of his rehabilitation within a comprehensive community mental health and residential program.

As a result of observing the process of aiding mentally ill among the homeless, all four assumptions have been seriously modified and it seems evident that the continued presence of mentally ill men and women on the street is primarily caused by the lack of suitable places for them to live and to receive the support services they need.

The first assumption was:

The Statutes Were Restrictive and Discouraged Escorting People To Hospital Emergency Rooms.

Observations in the field, combined with interviews with outreach workers and social agency executives make it apparent that the New York State's Mental Hygiene laws are not overly restrictive and in fact, provide ample authorization for assessing people in the street and, when necessary, having them hospitalized. In addition, since 1987, New York City has created special units at Bellevue Hospital to expedite admission and treatment of persons brought by police to the hospital under Section 9.37 of the New York State Mental Hygiene Law.

The interpretation in the field does vary as to which conditions meet the standard of dangerousness among the physicians making the street assessments. The outreach physician makes the decision as to whether an individual is able to make an adequate adaptation to street-dwelling conditions and is not in danger of harming self or others. The individual being observed and not given a trip to the hospital by one outreach team may very well be ordered to an emergency room later that day or on a subsequent day by another team. There was considerable difference in experience and skill among the teams and psychiatrists observed during trips with several teams. These differences, rather than the 9.37 statute, seemed to determine who got "designated".

According to Dr.Tsemberis, Director of Project H.E.L.P., Diane Sonde, Director of Project Reach-Out and Michael Friedman, Director of Westchester Mental Health Association, the statute was sufficiently liberal and permissive and should not be changed to make it more liberal. They point to the Washington State experience of over-utilization of involuntary commitment when "gravely ill" replaced the "dangerous" standard. The "dangerous" standard called for psychiatrists to determine whether individuals would harm themselves or others within a defined time frame. In contrast, the "gravely ill" standard requires only that the individual is impaired and unable to make self-preserving decisions. The "gravely ill" option makes it possible to involuntarily transport and commit many more individuals.

The second assumption was:

There Were Not Sufficient Professional Organizations In The Field To Implement "9.37".

During conduct of the study it was learned that New York City has an extensive network of outreach services capable of identifying and assisting almost all of the sick, bewildered, disaffiliated mentally ill living on the streets, in parks and in transportation terminals. Project H.E.L.P.'s day and evening teams operate every day of the year and are able to locate and observe people in lower Manhattan as well as respond to referrals in other sections of the borough and part of Brooklyn. The midtown area is covered by several programs, including Manhattan Bowery Corporation and the Open Door. The Upper East Side is served by the Lenox Hill Neighborhood Association Reach-Out Program and the Upper West Side by Project Reach-Out of the Goddard-Riverside Community Center. These organizations have in the past 10-12 years identified, assisted and monitored many thousands of mentally ill people, some of whom are contacted just once and others who become ongoing clients for many years. This often unrecognized network seems adequate for serving ongoing clients as well as rapidly engaging newcomers to their areas and making referrals to Project H.E.L.P.

The third assumption was:

Emergency Room Psychiatrists Were Rejecting And Not Admitting Homeless Mentally Ill.

During this study, it was learned that all municipal hospitals and those voluntary hospitals operating Section 9.39 emergency rooms were required to accept 9.37 patients but that most, if not all, such patients were being taken to Bellevue Hospital where a Homeless Psychiatric patient unit has been created, as well as a Transitional Living Center and a men's shelter. The Transitional

Living Center, nine hundred-bed men's shelter and Homeless Psychiatric Unit at the hospital give it the appearance of a community residence program within a hospital. It appears that this model is useful in better preparing individuals for referral to non-hospital programs. Since these special units for homeless persons were developed, almost ninety percent of the Project H.E.L.P. designations have been admitted. While there are inevitable differences in skill and attitude among emergency room psychiatrists, there seems now to be a more relaxed interpretation of the dangerous standard and increased willingness to admit and treat Project H.E.L.P. patients.

The fourth assumption was:

The Judges Are Reluctant To Order Involuntary Commitment Or Treatment And Side With Patients Who Request Release.

Observation in the Court seemed to indicate that the rules of "common sense" prevail most often and that there is usually agreement among judge, lawyer and clinician that patients who evidence clinical signs of illness need to be treated over extended periods of hospitalization for which they need to be committed. Project H.E.L.P. estimates that in more than ninety percent of cases in 1991-92 judges accepted medical recommendations for treatment and commitment. On the occasion when Court was observed, all four patients, two of whom were mentally ill homeless people and two of whom were not, were ordered by the judge to remain in the hospital and to accept treatment, including specific medications.

CONCLUSION

This study has revealed that in New York City the continued presence of mentally ill among the homeless reflects continuing conflicts between the city and state about responsibility for intermediate and long-term in-patient treatment, conflicts between clinicians and libertarians but, most importantly, a lack of supports for voluntary agency sponsored community-based programs to develop the capacity for replacing the total care previously provided by the state operated psychiatric facility.

The low-level, constant uneasiness of community resident does not seem to bring about support or demand for programs to relieve either their concerns or the suffering of mentally ill among the homeless. Periodically a violent act against self or others by a homeless person in the community does make headlines and with it comes renewed calls for action by the public and authorities.

The homeless mentally ill, whether street-bound or in shelters, draw attention to themselves when one of them stabs a young actress, menaces a neighborhood, or bludgeons an 80 year old woman to death. Following these recent violent acts, New York's governor, and the state and local commissioners, called for action to locate potential "killers" among the thousands of undomiciled mentally ill in shelters and remove them to city and state psychiatric hospitals. In a most recent case (January, 1993) a homeless man living in a shelter accused of committing a homicide, had long been known to psychiatric and criminal justice systems. He has for many years been part of the revolving-door army

of people suffering mental illness who, until they commit a horrible crime, seem to be no one's concern. There appear to have been a number of points at which this individual could have been inducted into a treatment program but was not. While we do not have information about efforts to engage him in treatment, it is likely that he was a difficult, resistive person whose condition was complicated by substance abuse.

The case once again brought public attention to the obvious need for psychological, social, vocational and clinical services to enable people to live successfully in the community. It also again reveals how people with serious and persistent mental illness are, as a result of the state's program of non-institutionalization, locked out of intermediate and long-term psychiatric hospital treatment.

A New York Times article of January 22, 1993 quotes New York State Commissioner of Mental Health as saying that shelter "residents who are dangerously mentally ill will be identified and placed in state mental hospitals, in some cases against their will". This policy, according to the Times, was "immediately attacked by the New York Civil Liberties Union, which said that involuntary hospitalization might well violate the rights of homeless people". The Times writer goes on to say that "while the program may identify and treat some extremely sick people, it does not deal with the deeper reasons that lead to thousand of New Yorkers flowing in and out of mental hospitals, jails, shelters and the streets".

CHAPTER 12

RECOMMENDATIONS FOR ACTION AND FUTURE RESEARCH

The statutes governing involuntary hospitalization of street-dwelling mentally ill seem adequate to insure that any individual requiring a trip to the hospital could be accomodated. The creation of the Psychiatric Homeless Unit at Bellevue Hospital and its Transitional Living Center allows for expedited admission of individuals brought to the hospital by Project H.E.L.P. In addition to Project H.E.L.P.'s case finding, several local outreach programs also identify and serve the mentally ill on the streets. This study reveals that in some sectors most, if not all, homeless mentally ill are known or could be identified. The continuation of the revolving door of brief hospitalization and return to the streets is largely attributable to the scarcity of places for the homeless mentally ill to go after the psychiatric admission. Two recommendations are made to alleviate the "revolving door". **First,** the creation of additional comprehensive community residences and, **second,** the creation and utilization of small, locally-based assessment centers for crisis stabilization and patient preparation for community residence and comprehensive mental health services.

The service network in New York City has successfully provided crucial services to large numbers of homeless mentally ill and its capability to do more needs to be expanded.

RECOMMENDATIONS

The **first** recommendation is for the expansion of voluntary agency sponsored community-based mental health, rehabilitation and social services designed specifically for the mentally ill homeless. It appears to this investigator that outreach services in several areas of the city have developed knowledge and skill in rapidly locating and identifying street-dwelling mentally ill within their geographic areas. When they collaborate with Project H.E.L.P., an organization authorized to order involuntary trips to hospital emergency rooms, those outreach programs have the potential capability of enrolling all homeless mentally ill in programs that include hospitals and community-based programs. In order to facilitate a program in which the homeless mentally ill have services and a place to go, a **second** recommendation is the establishment of a small, thirty to forty-bed, assessment center in each sector of 100,000 population of New York City. The assessment center should be located where homeless mentally ill are known to be concentrated and preferably in an area served by a general hospital.

The assessment center would be a free-standing not-for-profit facility licensed to accept people for evaluation and emergency treatment who are brough by outreach teams, police, families, community groups or who are walk-ins, every day, 24 hours a day. The assessment center would supplement

rather than replace the existing procedures for removing mentally ill homeless from the streets. An appropriate legal status would have to be worked out to allow carrying out the diagnostic and treatment functions of an Article 28 facility under the State Public Health Laws as well as designating the facility under Sections 9.37 and 9.39 of the Mental Hygiene Statutes. The center would be staffed by medical, psychiatric, nursing, social work and other personnel who could readily evaluate each individual. Such evaluation would be carried out on the street level floor of a multi-level structure to be designed. An individual requiring in-hospital medical or psychiatric care would be transferred to a hospital as soon as possible. Others deemed to be in crisis but not needing to be in a hospital would remain in the center and moved to a second-floor room for non-medical detoxification, personal hygiene, medication, stabilization and rest.

Those individuals who respond to "psychological intensive care" on the second floor and who are felt available for referral to community-based programs offering shelter and care will be moved to third or higher floors where they will receive ongoing observation, daytime activities, stress reduction and medication adjustments while being assisted in the referral process by case managers. Those who are accepted for residential placement and are awaiting transfer would be moved to single rooms on the uppermost floors. They would be encouraged in this phase to participate in day treatment programs outside the facility.

Individuals who do not respond to early referral and transfer could be retained on intermediate floors for extended evaluation and preparation.

Those who were decompensating on the streets and are unable to compensate sufficiently to remain in the community would be referred for the longer-term supervised and structured environment of a psychiatric hospital.

The assessment center should be identifiable as a facility serving the neighborhood and community as well as the individuals brought to it. It should be less institutional than a hospital and less overburdened than the hospital's emergency room. An assessment center could provide Project H.E.L.P. with an alternative to waiting for an individual they are observing to deteriorate on the street before hospitalizing him. Individuals might more readily enter an assessment center as voluntary patients than a hospital.

The assessment center could become the often missing necessary step in the process of encouraging the mentally ill homeless to come indoors and participate in their own treatment and rehabilitation.

It is the investigator's finding that outreach to street-dwelling mentally ill, including transporting them to psychiatric emergency rooms when is necessary, is very effective and that expanding such programs could materially alleviate the suffering of street-dwelling mentally ill persons. It is evident that when government acts responsibly to support programs like Project Reach-Out and H.E.L.P., many lives are saved and many people are restored to successful community adjustment. When Government makes services to street-bound mentally ill a priority, it gets results.

While psychiatrists are responsible in outreach programs to do curb-side assessments and decide on who gets a trip to the hospital, there are clear roles for social workers and nurses in this area of specialization. Social workers

have the fullest knowledge of community resources, programs and networks and are trained to develop referral systems. Social workers have, for the past 40 years, been in the forefront of community-based services to the chronic mentally ill and they generally create and administer the services the homeless will need.

Outreach programs respond to referrals, identify patients, provide follow-through and a variety of services over long periods. They are, therefore, an excellent field work opportunity for mature social work students, especially those in their second year. The social work intern will be able to learn about assessment, engagement, diagnosis, treatment and gaps in services for very needy patients who are often oppositional and resistant. The fact that such patients can also relate and utilize case work services can be very rewarding for students. This investigator encountered several social workers in outreach programs capable of teaching and supervising social work interns.

RESEARCH FOR THE FUTURE

Several areas for future research are suggested in regard to outreach and work with street-dwelling mentally ill.

The case study determined that there are highly skilled individuals working in outreach programs who readily provide information and share experiences with an investigator. A possible next research would be a substantial survey of these workers to establish what they see as practice principles as well as their views about agency policy and mission.

This case study found that there is a difference between patients who

"come indoors" to utilize residential and other services and those who do not. Similar findings have been reported by other investigation. A possible research would be a study of these two groups to identify characteristics of each group and ways of predicting who will give up living on the streets.

There are differences in statutes among states which effect the involuntary hospitalization of homeless mentally ill. A study comparing practices in several cities would be useful to demonstrate regional or sectional differences.

INDEX OF APPENDED ITEMS

1. Pennsylvania Mental Health Law
Article III., P. 50, Section 7301.

2. Illinois Revised Statutes
Section 3-600 through Section 3-611.

3. New York State Mental Hygiene Law
Section 9.27, Section 9.37, Section 9.41, 9.43, 9.45, 9.55 and 9.57.

4. New York City Department of Mental Health, Mental Retardation and Alcoholism Services internal memorandum on Involuntary Commitment Statutes, November 6, 1992.

5. New York State Office of Mental Health, Form 4718
Request by an examining physician to take into custody a mentally ill person. Request for Custody and Transportation of a Mentally Ill Person by a Peace Officer.

6. New York State Office of Mental Health, Form 475
Application for Involuntary Admission on Certificate of a Director of Community Services or Designee. Section 9.37.

7. New York State Office of Mental Health Form
Emergency or C.P.E.P. emergency admission custody/transport of a person alleged to be mentally ill to a hospital approved to receive emergency or C.P.E.P. emergency admissions - 2 pages. Sections 9.41, 9.45, 9.55 and 9.57.

8. Excerpt - 1991 Annual Report of the New York State Senate Standing Committee on Mental Hygiene.

9. New York Times, November 4, 1986. Daniel Goleman story on homeless mentally ill (Part I).

10. New York Times, November 11, 1986. Daniel Goleman story on homeless mentally ill (Part II).

11. Project Reach-Out Brochure - September, 1986.

12. "A Guide to Assessment: Working With People Who Are Homeless and Mentally Ill" - Alison Alpert and Helen Greer.

13. New York Times - undated - by Eben Shapiro. "Fear Returns to Sidewalks of West 96th Street Along With Homeless Man".

14. New York Times - August 29, 1992 by Celia N. Dugger.
"West Side Homeless Man Is Tentatively Ruled Ill".

15. New York Times September 3, 1992 by Celia W. Dugger.
"Threat Only When On Crack Homeless Man Foils System"

16. New York Times - undated - by Celia W. Dugger.
"Judge Orders Mentally Ill Manhattan Man to Remain in Hospital".

17. New York Times - by Philip J. Hilts.
"Mentally Ill Jailed On No Charges, Survey Says".

18. New York Times - undated - by Celia W. Dugger.
"A Danger to Themselves and Others".

19. New York Times - January 23, 1993 - by Sarah Lyall.
"Danger of Mentally Ill Homeless To Be Re-evaluated in New York".

20. New York Times - Undated - by Celia W. Dugger.
"New Plan For Homeless Mentally Ill Does Not Address Larger Questions".

21. New York Times - February 3, 1993 - by Ronald Sullivan.
"State Told to Free Man in Hospital".

22. New York Times - February 4, 1993 - by Lynda Richardson.
"Business As Usual For Shelter Teams".

23. New York Times - April 7, 1993 - by Elisabeth Rosenthal.
"Who Will Turn Violent? Hospitals Have To Guess".

24. New York Times - March 21, 1993 - by Lynda Richardson.
"Helping the Mentally Ill Return to the World".

25. Letter from Dr. Luis R. Marcos dated November 9, 1992.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
P.O. BOX 2675
HARRISBURG, PENNSYLVANIA 17105-2675

CHIEF COUNSEL:

TELEPHONE NUMBER:
AREA CODE (717) 783-2800

March 5, 1992

Murray Itzkowitz
The Bridge
248 W. 108th St.
New York, NY 10025

Dear Mr. Itzkowitz

Enclosed please find the Pennsylvania statute concerning involuntary mental health commitment, 50 P.S. § 7301, et seq.

Sincerely,

Howard Ulan
Assistant Counsel

Enclosure
HU:lrs

ARTICLE III. INVOLUNTARY EXAMINATION AND TREATMENT

Law Review Commentaries

Dangerousness and expertise. Christopher Slobogin, (1984) 133 U.Pa.L.Rev. 97.

Involuntary civil commitment of the mentally ill: A system in need of change. John E. B. Myers (1984) 29 Vill.L.Rev. 367.

United States Supreme Court

Mental patients, right to decide for themselves whether to submit to drug therapy, see Mills v. Rogers, 1982, 102 S.Ct. 2442, 457 U.S. 291, 73 L.Ed.2d 16.

Rights of mentally retarded persons who are involuntarily committed, see Youngberg v. Romeo, 1982, 102 S.Ct. 2452, 457 U.S. 307, 73 L.Ed.2d 28.

§ 7301. Persons who may be subject to involuntary emergency examination and treatment

(a) Persons Subject.—Whenever a person is severely mentally disabled and in need of immediate treatment, he may be made subject to involuntary emergency examination and treatment. A person is severely mentally disabled when, as a result of mental illness, his capacity to exercise self-control, judgment and discretion in the conduct of his affairs and social relations or to care for his own personal needs is so lessened that he poses a clear and present danger of harm to others or to himself.

(b) Determination of Clear and Present Danger.—(1) Clear and present danger to others shall be shown by establishing that within the past 30 days the person has inflicted or attempted to inflict serious bodily harm on another and that there is a reasonable probability that such conduct will be repeated. If, however, the person has been found incompetent to be tried or has been acquitted by reason of lack of criminal responsibility on charges arising from conduct involving infliction of or attempt to inflict substantial bodily harm on another, such 30-day limitation shall not apply so long as an application for examination and treatment is filed within 30 days after the date of such determination or verdict. In such case, a clear and present danger to others may be shown by establishing that the conduct charged in the criminal proceeding did occur, and that there is a reasonable probability that such conduct will be repeated. For the purpose of this section, a clear and present danger of harm to others may be demonstrated by proof that the person has made threats of harm and has committed acts in furtherance of the threat to commit harm.

(2) Clear and present danger to himself shall be shown by establishing that within the past 30 days:

(i) the person has acted in such manner as to evidence that he would be unable, without care, supervision and the continued assistance of others, to satisfy his need for nourishment, personal or medical care, shelter, or self-protection and safety, and that there is a reasonable probability that death, serious bodily injury or serious physical debilitation would ensue within 30 days unless adequate treatment were afforded under this act; or

(ii) the person has attempted suicide and that there is the reasonable probability of suicide unless adequate treatment is afforded under this act. For the purposes of this subsection, a clear and present danger may be demonstrated by the proof that the person has made threats to commit suicide and has committed acts which are in furtherance of the threat to commit suicide; or

(iii) the person has substantially mutilated himself or attempted to mutilate himself substantially and that there is the reasonable probability of mutilation unless adequate treatment is afforded under this act. For the purposes of this subsection, a clear and present danger shall be established by proof that the person has made threats to commit mutilation and has committed acts which are in furtherance of the threat to commit mutilation.

1976, July 9, P.L. 817, No. 143, § 301, effective in 60 days. As amended 1978, Nov. 26, P.L. 1362, No. 324, § 1, effective in 60 days.

Cross References

Effective date and applicability of act, see § 7501 of this title.

Law Review Commentaries

Civil commitment of non-criminal narcotic addicts. Abraham Abromovsky, Francis Barry McCarthy (1977) 38 U.Pitt.L.Rev. 477.

Pennsylvania standard for involuntary civil commitment of the mentally ill: A clear and present danger? Comment, 27 Duquesne L.Rev. 325 (1989).

Standards for involuntary civil commitment in Pennsylvania. (1977) 38 U.Pitt.L.Rev. 535.

Suicide: A Constitutional Right? Thomas J. Marzen, Mary K. O'Dowd, Daniel Crone and Thomas J. Balch, 24 Duquesne L.Rev. 1 (1985).

Library References

Mental Health ⇐36.

C.J.S. Insane Persons § 64.

United States Supreme Court

Involuntary commitment, standard of proof. Addington v. State of Texas, 99 S.Ct. 1804, 441 U.S. 418, 60 L.Ed.2d 323.

Rights of mentally retarded persons who are involuntarily committed, see Youngberg v. Romeo, 1982, 102 S.Ct. 2452, 457 U.S. 307, 73 L.Ed.2d 28.

Notes of Decisions

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1. In general

County employee had sufficient information to issue warrant for emergency examination and, thus, authorization of warrant was not willful misconduct and employee was immune from liability; nurse at the psychiatric institute told employee over telephone that patient had threatened suicide and committed acts in furtherance of suicide attempt within 30 days preceding the warrant. Uram v. County of Allegheny, 567 A.2d 753, 130 Pa.Cmwlth. 148, 1989.

Defendant in any case was not entitled to reversal of his murder conviction and remand for

"further proceedings under the MHPA," for alleged failure of the trial court to proceed under Juvenile Act provision (42 Pa.C.S.A. § 6356) for disposition of mentally ill or mentally retarded child. Com. v. Davis, 479 A.2d 1041, 330 Pa.Super. 551, 1984, affirmed 510 A.2d 722, 510 Pa. 536.

Mentally retarded individual subject to commitment is entitled, under state law, to placement in least restrictive alternative available. In Interest of Stover, 443 A.2d 327, 297 Pa.Super. 116, 1982.

Presence of mental illness cannot necessarily be inferred from fact that person acted tortiously, criminally, or in a manner displaying delinquency. Com. v. Hubert, 430 A.2d 1160, 494 Pa. 148, 1981.

In proceeding to commit juvenile delinquent to state mental institution under Mental Health Procedures Act, evidence was insufficient to support conclusion that delinquent was severely mentally disabled, in need of immediate treatment and a clear and present danger to others based on incident in which delinquent threatened child care worker at detention center. Id.

Intervening change in the law regarding mental commitment procedures does not render moot a former committee's attempt to secure expungement of records of commitment suffered under allegedly defective procedures, even if those procedures have since been changed. In re S.C., 421 A.2d 853, 280 Pa.Super. 539, 1980.

Standards for involuntary commitment on the basis of a clear and present danger being presented to the committee or others are applicable to juveniles. Id.

In determining whether child is severely mentally disabled for purposes of ordering involuntary commitment under Mental Health Procedures Act, court must ascertain whether, without care above and beyond that normally given child of his age, child will be subject to reasonable probability of death, serious bodily injury, or serious debilitation within 30 days. In Interest of Green, 417 A.2d 708, 273 Pa.Super. 397, 1980.

Confusing state of transcript of hearing on petition for involuntary emergency psychiatric treatment of patient, including many "inaudibles" in transcript and improper method of transcribing testimony in which transcript was prepared by member of staff of patient's attorney from tape of the proceedings, required remand. Com. ex rel. Platt v. Platt, 404 A.2d 410, 266 Pa.Super. 276, 1979.

For purposes of determining whether person is subject to involuntary emergency examination and treatment, person is "severely mentally disabled," if, as result of mental illness, such person's capacity to exercise self-control, judgment, and discretion in conduct of his affairs and social relations or to care for his own personal needs is so lessened or impaired that he poses a clear and present danger of harm to others or to himself; further, for such purposes, "clear and present danger" is presented if person has within past 30 days inflicted or attempted to inflict serious bodily harm on another and there is a reasonable probability that such conduct will be repeated. Id.

2. Clear and present danger

Standards for determining clear and present danger, allowing involuntary commitment under Pennsylvania law, are high. Hasenei v. U.S., 541 F.Supp. 999, D.C.1982.

In order for individual, who has been acquitted of crime due to lack of criminal responsibility, to be involuntarily recommitted to mental institution under this section, it must be demonstrated that conduct by patient that led to criminal proceedings occurred, and that there is reasonable probability that conduct would occur again. In re Watt, 525 A.2d 421, 363 Pa.Super. 56, 1987.

That insanity acquittee is a "clear and present danger to others" as defined by statute as criterion of involuntary recommitment to state mental health facility [50 P.S. § 7301(b)(1)] may be established either under standards applicable to all involuntary commitments or by showing that conduct that led to criminal proceedings occurred and that reasonable possibility exists that conduct will occur again. Com. v. Helms, 506 A.2d 1384, 352 Pa.Super. 65, 1986.

Lack of recent evidence of actual violent conduct by defendant continuously confined to state mental hospital since date when he allegedly killed his neighbor would not negate finding that patient was a "clear and present danger to others" as defined by statute [50 P.S. § 7301(b)(1)] as criterion for involuntary recommitment. Com. v. Helms, 506 A.2d 1384, 352 Pa.Super. 65, 1986.

Statute defining "clear and present danger of harm to others" as criterion for involuntary commitment to state mental health facilities [50 P.S. § 7301(b)(1)] allows, but does not require, that danger be shown by threats of harm or acts in furtherance thereof and allows danger to be shown by other means. Com. v. Helms, 506 A.2d 1384, 352 Pa.Super. 65, 1986.

Defendant minor would not be subject to involuntary commitment under Mental Health Procedures Act without showing of acts of danger to the defendant himself or to others which had occurred within the prior 30 days. Com. v. Davis, 479 A.2d 1041, 330 Pa.Super. 551, 1984, affirmed 510 A.2d 722, 510 Pa. 536.

Contrary to this section, 82-year-old man was involuntarily committed to state mental hospital for 20 days because he was senile and not because he posed clear and present danger of harm to others or to himself. In re Remley, 471 A.2d 514, 324 Pa.Super. 163, 1984.

This section providing for involuntary commitment upon posing clear and present danger of harm to self did not require that everyone who needed assistance of others due to severe mental disability should be committed, but, rather, required that they both need such help and would not get it without being committed. In re Remley, 471 A.2d 514, 324 Pa.Super. 163, 1984.

Evidence presented to mental health review officer and summarized in certification for extended involuntary treatment was sufficient to justify finding that patient was clear and present danger to himself and that least restrictive environment in which he could safely remain consistent with provision of adequate treatment was as inpatient on closed ward at state hospital. In re Condry, 450 A.2d 136, 304 Pa.Super. 131, 1982.

Involuntary committee who had been charged with criminal mischief and assault as result of occurrences in a group home for the mentally retarded was a person severely mentally disabled and subject to commitment because as a result of mental illness his capacity to exercise self-control and discretion is so lessened that he poses clear and present danger of harm to others or himself. In re Steinhiser, 424 A.2d 1006, 56 Pa.Cmwlth. 349, 1981.

Finding of clear and present danger justifying involuntary commitment must be based on an overt act occurring within 30 days prior to the hearing and, if allegedly dangerous to others, must have threatened or resulted in serious bodily harm or, if allegedly self-harmful, must have been manifested by attempts at suicide or self-mutilation. In re S.C., 421 A.2d 853, 280 Pa.Super. 539, 1980.

Terms of clear and present danger standard applicable in determining whether individual is severely mentally disabled for purposes of ordering involuntary commitment are relevant only to mentally ill adults. In Interest of Green, 417 A.2d 708, 273 Pa.Super. 397, 1980.

Evidence in proceeding for involuntary commitment of child was insufficient to show clear and present danger that child would have been subject to reasonable probability of death, serious bodily injury, or serious debilitation within 30 days without excessive care and supervision, under provision of this section requiring such for involuntary commitment, particularly considering policy which favored voluntary over involuntary commitment. Id.

2.5. Counsel

Where counsel for alleged mental incompetent failed to object at commitment hearing when Commonwealth's only witness, examining psychiatrist, testified that commitment forms and telephone conversation with his client's grandmother revealed that she had assaulted her grandmother and had possessed gun which was taken from her by police, counsel was ineffective, because that testimony was clearly hearsay and was crucial in establishing whether alleged mental incompetent presented clear and present danger to others under this section. In re Hutchinson, 454 A.2d 1008, 500 Pa. 152, 1982.

3. Due process

Simultaneous written application and telephone application for warrant for emergency examination of patient satisfied requirements of Mental Health Procedures Act [50P.S. §§ 7101 to 7503] and, thus, patient was not deprived of liberty or privacy interest without due process of law and failed to state cause of action against county for deprivation of civil rights. Uram v. County of Allegheny, 567 A.2d 753, 130 Pa.Cmwlth. 148, 1989.

Even though government officials may be motivated by desire to help individual, actions of government must be strictly circumscribed by law, and this is especially so when governmental action involves deprivation of liberty, such as involuntary commitment to state mental hospital, and courts must be vigilant in ensuring compliance with legal safeguards. In re Remley, 471 A.2d 514, 324 Pa.Super. 163, 1984.

Involuntary civil commitment of mentally ill persons constitutes deprivation of liberty and may be accomplished only in accordance with due process protections. In re Hutchinson, 454 A.2d 1008, 500 Pa. 152, 1982.

Substantial deprivation of individual liberty inherent in civil commitment may only be accomplished in accordance with due process standards; where Mental Health Procedures Act has provided for specific procedural protections, and procedures mandated are not followed, involuntary commitment is improper. Com. v. C.B., 452 A.2d 1372, 307 Pa.Super. 176, 1982.

Where court of common pleas specifically stated that, in considering contention of involuntary committee, it had adhered to standards enumerated by federal district court case holding certain aspects of the Mental Health and Retardation Act (§ 4101 et seq. of this title) unconstitutional and where the court order and memorandum comported with due process safeguards of the Mental Health Procedures Act, the commitment was proper. In re Steinhiser, 424 A.2d 1006, 56 Pa. Cmwlth. 349, 1981.

Trial court which ordered involuntary commitment of juvenile because of her inability to function in the community on her own applied less stringent standards than are permissible under the law and thus violated the committee's due process rights. In re S.C., 421 A.2d 853, 280 Pa.Super. 539, 1980.

4. Records

Patient whose involuntary commitment was improper for insufficient notice of hearing under Mental Health Procedures Act was entitled to expungement of all hospital and court records of order of commitment. Com. v. C.B., 452 A.2d 1372, 307 Pa.Super. 176, 1982.

Where petitioner sought declaration that emergency involuntary commitments to state hospital were invalid and sought destruction of hospital records, specific petition for declaratory judgment might have been more appropriate than petition in equity. Yezerski v. Fong, 428 A.2d 736, 58 Pa. Cmwlth. 566, 1981.

Dismissal by court of common pleas of petition for declaration that involuntary emergency commitments to state hospital were invalid and for order requiring that the state hospital destroy records was not proper where such court had jurisdiction over validity of commitment, even though court could not order destruction of records. Id.

Court of common pleas could not issue order against director of state hospital requiring destruction of records generated by involuntary emergency commitments. Id.

5. Evidence

Evidence was sufficient to support trial court's determination that recommitment of mental patient who had been acquitted of criminal homicide due to lack of criminal responsibility was necessary, though there was no recent evidence of actual violent conduct, where psychiatrists testified that patient was still psychotic, albeit, in partial remission, and that there was significant risk that he would decompensate into overt psy-

chotic behavior if placed in setting with less structure than that provided at state mental hospital. In re Watt, 525 A.2d 421, 363 Pa.Super. 56, 1987.

In case involving involuntary commitment of 82-year-old man to state mental hospital for 20 days, there was not quantum of evidence that man inflicted or attempted to inflict serious bodily injury on others or that there was reasonable probability that such conduct would be repeated as required by enabling this section. In re Remley, 471 A.2d 514, 324 Pa.Super. 163, 1984.

In case involving involuntary commitment of 82-year-old man to state mental hospital for 20 days, testimony established that man required domestic services of his wife, but there was no evidence that man would probably die, incur serious bodily injury or serious physical debilitation if he were not committed, and thus statutory standard was not met. In re Remley, 471 A.2d 514, 324 Pa.Super. 163, 1984.

Testimony before mental health review officer was insufficient to show that appellant represented a clear and present danger either to others, as the officer found, or to herself, as the lower court found, and the evidence was thus insufficient to support appellant's commitment under the Mental Health Procedures Act to a mental hospital for extended involuntary emergency treatment. Com. v. Blaker, 446 A.2d 976, 293 Pa.Super. 391, 1981.

Evidence was insufficient to support involuntary commitment of appellant to state hospital. Com. ex rel. Gibson v. DiGiacinto, 439 A.2d 105, 497 Pa. 66, 1981.

6. Review

In recommitment proceedings, evidence did not show that mentally retarded woman in her middle 50's, subject to some form of commitment, should have been committed to Laurelton Center as least restrictive alternative, but since period of commitment had expired, to extent that woman challenged her commitment to Laurelton, her appeal was moot. In Interest of Stover, 443 A.2d 327, 297 Pa.Super. 116, 1982.

§ 7302. Involuntary emergency examination and treatment authorized by a physician—not to exceed seventy-two hours

(a) Application for Examination.—Emergency examination may be undertaken at a treatment facility upon the certification of a physician stating the need for such examination; or upon a warrant issued by the county administrator authorizing such examination; or without a warrant upon application by a physician or other authorized person who has personally observed conduct showing the need for such examination.

(1) Warrant for Emergency Examination.—Upon written application by a physician or other responsible party setting forth facts constituting reasonable grounds to believe a person is severely mentally disabled and in need of immediate treatment, the county administrator may issue a warrant requiring a person authorized by him, or any peace officer, to take such person to the facility specified in the warrant.

(2) Emergency Examination Without a Warrant.—Upon personal observation of the conduct of a person constituting reasonable grounds to believe that he is severely mentally disabled and in need of immediate treatment, and physician or peace officer, or anyone authorized by the county administrator may take such person to an approved facility for an emergency examination. Upon arrival, he shall make a written statement setting forth the grounds for believing the person to be in need of such examination.

(b) Examination and Determination of Need for Emergency Treatment.—A person taken to a facility shall be examined by a physician within two hours of arrival in order to determine if the person is severely mentally disabled within the meaning of section 301[1] and in need of immediate treatment. If it is determined that the person is severely mentally disabled and in need of emergency treatment, treatment shall be begun immediately. If the physician does not so find, or if at any time it appears there is no longer a need for immediate treatment, the person shall be discharged and returned to such place as he may reasonably direct. The physician shall make a record of the examination and his findings. In no event shall a person be accepted for involuntary emergency treatment if a previous application was granted for such treatment and the new application is not based on behavior occurring after the earlier application.

(c) Notification of Rights at Emergency Examination.—Upon arrival at the facility, the person shall be informed of the reasons for emergency examination and of his right to communicate immediately with others. He shall be given reasonable use of the telephone. He shall be requested to furnish the names of parties whom he may want notified of his custody and kept informed of his status. The county administrator or the director of the facility shall:

(1) give notice to such parties of the whereabouts and status of the person, how and when he may be contacted and visited, and how they may obtain information concerning him while he is in inpatient treatment; and

(2) take reasonable steps to assure that while the person is detained, the health and safety needs of any of his dependents are met, and that his personal property and the premises he occupies are secure.

(d) Duration of Emergency Examination and Treatment.—A person who is in treatment pursuant to this section shall be discharged whenever it is determined that he no longer is in need of treatment and in any event within 120 hours, unless within such period:

(1) he is admitted to voluntary treatment pursuant to section 202 of this act;[2] or

(2) a certification for extended involuntary emergency treatment is filed pursuant to section 303 of this act.[3]

1976, July 9, P.L. 817, No. 143, § 302, effective in 60 days. As amended 1978, Nov. 26, P.L. 1362, No. 324, § 1, effective in 60 days.

[1] Section 7301 of this title.
[2] Section 7202 of this title.
[3] Section 7303 of this title.

Library References

Mental Health ⇐31 et seq.
C.J.S. Insane Persons §§ 58, 61.

United States Supreme Court

Mental Patients, right to decide for themselves whether to submit to drug therapy, see Mills v. Rogers, 1982, 102 S.Ct. 2442, 457 U.S. 291, 73 L.Ed.2d 16.

Rights of mentally retarded persons who are involuntarily committed, see Youngberg v. Romeo, 1982, 102 S.Ct. 2452, 457 U.S. 307, 73 L.Ed.2d 28.

Notes of Decisions

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1. In general

County employee could not be found to have committed willful misconduct in processing emergency examination warrant on basis of information received from psychiatric institute's nurse over telephone and, thus, employee was immune from liability for allegedly wrongful issuance of warrant that led to hospitalization, examination, and release of patient; receiving information over telephone and subsequently receiving written application satisfied requirements for emergency warrant. Uram v. County of Allegheny, 567 A.2d 753, 130 Pa.Cmwlth. 148, 1989.

Police officer who stated that patient did not appear to need treatment did not have authority to withdraw warrant for emergency examination and, thus, county employee did not commit willful misconduct by failing to withdraw warrant and was immune from liability to patient. Uram v. County of Allegheny, 567 A.2d 753, 130 Pa. Cmwlth. 148, 1989.

Where a patient is being treated under this section, he may not be involuntarily committed under § 7304 of this title, providing that court of common pleas may order involuntary commitment for period not to exceed 90 days prior to emergency treatment under § 7303 of this title, providing for extended involuntary emergency treatment after informal conferences before mental health review officer or judge for a period of no more than 20 days. In re Ann S., 421 A.2d 370, 279 Pa.Super. 618, 1980.

Evidence at informal hearing was insufficient to enable review officer or court to order commitment of patient for involuntary emergency psychiatric treatment. Com. ex rel. Platt v. Platt, 404 A.2d 410, 266 Pa.Cmwlth. 276, 1979.

2. Discharge

Discharge from mental health commitment in state hospital does not of itself moot challenges to validity of commitment. Yezerski v. Fong, 428 A.2d 736, 58 Pa.Cmwlth. 566, 1981.

Impact and degree of stigma associated with the involuntary commitment are not to be evaluated in deciding whether the discharge of the committed party has made moot the question of the legality of the commitment. In re S.C., 421 A.2d 853, 280 Pa.Super. 539, 1980.

Discharge of an individual from involuntary commitment does not automatically make moot the question of the legality of the commitment. Id.

§ 7303. Extended involuntary emergency treatment certified by a judge or mental health review officer—not to exceed twenty days

(a) Persons Subject to Extended Involuntary Emergency Treatment.—Application for extended involuntary emergency treatment may be made for any person who is being treated pursuant to section 302[1] whenever the facility determines that

the need for emergency treatment is likely to extend beyond 120 hours. The application shall be filed forthwith in the court of common pleas, and shall state the grounds on which extended emergency treatment is believed to be necessary. The application shall state the name of any examining physician and the substance of his opinion regarding the mental condition of the person.

(b) Appointment of Counsel and Scheduling of Informal Hearing.—Upon receiving such application, the court of common pleas shall appoint an attorney who shall represent the person unless it shall appear that the person can afford, and desires to have, private representation. Within 24 hours after the application is filed, an informal hearing shall be conducted by a judge or by a mental health review officer and, if practicable, shall be held at the facility.

(c) Informal Conference on Extended Emergency Treatment Application.—(1) At the commencement of the informal conference, the judge or the mental health review officer shall inform the person of the nature of the proceedings. Information relevant to whether the person is severely mentally disabled and in need of treatment shall be reviewed, including the reasons that continued involuntary treatment is considered necessary. Such explanation shall be made by a physician who examined the person and shall be in terms understandable to a layman. The judge or mental health review officer may review any relevant information even if it would be normally excluded under rules of evidence if he believes that such information is reliable. The person or his representative shall have the right to ask questions of the physician and of any other witnesses and to present any relevant information. At the conclusion of the review, if the judge or the review officer finds that the person is severely mentally disabled and in need of continued involuntary treatment, he shall so certify. Otherwise, he shall direct that the facility director or his designee discharge the person.

(2) A record of the proceedings which need not be a stenographic record shall be made. Such record shall be kept by the court or mental health review officer for at least one year.

(d) Contents of Certification.—A certification for extended involuntary treatment shall be made in writing upon a form adopted by the department and shall include:

(1) findings by the judge or mental health review officer as to the reasons that extended involuntary emergency treatment is necessary;

(2) a description of the treatment to be provided together with an explanation of the adequacy and appropriateness of such treatment, based upon the information received at the hearing;

(3) any documents required by the provisions of section 302;

(4) the application as filed pursuant to section 303(a);[2]

(5) a statement that the person is represented by counsel; and

(6) an explanation of the effect of the certification, the person's right to petition the court for release under subsection (g), and the continuing right to be represented by counsel.

(e) Filing and Service.—The certification shall be filed with the director of the facility and a copy served on the person, such other parties as the person requested to be notified pursuant to section 302(c), and on counsel.

(f) Effect of Certification.—Upon the filing and service of a certification for extended involuntary emergency treatment, the person may be given treatment in an approved facility for a period not to exceed 20 days.

(g) Petition to Common Pleas Court.—In all cases in which the hearing was conducted by a mental health review officer, a person made subject to treatment pursuant to this section shall have the right to petition the court of common pleas for review of the certification. A hearing shall be held within 72 hours after the petition is filed unless a continuance is requested by the person's counsel. The hearing shall include a review of the certification and such evidence as the court may receive or require. If the court determines that further involuntary treatment is necessary and

that the procedures prescribed by this act have been followed, it shall deny the petition. Otherwise, the person shall be discharged.

(h) Duration of Extended Involuntary Emergency Treatment.—Whenever a person is no longer severely mentally disabled or in need of immediate treatment and, in any event, within 20 days after the filing of the certification, he shall be discharged, unless within such period:

(1) he is admitted to voluntary treatment pursuant to section 202;[3] or

(2) the court orders involuntary treatment pursuant to section 304.[4]

1976, July 9, P.L. 817, No. 143, § 302, effective in 60 days. As amended 1978, Nov. 26, P.L. 1362, No. 324, § 1, effective in 60 days.

[1] Section 7302 of this title.

[2] Section 7303 of this title.

[3] Section 7202 of this title.

[4] Section 7304 of this title.

United States Supreme Court

Mental patients, right to decide for themselves whether to submit to drug therapy, see Mills v. Rogers, 1982, 102 S.Ct. 2442, 457 U.S. 291, 73 L.Ed.2d 16.

Rights of mentally retarded persons who are involuntarily committed, see Youngberg v. Romeo, 1982, 102 S.Ct. 2452, 457 U.S. 307, 73 L.Ed.2d 28.

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1. In general

Plaintiff, a pretrial detainee who was involuntarily committed to mental health facility after he cut his writs in an unsuccessful suicide attempt, had no justifiable expectation of remaining in an involuntary commitment status at the mental health facility, and he was therefore not deprived of due process of law by reason of the fact that, on two occasions, he was transferred back to the county farm prison without first being provided a hearing. Santori v. Fong, 484 F.Supp. 1029, D.C. 1980.

Officials at mental health facility, to which pretrial detainee was involuntarily committed after he cut his wrist in an unsuccessful suicide attempt, were entitled to exercise their professional judgment when they transferred the detainee back to county farm prison for a four-day period, in the face of an impending work stoppage by staff personnel at the mental health facility; similarly, as to the final discharge, the officials properly returned the detainee to the county farm prison, as they were required to do by the Mental Health Procedures Act. Id.

In case involving involuntary commitment of 82-year-old man to state mental hospital for 20 days, court below, which accepted state physician's diagnosis of senility, acknowledged that it perceived man's needs to be for services of skilled nursing home rather than for services provided in mental hospital, and thus confinement, even for 20 days, in hospital was improper. In re Remley, 471 A.2d 514, 324 Pa.Super. 163, 1984.

Certification for extended involuntary commitment which did not contain description of treatment to be provided was insufficient, warranting reversal of involuntary commitment order. In re Condry, 450 A.2d 136, 304 Pa.Super. 131, 1982.

Where a patient is being treated under § 7302 of this title, he may not be involuntarily committed under § 7304 of this title, providing that court of common pleas may order involuntary commitment for period not to exceed 90 days prior to emergency treatment under this section, providing for extended involuntary emergency treatment after informal conferences before mental health review officer or judge for a period of no more than 20 days. In re Ann S., 421 A.2d 370, 279 Pa.Super. 618, 1980.

As this section requiring testimony of treating physician was adopted subsequent to act establishing patient-physician privilege, provision of Mental Health Act takes precedence over this section establishing privilege. Com. ex rel. Platt v. Platt, 404 A.2d 410, 266 Pa.Super. 276, 1979.

Since Mental Health Procedures Act (50 P.S. § 7101 et seq.) was adopted subsequent to 28 P.S. § 328 establishing physician-patient privilege, and as this section governing testimony of physician was special provision requiring testimony of physician who treated patient, such special section controlled the general physician-patient section and constituted an exception thereto; thus, physician-patient privilege did not render incompetent the testimony of the patient's psychiatrist in a mental health proceeding. Id.

For purposes of proceeding seeking commitment for involuntary emergency psychiatric treatment, patient's right to privacy of medical records was required to give way to interests of society in having such patient treated; thus, psychiatrist should have been permitted to testify at informal hearing concerning emergency treatment of patient. Id.

Certificate of physician attached to original petition for involuntary emergency psychiatric treatment did not satisfy requirement that physician give reasons as to why involuntary treatment was necessary inasmuch as certificate deprived patient of right to question physician. Id.

1.3. Certification form

Inclusion of form, required to document certification by Department of Public Welfare regulations governing commitment proceedings, in record of involuntary commitment hearing held before mental health review officer was adequate to fulfill intent of Mental Health Procedures Act § 7303(d)(1-6), requiring written certification for extended involuntary treatment, and demands of pertinent regulation. In re S.O., 492 A.2d 727, 342 Pa.Super. 215, 1985.

1.5. Hearing

Hearsay evidence is not rendered admissible in all proceedings under Mental Health Procedures Act on theory that hearsay is admissible at informal hearing required for an application for extended emergency treatment not to extend 20 days. In re Hutchinson, 454 A.2d 1008, 500 Pa. 152, 1982.

Involuntary commitment hearing complied with procedural requirements of Mental Health Procedures Act where, although counsel for mental health authorities indicated that he had no evidence to present other than certification of mental health review officer, he had doctor present who had examined patient, but neither court nor patient chose to question such doctor. In re Condry, 450 A.2d 136, 304 Pa.Super. 131, 1982.

In involuntary commitment hearing, mental health authority is not required to offer evidence in nature of de novo hearing or to offer transcript of hearing occurring before mental health review officer. Id.

2. Time of hearing

Where committee in the trial court did not contend that the required hearing had not been timely held within 24 hours of the filing of the petition for extended emergency care but merely contended that the petition for extended treatment was not timely filed within the initial 72-hour emergency commitment, contention that the hearing was not timely held was waived. In re S.C., 421 A.2d 853, 280 Pa.Super. 539, 1980.

3. Review

Although 20-day involuntary commitment period of 82-year-old man to state mental hospital had long since expired, Superior Court would nevertheless consider appeal from commitment order in order to maintain appellate oversight of this liberty-depriving procedure. In re Remley, 471 A.2d 514, 324 Pa.Super 163, 1984.

Appeals from involuntary commitment orders which have expired are not moot, since involuntary commitment affects important liberty interest and since by their nature, most such orders expire before appellate review is possible. In re Condry, 450 A.2d 136, 304 Pa.Super. 131, 1982.

Although order of involuntary commitment expired two days after the instant appeal was taken from an order entered pursuant to the Mental Health Procedures Act committing appellant to a mental hospital for extended involuntary emergency treatment, the appeal was not moot, since involuntary commitment affects an important liberty interest and since, by their nature, most involuntary commitment orders expire before appellate review is possible. Com. v. Blaker, 446 A.2d 976, 293 Pa.Super. 391, 1981.

Mental health review officer may not issue a final order of commitment and an appeal from an "order" of a mental health review officer for the involuntary treatment of a patient is not a final order from which an appeal may lie. In re Chambers, 422 A.2d 1140, 282 Pa.Super. 327, 1980.

§ 7304. Court-ordered involuntary treatment not to exceed ninety days

(a) Persons for Whom Application May be Made.—(1) A person who is severely mentally disabled and in need of treatment, as defined in section 301(a),[1] may be made subject to court-ordered involuntary treatment upon a determination of clear and present danger under section 301(b)(1) (serious bodily harm to others), or section 301(b)(2)(i) (inability to care for himself, creating a danger of death or serious harm to himself), or 301(b)(2)(ii) (attempted suicide), or 301(b)(2)(iii) (self-mutilation).

(2) Where a petition is filed for a person already subject to involuntary treatment, it shall be sufficient to represent, and upon hearing to reestablish, that the conduct originally required by section 301 in fact occurred, and that his condition continues to evidence a clear and present danger to himself or others. In such event, it shall not be necessary to show the reoccurrence of dangerous conduct, either harmful or debilitating, within the past 30 days.

(b) Procedures for Initiating Court-ordered Involuntary Treatment for Persons Already Subject to Involuntary Treatment.—(1) Petition for court-ordered involuntary treatment for persons already subject to treatment under sections 303, 304 and 305[2] may be made by the county administrator or the director of the facility to the court of common pleas.

(2) The petition shall be in writing upon a form adopted by the department and shall include a statement of the facts constituting reasonable grounds to believe that the person is severely mentally disabled and in need of treatment. The petition shall state the name of any examining physician and the substance of his opinion regarding the mental condition of the person. It shall also state that the person has been given the information required by subsection (b)(3).

(3) Upon the filing of the petition the county administrator shall serve a copy on the person, his attorney, and those designated to be kept informed, as provided in section 302(c),[3] including an explanation of the nature of the proceedings, the person's right to an attorney and the services of an expert in the field of mental health, as provided by subsection (d).

(4) A hearing on the petition shall be held in all cases, not more than five days after the filing of the petition.

(5) Treatment shall be permitted to be maintained pending the determination of the petition.

(c) Procedures for Initiating Court-ordered Involuntary Treatment for Persons Not in Involuntary Treatment.—(1) Any responsible party may file a petition in the court of common pleas requesting court-ordered involuntary treatment for any person not already in involuntary treatment for whom application could be made under subsection (a).

(2) The petition shall be in writing upon a form adopted by the department and shall set forth facts constituting reasonable grounds to believe that the person is within the criteria for court-ordered treatment set forth in subsection (a). The petition shall state the name of any examining physician and the substance of his opinion regarding the mental condition of the person.

(3) Upon a determination that the petition sets forth such reasonable cause, the court shall appoint an attorney to represent the person and set a date for the hearing as soon as practicable. The attorney shall represent the person unless it shall appear that he can afford, and desires to have, private representation.

(4) The court, by summons, shall direct the person to appear for a hearing. The court may issue a warrant directing a person authorized by the county administrator or a peace officer to bring such person before the court at the time of the hearing if there are reasonable grounds to believe that the person will not appear voluntarily. A copy of the petition shall be served on such person at least three days before the hearing together with a notice advising him that an attorney has been appointed who shall represent him unless he obtains an attorney himself, that he has a right to be assisted in the proceedings by an expert in the field of mental health, and that he may request or be made subject to psychiatric examination under subsection (c)(5).

(5) Upon motion of either the petitioner or the person, or upon its own motion, the court may order the person to be examined by a psychiatrist appointed by the court. Such examination shall be conducted on an outpatient basis, and the person shall have the right to have counsel present. A report of the examination shall be given to the court and counsel at least 48 hours prior to the hearing.

(6) Involuntary treatment shall not be authorized during the pendency of a petition except in accordance with section 302 or section 303.

(d) Professional Assistance.—A person with respect to whom a hearing has been ordered under this section shall have and be informed of a right to employ a physician, clinical psychologist or other expert in mental health of his choice to assist him in connection with the hearing and to testify on his behalf. If the person cannot afford to engage such a professional, the court shall, on application, allow a reasonable fee for such purpose. The fee shall be a charge against the mental health and mental retardation program of the locality.

(e) Hearings of Petition for Court-order Involuntary Treatment.—A hearing on a petition for court-ordered involuntary treatment shall be conducted according to the following:

(1) The person shall have the right to counsel and to the assistance of an expert in mental health.

(2) The person shall not be called as a witness without his consent.

(3) The person shall have the right to confront and cross-examine all witnesses and to present evidence in his own behalf.

(4) The hearing shall be public unless it is requested to be private by the person or his counsel.

(5) A stenographic or other sufficient record shall be made, which shall be impounded by the court and may be obtained or examined only upon the request of the person or his counsel or by order of the court on good cause shown.

(6) The hearing shall be conducted by a judge or by a mental health review officer and may be held at a location other than a courthouse when doing so appears to be in the best interest of the person.

(7) A decision shall be rendered within 48 hours after the close of evidence.

(f) Determination and Order.—Upon a finding by clear and convincing evidence that the person is severely mentally disabled and in need of treatment and subject to subsection (a), an order shall be entered directing treatment of the person in an approved facility as an inpatient or an outpatient, or a combination of such treatment as the director of the facility shall from time to time determine. Inpatient treatment shall be deemed appropriate only after full consideration has been given to less restrictive alternatives. Investigation of treatment alternatives shall include consideration of the person's relationship to his community and family, his employment possibilities, all available community resources, and guardianship services. An order for inpatient treatment shall include findings on this issue.

(g) Duration of Court-ordered Involuntary Treatment.—(1) A person may be made subject to court-ordered involuntary treatment under this section for a period not to exceed 90 days, excepting only that: Persons may be made subject to court-ordered involuntary treatment under this section for a period not to exceed one year if the person meets the criteria established by clause (2).

(2) A person may be subject to court-ordered involuntary treatment for a period not to exceed one year if:

(i) severe mental disability is based on acts giving rise to the following charges under the Pennsylvania Crimes Code:[4] murder (§ 2502); voluntary manslaughter (§ 2503); aggravated assault (§ 2702); kidnapping (§ 2901); rape (§ 3121(1) and (2)); involuntary deviate sexual intercourse (§ 3123(1) and (2)); arson (§ 3301); and

(ii) a finding of incompetency to be tried or a verdict of acquittal because of lack of criminal responsibility has been entered.

(3) If at any time the director of a facility concludes that the person is not severely mentally disabled or in need of treatment pursuant to subsection (a), he shall discharge the person provided that no person subjected to involuntary treatment pursuant to clause (2) may be discharged without a hearing conducted pursuant to clause (4).

(4) In cases involving involuntary treatment pursuant to clause (2), whenever the period of court-ordered involuntary treatment is about to expire and neither the director nor the county administrator intends to apply for an additional period of court-ordered involuntary treatment pursuant to section 305 or at any time the director concludes that the person is not severely mentally disabled or in need of treatment, the director shall petition the court which ordered the involuntary treatment for the unconditional or conditional release of the person. Notice of such petition shall be given to the person, the county administrator and the district attorney. Within 15 days after the petition has been filed, the court shall hold a hearing to determine if the person is severely mentally disabled and in need of treatment. Petitions which must be filed simply because the period of involuntary treatment will expire shall be filed at least ten days prior to the expiration of the court-ordered period of involuntary treatment. If the court determines after hearing that the person is severely mentally disabled and in need of treatment, it may order additional involuntary treatment not to exceed one year; if the court does not so determine, it shall order the discharge of the person.

1976, July 9, P.L. 817, No. 143, § 304, effective in 60 days. As amended 1978, Nov. 26, P.L. 1362, No. 324, § 1, effective in 60 days.

1 Section 7301 of this title.

2 Sections 7303, 7304 and 7305 of this title.

3 Section 7302 of this title.

4 18 Pa.C.S.A. § 101 et seq.

Law Review Commentaries

Suicide: A Constitutional Right? Thomas J. Marzen, Mary K. O'Dowd, Daniel Crone and Thomas J. Balch, 24 Duquesne L.Rev. 1 (1985).

United States Supreme Court

Mental patients, right to decide for themselves whether to submit to drug therapy, see Mills v. Rogers, 1982, 102 S.Ct. 2442, 457 U.S. 291, 73 L.Ed.2d 16.

Rights of mentally retarded persons who are involuntarily committed, see Youngberg v. Romeo, 1982, 102 S.Ct. 2452, 457 U.S. 307, 73 L.Ed.2d 28.

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1. In general

Requirement that upon involuntary recommitment it be established that conduct originally required for involuntary commitment in fact occurred was satisfied as long as patient's commitment history showed that requisite behavior occurred in past, unless on recommitment patient affirmatively challenged original commitment; in that event, burden was on patient to show that original commitment was improper. Com. v. Romett, 538 A.2d 1339, 372 Pa.Super. 41, 1988, appeal denied 559 A.2d 36, 522 Pa. 575.

Provisions of the Mental Health Procedures Act authorizing a court to order involuntary treatment following an examination in aid of sentencing were applicable to 17-year-old juvenile adjudicated a delinquent and were properly made a basis for ordering that juvenile be committed for inpatient psychiatric treatment to a forensic adolescent unit of a state hospital for a period not to exceed 90 days. In re McMullins, 462 A.2d 718, 315 Pa.Super. 531, 1983.

Presence of mental illness cannot necessarily be inferred from fact that person acted tortiously, criminally, or in a manner displaying delinquency. Com. v. Hubert, 430 A.2d 1160, 494 Pa. 148, 1981.

Decision of mental health review officer ordering involuntary outpatient treatment was not final appealable order; hearing officer's "order" was not an "order of court" as contemplated by 42 Pa.C.S.A. § 742 and by Pa.R.A.P. 341, 42 Pa.C.S.A. In re Bishop, 422 A.2d 831, 282 Pa.Super. 67, 1980.

Where a patient is being treated under § 7302 of this title, he may not be involuntarily committed under this section, providing that court of common pleas may order involuntary commitment for period not to exceed 90 days prior to emergency treatment under § 7303 of this title, providing for extended involuntary emergency treatment after informal conferences before mental health review officer or judge for a period of no more than 20 days. In re Ann S., 421 A.2d 370, 279 Pa.Super. 618, 1980.

Authority to confine dangerous persons arises from state's inherent police powers. In re Hutchinson, 421 A.2d 261, 279 Pa.Super. 401, 1980, affirmed 454 A.2d 1008, 500 Pa. 152.

On appeal from involuntary commitment proceeding, in which county contended that lower court erred in ordering county to pay for mentally ill child's interim placement in private psychiatric facility subject to right to seek reimbursement from state and that Commonwealth was obligated to pay for child's interim care, where Commonwealth was not party to action and county did not allege that it had sought and been denied reimbursement by state, contention was prematurely raised and Superior Court would not resolve it. In Interest of Green, 417 A.2d 708, 273 Pa.Super. 397, 1980.

Record of proceedings on petition for defendant's involuntary commitment, when considered in light of defendant's psychiatric history and his total lack of cooperation within mental health system of county, led Superior Court to conclude that lower court in its commitment order did in fact consider, before imposing involuntary inpatient treatment upon defendant, "less restrictive alternatives" for defendant, but then rejected same. Com. ex rel. Gibson v. DiGiacinto, 395 A.2d 938, 261 Pa.Super. 53, 1978, reversed on other grounds 439 A.2d 105, 497 Pa. 66.

An individual who was involved in recurrent increasing episodes of aggressive behavior, who threatened suicide and whose capacity for self-control was diminished posed a clear and present danger to others and could be involuntarily committed for 90 days under the Mental Health Procedures Act, 50 P.S. § 7101. In re Butchko, 34 D. & C.3d 1, 1984.

Persons in state mental facilities committed under the Mental Health and Mental Retardation Act of 1966 (§ 4101 et seq. of this title), for whom recommitment petitions have been filed under this section, on which the courts have not acted, should be kept in custody and treatment pending court action. 1977 Op.Atty.Gen. No. 4.

2. Due process

Utilization of this section in place of the provision of the Mental Health and Mental Retardation Act governing mentally retarded persons, without affording defendant, originally diagnosed as mentally retarded, procedural protections afforded incompetents facing civil commitment, was violative of due process and equal protection, requiring a new commitment hearing based on a new petition and appropriate notice in order to permit preparation of a proper defense. Com. v. Maggio, 509 A.2d 383, 353 Pa.Super. 157, 1986.

Due process requires that requisite statutory grounds for involuntary commitment be proven by clear and convincing evidence. Com. v. Helms, 506 A.2d 1384, 352 Pa.Super. 65, 1986.

Patient access to whatever record has been made at involuntary commitment hearing, and in

form it exists, is required at minimum to comport with due process. In re S.O., 492 A.2d 727, 342 Pa.Super. 215, 1985.

Involuntary commitment is improper where mandated procedures are not followed, and appropriate remedy is to vacate commitment order and expunge record. In re S.O., 492 A.2d 727, 342 Pa.Super. 215, 1985.

Involuntary civil commitment of mentally ill persons constitutes substantial deprivation of liberty which may only be accomplished in accordance with due process protection. In re Hutchinson, 421 A.2d 261, 279 Pa.Super. 401, 1980, affirmed 454 A.2d 1008, 500 Pa. 152.

All rights given to a person accused of crime do not automatically apply to person in civil commitment hearing. Id.

3. Counsel

An alleged mental incompetent is entitled to effective representation by competent counsel, and such person may raise allegations of ineffective assistance of counsel in attacking commitment order; upon review of challenge to counsel's effectiveness, courts must examine record of proceedings to ascertain whether counsel's actions had reasonable basis designed to effectuate client's interests, and where no such basis appears in record, counsel shall be deemed ineffective, and new hearing, at which alleged mental incompetent may be represented by competent counsel, must be held. In re Hutchinson, 454 A.2d 1008, 500 Pa. 152, 1982.

Respondent's counsel, in hearing pursuant to Mental Health Procedures Act, could have had no reasonable basis for failing to object to hearsay testimony offered by only Commonwealth witness regarding statements made by respondent's grandmother which were offered to prove that defendant did indeed commit alleged assault, and thus, respondent was deprived of effective assistance of counsel. In re Hutchinson, 421 A.2d 261, 279 Pa.Super. 401, 1980, affirmed 454 A.2d 1008, 500 Pa. 152.

Requirement of assistance of counsel in Mental Health Procedures Act implicitly requires assistance of "effective" counsel and respondent in civil commitment hearing under MHPA may bring appeal alleging ineffective assistance of counsel. Id.

3.5. Notice

Patient who was held, pursuant to his agreement, for 72 hours after his request to withdraw from voluntary commitment, but who was not served with petition for his involuntary commitment until day before hearing, did not receive sufficient notice under Mental Health Procedures Act, and subsequent commitment was improper. Com. v. C.B., 452 A.2d 1372, 307 Pa.Super. 176, 1982.

Hospital authorities' oral "constructive notice" to patient at state hospital that they were going to petition court for his involuntary treatment was not sufficient to satisfy notice provision of Mental Health Procedures Act which required service of petition for involuntary treatment. Id.

4. Hearing

Insanity acquittee's request for closure of hearing in involuntary commitment proceedings did not mandate closure; request for closure did not, without more, override constitutional open court principle. Com. v. Milice, 584 A.2d 997, Super. 1991.

Trial court did not abuse its discretion in refusing to close involuntary commitment hearing, despite presentation of confidential medical testimony about insanity acquittee's mental illness; insanity plea placed issue of mental illness before court in criminal trial, that trial had been widely covered by press, testimony at involuntary commitment hearing involved comparison of various institutions to which acquittee sought to be transferred, and criminal charges arose out of violent outburst in which acquittee's neighbors had been seriously injured. Com. v. Milice, 584 A.2d 997, Super.1991.

Hearsay was not admissible in hearing pursuant to Mental Health Procedures Act to commit a person for involuntary treatment for a period of not more than 90 days. In re Hutchinson, 421 A.2d 261, 279 Pa.Super. 401, 1980, affirmed 454 A.2d 1008, 500 Pa. 152.

An order granting the prayer of a petition for extended involuntary treatment of respondent under § 7305 of this title would not have been set aside for failure of the court to hear the petition within the period of respondent's initial confinement under this section. In re Tally, 18 D. & C.3d 359, 1980.

4.5. Evidence

There was sufficient evidence that conduct originally required for involuntary commitment of patient in fact occurred and that patient's condition continued to evidence clear and present danger that such acts could occur to support patient's recommitment to psychiatric facility for third additional period of treatment, given patient's repeated, unprovoked assaultive behavior toward staff members during most recent hospitalization and patient's diagnosis as paranoia schizophrenia with delusions that others were threatening her, together with prognosis that her assaultive behavior would continue without further treatment. Com. v. Romett, 538 A.2d 1339, 372 Pa.Super. 41, 1988, appeal denied 559 A.2d 36, 522 Pa. 575.

Trial court did not have to receive additional evidence concerning patient's original involuntary commitment before taking notice of fact that patient was originally committed on showing of her clear and present danger to others, in recommitting patient for third additional period of treatment, where patient did not challenge her original commitment at any stage of recommitment proceedings below. Com. v. Romett, 538 A.2d 1339, 372 Pa.Super. 41, 1988, appeal denied 559 A.2d 36, 522 Pa. 575.

Evidence was insufficient to support involuntary commitment of appellant to state hospital. Com. ex rel. Gibson v. DiGiacinto, 439 A.2d 105, 497 Pa. 66, 1981.

In proceeding to commit juvenile delinquent to state mental institution under Mental Health Procedures Act, evidence was insufficient to support conclusion that delinquent was severely mentally

disabled, in need of immediate treatment and a clear and present danger to others based on incident in which delinquent threatened child care worker at detention center. Com. v. Hubert, 430 A.2d 1160, 494 Pa. 148, 1981.

5. Review

Appeal from order providing for involuntary commitment of juvenile was not moot due to expiration of order since order affected an important liberty interest and it was not uncommon for such an order to expire before appellate review was possible. In re McMullins, 462 A.2d 718, 315 Pa.Super. 531, 1983.

Since order of involuntary commitment affects important liberty interest, and because by their nature most voluntary commitment orders expire before appellate review is possible, appeal of 90-day commitment which was no longer in effect at time of appeal was not moot. Com. v. C.B., 452 A.2d 1372, 307 Pa.Super. 176, 1982.

Expiration of 30-day period to which appellants had been committed to state hospital did not moot appeal in commitment order. In re Wilson, 449 A.2d 711, 303 Pa.Super. 326, 1982.

Issues not raised in the lower court are waived and cannot be raised for first time on appeal in a matter involving civil commitment. Id.

Where appellant appealing from order recommitting him to state hospital, failed to file exceptions to the adjudication below, no issues have been preserved for appellate review, and since counsel's brief did not include a separate statement of questions involved or a statement of the precise relief sought and a copy of the lower court's opinion, those deficiencies might also have resulted in appeal being quashed or dismissed. Id.

Although no issues were reserved for applicable review of order recommitting appellant to in-patient psychiatric care at state hospital, appellant was not without a remedy as he could petition lower court for leave to file exceptions nunc pro tunc or could seek review by alleging ineffective assistance of counsel for failing to file exceptions. Id.

Although 90-day commitment period ordered by lower court had expired, appeal was not moot in light of fact that appeals from orders for involuntary commitment rarely reach court within 90 days and were court to dismiss such appeals as moot, challenged procedure would continue, yet its propriety would evade review. In re Ann S., 421 A.2d 370, 279 Pa.Super. 618, 1980.

6. Treatment alternatives

Evidence supported trial court's finding that state hospital provided least restrictive environment consistent with insanity acquittee's needs for treatment. Com. v. Milice, 584 A.2d 997, Super. 1991.

Evidence was sufficient to support trial court's determination that state mental hospital was least restrictive setting available for mental patient who had been acquitted of criminal homicide based upon lack of criminal responsibility, where psychiatrists testified that in even slightly less restrictive setting, without external structure state hospital provided, patient could regress to point of being overtly psychotic and exhibit same behaviors he had prior to his hospitalization. In re Watt, 525 A.2d 421, 363 Pa.Super. 56, 1987.

§ 7305. Additional periods of court-ordered involuntary treatment

(a) At the expiration of a period of court-ordered involuntary treatment under section 304(g) [1] or this section, the court may order treatment for an additional period upon the application of the county administrator or the director of the facility in which the person is receiving treatment. Such order shall be entered upon hearing on findings as required by sections 304(a) and (b), and the further finding of a need for continuing involuntary treatment as shown by conduct during the person's most recent period of court-ordered treatment. The additional period of involuntary treatment shall not exceed 180 days; provided that persons meeting the criteria of section 304(g)(2) may be subject to an additional period of up to one year of involuntary treatment. A person found dangerous to himself under section 301(b)(2)(i), (ii) or (iii) [2] shall be subject to an additional period of involuntary full-time inpatient treatment only if he has first been released to a less restrictive alternative. This limitation shall not apply where, upon application made by the county administrator or facility director, it is determined by a judge or mental health review officer that such release would not be in the person's best interest.

(b) The director of the facility in which the person is receiving treatment shall notify the county administrator at least ten days prior to the expiration of a period of involuntary commitment ordered under section 304 or this section.

1976, July 9, P.L. 817, No. 143, § 305, effective in 60 days. As amended 1978, Nov. 26, P.L. 1362, No. 324, § 1, effective in 60 days.

[1] Section 7304 of this title.

[2] Section 7301 of this title.

ILLINOIS REVISED STATUTES

*** THIS SECTION IS CURRENT THROUGH THE 1990 SUPPLEMENT (1989 SESSIONS) ***

CHAPTER 91 1/2. MENTAL HEALTH

MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES CODE

CHAPTER III. ADMISSION, TRANSFER AND DISCHARGE PROCEDURES
FOR THE MENTALLY ILL

ARTICLE VI. EMERGENCY ADMISSION BY CERTIFICATION

Ill. Rev. Stat. ch. 91 1/2, par. 3-600 (1989)

3-600. Involuntary admission--Immediate hospitalization

Ill. Rev. Stat. ch. 91 1/2, par. 3-600 (1989)

§ 3-600. A person 18 years of age or older who is subject to involuntary admission and in need of immediate hospitalization may be admitted to a mental health facility pursuant to this Article.

*** THIS SECTION IS CURRENT THROUGH THE 1990 SUPPLEMENT (1989 SESSIONS) ***

CHAPTER 91 1/2. MENTAL HEALTH

MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES CODE

CHAPTER III. ADMISSION, TRANSFER AND DISCHARGE PROCEDURES FOR THE MENTALLY ILL

ARTICLE VI. EMERGENCY ADMISSION BY CERTIFICATION

Ill. Rev. Stat. ch. 91 1/2, par. 3-601 (1989)

3-601. Petition--Contents

Ill. Rev. Stat. ch. 91 1/2, par. 3-601 (1989)

§ 3-601. (a) When a person is asserted to be subject to involuntary admission and in such a condition that immediate hospitalization is necessary for the protection of such person or others from physical harm, any person 18 years of age or older may present a petition to the facility director of a mental health facility in the county where the respondent resides or is present. The petition may be prepared by the facility director of the facility.

(b) The petition shall include:

1. a detailed statement of the reason for the assertion that the respondent is subject to involuntary admission, including a description of any acts or significant threats supporting the assertion and the time and place of their occurrence;

2. the name and address of the spouse, parent, guardian and close relative, or if none, the name and address of any known friend of the respondent. If the petitioner is unable to supply any such names and addresses, he shall state that diligent inquiry was made to learn this information and specify the steps taken;

3. the petitioner's relationship to the respondent and a statement as to whether the petitioner has legal or financial interest in the matter or is involved in litigation with the respondent;

4. the names, addresses and phone numbers of the witnesses by which the

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CHAPTER 91 1/2. MENTAL HEALTH

MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES CODE

CHAPTER III. ADMISSION, TRANSFER AND DISCHARGE PROCEDURES FOR THE MENTALLY ILL

ARTICLE VI. EMERGENCY ADMISSION BY CERTIFICATION

Ill. Rev. Stat. ch. 91 1/2, par. 3-602 (1989)

3-602. Certificate of physician, qualified examiner, or clinical psychologist

Ill. Rev. Stat. ch. 91 1/2, par. 3-602 (1989)

§ 3-602. The petition shall be accompanied by a certificate executed by a physician, qualified examiner, or clinical psychologist which states that the respondent is subject to involuntary admission and requires immediate hospitalization. The certificate shall indicate that the physician, qualified examiner, or clinical psychologist personally examined the respondent not more than 72 hours prior to admission. It shall also contain the physician's, qualified examiner's, or clinical psychologist's clinical observations, other factual information relied upon in reaching a diagnosis, and a statement as to whether the respondent was advised of his rights under Section 3-208.

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ARTICLE VI. EMERGENCY ADMISSION BY CERTIFICATION

Ill. Rev. Stat. ch. 91 1/2, par. 3-603 (1989)

3-603. Detention pending certificate--Petition

Ill. Rev. Stat. ch. 91 1/2, par. 3-603 (1989)

§ 3-603. (a) If no physician, qualified examiner, or clinical psychologist is immediately available or it is not possible after a diligent effort to obtain the certificate provided for in Section 3-602, the respondent may be detained for examination in a mental health facility upon presentation of the petition alone pending the obtaining of such a certificate.

(b) In such instance the petition shall conform to the requirements of Section 3-601 and further specify that:

1. the petitioner believes, as a result of his personal observation, that the respondent is subject to involuntary admission;

2. a diligent effort was made to obtain a certificate; and

3. no physician, qualified examiner, or clinical psychologist could be found who has examined or could examine the respondent.

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Ill. Rev. Stat. ch. 91 1/2, par. 3-604 (1989)

3-604. Detention pending certificate--Limitation

Ill. Rev. Stat. ch. 91 1/2, par. 3-604 (1989)

§ 3-604. No person detained for examination under this Article on the basis of a petition alone may be held for more than 24 hours unless within that period a certificate is furnished to or by the mental health facility. If no certificate is furnished, the respondent shall be released forthwith.

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ARTICLE VI. EMERGENCY ADMISSION BY CERTIFICATION

Ill. Rev. Stat. ch. 91 1/2, par. 3-605 (1989)

3-605. Custody--Transportation

Ill. Rev. Stat. ch. 91 1/2, par. 3-605 (1989)

§ 3-605. Upon receipt of a petition and certificate prepared pursuant to this Article, the county sheriff of the county in which a respondent is found shall take a respondent into custody and transport him to a mental health facility. In the event it is determined by such facility that the respondent is in need of commitment or treatment at another mental health facility, the county sheriff shall transport the respondent to the appropriate mental health facility.

(b) In counties with populations in excess of 500,000, the county sheriff may delegate his duties hereunder to another law enforcement body within that county if such law enforcement body agrees.

(c) The transporting authority acting in good faith and without negligence in connection with the transportation of respondents shall incur no liability, civil or criminal, by reason of such transportation.

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ARTICLE VI. EMERGENCY ADMISSION BY CERTIFICATION

Ill. Rev. Stat. ch. 91 1/2, par. 3-606 (1989)

3-606. Peace officers--Petitions

Ill. Rev. Stat. ch. 91 1/2, par. 3-606 (1989)

§ 3-606. A peace officer may take a person into custody and transport him to a mental health facility when, as a result of his personal observation, the peace officer has reasonable grounds to believe that the person is subject to involuntary admission and in need of immediate hospitalization to protect such person or others from physical harm. Upon arrival at the facility, the peace officer shall complete the petition under Section 3-601.

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ARTICLE VI. EMERGENCY ADMISSION BY CERTIFICATION

Ill. Rev. Stat. ch. 91 1/2, par. 3-607 (1989)

3-607. Court orders--Temporary detention--Admission

Ill. Rev. Stat. ch. 91 1/2, par. 3-607 (1989)

§ 3-607. When, as a result of personal observation and testimony in open court, any court has reasonable grounds to believe that a person appearing before it is subject to involuntary admission and in need of immediate hospitalization to protect such person or others from physical harm, the court may enter an order for the temporary detention and examination of such person. The order shall set forth in detail the facts which are the basis for its conclusion. The court may order a peace officer to take the person into custody and transport him to a mental health facility. The person may be detained for examination for no more than 24 hours. If a petition and certificate, as provided in this Article, are executed within the 24 hours, the person may be admitted and the provisions of this Article shall apply. If no petition or certificate is executed, the person shall be released.

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ARTICLE VI. EMERGENCY ADMISSION BY CERTIFICATION

Ill. Rev. Stat. ch. 91 1/2, par. 3-608 (1989)

3-608. Treatment--Right to refuse--Records

Ill. Rev. Stat. ch. 91 1/2, par. 3-608 (1989)

§ 3-608. Upon completion of one certificate, the facility may begin treatment of the respondent. However, the respondent shall be informed of his right to refuse medication and if he refuses, medication shall not be given unless it is necessary to prevent the respondent from causing serious harm to himself or others. The facility shall record what treatment is given to the respondent together with the reasons therefor.

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ARTICLE VI. EMERGENCY ADMISSION BY CERTIFICATION

Ill. Rev. Stat. ch. 91 1/2, par. 3-609 (1989)

3-609. Right to copies of petition--Telephone calls

Ill. Rev. Stat. ch. 91 1/2, par. 3-609 (1989)

§ 3-609. Within 12 hours after his admission, the respondent shall be given a copy of the petition and a statement as provided in Section 3-206. Not later than 24 hours, excluding Saturdays, Sundays and holidays, after admission, a copy of the petition and statement shall be given or sent to the respondent's attorney and guardian, if any. The respondent shall be asked if he desires such documents sent to any other persons, and at least 2 such persons designated by the respondent shall receive such documents. The respondent shall be allowed to complete no less than 2 telephone calls at the time of his admission to such persons as he chooses.

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ARTICLE VI. EMERGENCY ADMISSION BY CERTIFICATION

Ill. Rev. Stat. ch. 91 1/2, par. 3-610 (1989)

3-610. Examination by psychiatrist--Release

Ill. Rev. Stat. ch. 91 1/2, par. 3-610 (1989)

§ 3-610. As soon as possible but not later than 24 hours, excluding Saturdays, Sundays and holidays, after admission of a respondent pursuant to this Article, the respondent shall be examined by a psychiatrist. The psychiatrist may be a member of the staff of the facility but shall not be the person who executed the first certificate. If the respondent is not examined or if the psychiatrist does not execute a certificate pursuant to Section 3-602, the respondent shall be released forthwith.

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ARTICLE VI. EMERGENCY ADMISSION BY CERTIFICATION

Ill. Rev. Stat. ch. 91 1/2, par. 3-611 (1989)

3-611. Filing--Hearing date--Notice

Ill. Rev. Stat. ch. 91 1/2, par. 3-611 (1989)

§ 3-611. Within 24 hours, excluding Saturdays, Sundays and holidays, after the respondent's admission under this Article, the facility director of the facility shall file 2 copies of the petition, the first certificate, and proof of service of the petition and statement of rights upon the respondent with the court in the county in which the facility is located. Upon completion of the second certificate, the facility director shall promptly file it with the court. The facility director shall make copies of the certificates available to the attorneys for the parties upon request. Upon the filing of the petition and first certificate, the court shall set a hearing to be held within 5 days, excluding Saturdays, Sundays and holidays, after receipt of the petition. The court shall direct that notice of the time and place of the hearing be served upon the respondent, his responsible relatives, and the persons entitled to receive a copy of the petition pursuant to Section 3-609.

§ 9.27 Involuntary admission on medical certification

(a) The director of a hospital may receive and retain therein as a patient any person alleged to be mentally ill and in need of involuntary care and treatment upon the certificates of two examining physicians, accompanied by an application for the admission of such person. The examination may be conducted jointly but each examining physician shall execute a separate certificate.

(b) Such application must have been executed within ten days prior to such admission. It may be executed by any one of the following:

1. any person with whom the person alleged to be mentally ill resides.

2. the father or mother, husband or wife, brother or sister, or the child of any such person or the nearest available relative.

3. the committee of such person.

4. an officer of any public or well recognized charitable institution or agency or home in whose institution the person alleged to be mentally ill resides.

5. the director of community services or social services official, as defined in the social services law, of the city or county in which any such person may be.

6. the director of the hospital or of a general hospital, as defined in article twenty-eight of the public health law, in which the patient is hospitalized.

7. the director or person in charge of a facility providing care to alcoholics, or substance abusers or substance dependent persons.

8. the director of the division for youth, acting in accordance with the provisions of section five hundred seventeen of the executive law.

9. subject to the terms of any court order or any instrument executed pursuant to section three hundred eighty-four-a of the social services law, a social services official or authorized agency which has, pursuant to the social services law, care and custody or guardianship and custody of a child over the age of sixteen.

10. subject to the terms of any court order a person or entity having custody of a child pursuant to an order issued pursuant to section seven hundred fifty-six or one thousand fifty-five of the family court act.

11. a qualified psychiatrist who is either supervising the treatment of or treating such person for a mental illness in a facility licensed or operated by the office of mental health.

(c) Such application shall contain a statement of the facts upon which the allegation of mental illness and need for care and treatment are based and shall be executed under penalty of perjury but shall not require the signature of a notary public thereon.

(d) Before an examining physician completes the certificate of examination of a person for involuntary care and treatment, he shall consider alternative forms of care and treatment that might be adequate to provide for the person's needs without requiring involuntary hospitalization. If the examining physician knows that the person he is examining for involuntary care and treatment has been under prior treatment, he shall, insofar as possible, consult with the physician or psychologist furnishing such prior treatment prior to completing his certificate. Nothing in this section shall prohibit or invalidate any involuntary admission made in accordance with the provisions of this chapter.

(e) The director of the hospital where such person is brought shall cause such person to be examined forthwith by a physician who shall be a member of the psychiatric staff of such hospital other than the original examining physicians whose certificate or certificates accompanied the application and, if such person is

found to be in need of involuntary care and treatment, he may be admitted thereto as a patient as herein provided.

(f) Following admission to a hospital, no patient may be sent to another hospital by any form of involuntary admission unless the mental hygiene legal service has been given notice thereof.

(g) Applications for involuntary admission of patients to residential treatment facilities for children and youth or transfer of involuntarily admitted patients to such facilities shall be reviewed by the pre-admission certification committee serving such facility in accordance with section 9.51 of this article.

(h) If a person is examined and determined to be mentally ill, the fact that such person suffers from alcohol or substance abuse shall not preclude commitment under this section.

(i) After an application for the admission of a person has been completed and both physicians have examined such person and separately certified that he or she is mentally ill and in need of involuntary care and treatment in a hospital, either physician is authorized to request peace officers, when acting pursuant to their special duties, or police officers, who are members of an authorized police department or force or of a sheriff's department, to take into custody and transport such person to a hospital for determination by the director whether such person qualifies for admission pursuant to this section. Upon the request of either physician an ambulance service, as defined by subdivision two of section three thousand one of the public health law, is authorized to transport such person to a hospital for determination by the director whether such person qualifies for admission pursuant to this section.

(Formerly § 31.27, L.1972, c. 251; amended L.1972, c. 644, § 1; L.1972, c. 758, § 3; L.1973, c. 73, § 3; L.1975, c. 667, § 4; L.1977, c. 659, §§ 3, 4; renumbered 9.27, and amended L.1977, c. 978, §§ 6, 7, 10; amended L.1980, c. 471, § 3; L.1981, c. 947, §§ 3, 4; L.1985, c. 343, §§ 2, 3; L.1985, c. 789, § 10; L.1987, c. 847, § 1.)

Historical Note

1987 Amendment. Subd. (i). L.1987, c. 847, § 1, eff. Aug. 10, 1987, in sentence beginning "After an application" substituted ", when acting pursuant to their special duties, or police officers," for "of the state, town, village, county and city".

1985 Amendments. Subd. (b), par. 5. L.1985, c. 343, § 2, eff. July 16, 1985, substituted "social services law" for "social service law".

Subd. (b), par. 6. L.1985, c. 343, § 2, eff. July 16, 1985, inserted "or of a general hospital, as defined in article twenty-eight of the public health law,".

Subd. (b), par. 11. L.1985, c. 343, § 2, eff. July 16, 1985, added par. 11.

Subd. (f). L.1985, c. 789, § 10, eff. Apr. 1, 1986, substituted "mental hygiene legal service" for "mental health information service".

Subd. (i). 1985, c. 343, § 3, eff. July 16, 1985, added subd. (i).

1981 Amendment. Subd. (b), par. 9. L.1981, c. 947, § 3, eff. July 1, 1981, added par. 9.

Where claim was brought against State to recover damages arising out of claimant's alleged unlawful detention and confinement at hospital for the insane pursuant to court order, sanity of claimant at time of his commitment was not an issue and could not be reviewed. Williams v. State, 1959, 15 Misc.2d 721, 183 N.Y.S.2d 216.

§ 9.37 Involuntary admission on certificate of a director of community services or his designee

(a) The director of a hospital, upon application by a director of community services or an examining physician duly designated by him, may receive and care for in such hospital as a patient any person who, in the opinion of the director of community services or his designee, has a mental illness for which immediate inpatient care and treatment in a hospital is appropriate and which is likely to result in serious harm to himself or others; "likelihood of serious harm" shall mean:

1. substantial risk of physical harm to himself as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that he is dangerous to himself, or

2. a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear or serious physical harm.

The need for immediate hospitalization shall be confirmed by a staff physician of the hospital prior to admission. Within seventy-two hours, excluding Sunday and holidays, after such admission, if such patient is to be retained for care and treatment beyond such time and he does not agree to remain in such hospital as a voluntary patient, the certificate of another examining physician who is a member of the psychiatric staff of the hospital that the patient is in need of involuntary care and treatment shall be filed with the hospital. From the time of his admission under this section the retention of such patient for care and treatment shall be subject to the provisions for notice, hearing, review, and judicial approval of continued retention or transfer and continued retention provided by this article for the admission and retention of involuntary patients, provided that, for the purposes of such provisions, the date of admission of the patient shall be deemed to be the date when the patient was first received in the hospital under this section.

(b) The application for admission of a patient pursuant to this section shall be based upon a personal examination by a director of community services or his designee. It shall be in writing and shall be filed with the director of such hospital at the time of the patient's reception, together with a statement in a form prescribed by the commissioner giving such information as he may deem appropriate.

(c) Examining physicians designated by the director of community services shall be approved by the commissioner. A designee shall continue to have the power to act under this section until a certificate revoking his designation is filed by the officer appointing him or by a successor to such officer or by the commissioner.

(d) Notwithstanding the provisions of subdivision (b) of this section, in counties with a population of less than two hundred thousand, a director, of community services who is a licensed psychologist pursuant to article one hundred fifty-three of the education law or a certified social worker pursuant to article one hundred fifty-four of the education law but who is not a physician may apply for the admission of a patient pursuant to this section without a medical examination by a designated physician, if a hospital approved by the commissioner pursuant to section 9.39 of this chapter is not located within thirty miles of the patient, and the director of community services has made a reasonable effort to locate a designated examining physician but such a designee is not immediately available and the director of community services, after personal observation of the person, reasonably believes that he may have a mental illness which is likely to result in serious harm to himself or others and inpatient care and treatment of such person in a hospital may be appropriate. In the event of an application pursuant to this subdivision, a physician of the receiving hospital shall examine the patient and shall not admit the patient unless he or she determines that the patient has a mental illness for which immediate inpatient care and treatment in a hospital is appropriate and which is likely to result in serious harm to himself or others. If the patient is admitted, the need for hospitalization shall be confirmed by another staff physician within twenty-four hours. An application pursuant to this subdivision shall be in writing and shall be filed with the director of such hospital at the time of the patient's reception, together with a statement in a form prescribed by the commissioner giving such information as he may deem appropriate, including a statement of the efforts made by the director of community services to locate a designated examining physician prior to making an application pursuant to this subdivision.

(e) After signing the application, the director of community services or his designee shall be authorized and empowered to take into custody, detain, transport, and provide temporary care for any such person. Upon the written request of such director or his designee it shall be the duty of peace officers, when acting pursuant to their special duties, or police officers who are members of the state police or of an authorized police department or force or of a sheriff's department to take into custody and transport any such person as requested and directed by such director or designee.

(d) If at any time it is determined that the person is no longer in need of immediate observation, care and treatment in accordance with this section and is not in need of involuntary care and treatment in a hospital, such person shall be released without regard to the provisions of section 29.15 of this chapter, unless such person agrees to be admitted to another appropriate hospital as a voluntary or informal patient.

(e) If at any time within the seventy-two hour period it is determined that such person continues to require immediate observation, care and treatment in accordance with this section and such requirement is likely to continue beyond the seventy-two hour period, such person shall be removed within a reasonable period of time to an appropriate hospital authorized to receive and retain patients pursuant to section 9.39 of this article and such person shall be evaluated for admission and, if appropriate, shall be admitted to such hospital in accordance with section 9.39 of this article, except that if the person is admitted, the fifteen day retention period of subdivision (b) of section 9.39 of this article shall be calculated from the time such person was initially registered into the emergency room of the comprehensive psychiatric emergency program. Any person removed to a hospital pursuant to this paragraph shall be removed without regard to the provisions of section 29.11 or 29.15 of this chapter and shall not be considered to have been transferred or discharged to another hospital.

(f) Nothing in this section shall preclude the involuntary admission of a person to an appropriate hospital pursuant to the provisions of this article if at any time during the seventy-two hour period it is determined that the person is in need of involuntary care and treatment in a hospital and the person does not agree to be admitted to a hospital as a voluntary or informal patient. Efforts shall be made to assure that any arrangements for such involuntary admissions in an appropriate hospital shall be made within a reasonable period of time.

(g) If a person is examined and determined to be mentally ill the fact that such person suffers from alcohol or substance abuse shall not preclude receipt or retention under this section.

(h) All time periods referenced in this section shall be calculated from the time such person is initially registered into the emergency room of the comprehensive psychiatric emergency program.

(Added L.1989, c. 723, § 6.)

Historical and Statutory Notes

Effective Date; Expiration. Section effective July 24, 1989, and to expire July 24, 1994, pursuant to section 21 of L.1989, c. 723, set out as a note under section 31.27.

§ 9.41 Emergency admissions for immediate observation, care, and treatment; powers of certain peace officers and police officers

Any peace officer, when acting pursuant to his or her special duties, or police officer who is a member of the state police or of an authorized police department or force or of a sheriff's department may take into custody any person who appears to be mentally ill and is conducting himself or herself in a manner which is likely to result in serious harm to the person or others. Such officer may direct the removal of such person or remove him or her to any hospital specified in subdivision (a) of section 9.39 or any comprehensive psychiatric emergency program specified in subdivision (a) of section 9.40, or, pending his or her examination or admission to any such hospital or program, temporarily detain any such person in another safe

and comfortable place, in which event, such officer shall immediately notify the director of community services or, if there be none, the health officer of the city or county of such action.

(As amended L.1989, c. 723, § 7.)

Historical and Statutory Notes

1989 Amendment. L.1989, c. 723, § 7, deleted definition of "likelihood to result in serious harm", made provisions gender neutral and made reference to subd. (a) of section 9.40.

Effective Date of Amendment by L.1989, c. 723; Expiration. Amendment by L.1989, c. 723, eff. July 24, 1989, and to expire July 24, 1994, pursuant to section 21 of L.1989, c. 723, set out as a note under section 31.27.

§ 9.43 Emergency admissions for immediate observation, care, and treatment; powers of courts

(a) Whenever any court of inferior or general jurisdiction is informed by verified statement that a person is apparently mentally ill and is conducting himself or herself in a manner which in a person who is not mentally ill would be deemed disorderly conduct or which is likely to result in serious harm to himself or herself, such court shall issue a warrant directing that such person be brought before it. If, when said person is brought before the court, it appears to the court, on the basis of evidence presented to it, that such person has or may have a mental illness which is likely to result in serious harm to himself or herself or others, the court shall issue a civil order directing his or her removal to any hospital specified in subdivision (a) of section 9.39 or any comprehensive psychiatric emergency program specified in subdivision (a) of section 9.40, willing to receive such person for a determination by the director of such hospital or program whether such person should be retained therein pursuant to such section.

(b) Whenever a person before a court in a criminal action appears to have a mental illness which is likely to result in serious harm to himself or herself or others and the court determines either that the crime has not been committed or that there is not sufficient cause to believe that such person is guilty thereof, the court may issue a civil order as above provided, and in such cases the criminal action shall terminate.

(As amended L.1989, c. 723, § 7.)

Historical and Statutory Notes

1989 Amendment. L.1989, c. 723, § 7, deleted reference to section 31.39, made provisions gender neutral, and added references to subd. (a) of section 9.39 and subd. (a) of section 9.40.

Effective Date of Amendment by L.1989, c. 723; Expiration. Amendment by L.1989, c. 723, eff. July 24, 1989, and to expire July 24, 1994, pursuant to section 21 of L.1989, c. 723, set out as a note under section 31.27.

§ 9.45 Emergency admissions for immediate observation, care, and treatment; powers of directors of community services

The director of community services or the director's designee shall have the power to direct the removal of any person, within his or her jurisdiction, to a hospital approved by the commissioner pursuant to subdivision (a) of section 9.39 of this article, or to a comprehensive psychiatric emergency program pursuant to subdivision (a) of section 9.40 of this article, if the parent, adult sibling, spouse or child of the person, the committee of the

person, a licensed psychologist or licensed social worker currently responsible for providing treatment services to the person, a licensed physician, health officer, peace officer or police officer reports to him that such person has a mental illness for which immediate care and treatment in a hospital is appropriate and which is likely to result in serious harm to himself or herself or others. It shall be the duty of peace officers, when acting pursuant to their special duties, or police officers, who are members of an authorized police department or force or of a sheriff's department to assist representatives of such director to take into custody and transport any such person. Upon the request of a director of community services or the director's designee an ambulance service, as defined in subdivision two of section three thousand one of the public health law, is authorized to transport any such person. Such person may then be retained in a hospital pursuant to the provisions of section 9.39 or in a comprehensive psychiatric emergency program pursuant to the provisions of section 9.40 of this article.

(As amended L.1989, c. 723, § 7; L.1990, c. 860, § 1.)

Historical and Statutory Notes

1990 Amendment. L.1990, c. 860, § 1, included adult sibling, committee of the person and licensed psychologist or social worker within list of persons who may report mental illness to director.

1989 Amendment. L.1989, c. 723, § 7, made provisions gender neutral and added reference to include subd. (a) of section 9.40.

Effective Date of Amendment by L.1990, c. 860; Revision by L.1989, c. 723; Unaffected. L.1990 c. 860, § 2, provided: "This act [amending this section] shall take effect on the sixtieth day after it shall have become a law [eff. Sept. 23, 1990] and shall not affect the revision of section 9.45 of the mental hygiene law as enacted by chapter 723 of the laws of 1989, as amended."

Effective Date of Amendment by L.1989, c. 723; Expiration. Amendment by L.1989, c. 723, eff. July 24, 1989, and to expire July 24, 1994, pursuant to section 21 of L.1989, c. 723, set out as a note under section 31.27.

§ 9.55 Emergency admissions for immediate observation, care, and treatment; powers of qualified psychiatrists

A qualified psychiatrist shall have the power to direct the removal of any person, whose treatment for a mental illness he or she is either supervising or providing in a facility licensed or operated by the office of mental health which does not have an inpatient psychiatric service, to a hospital approved by the commissioner pursuant to subdivision (a) of section 9.39 of this article, if he or she determines upon examination of such person that such person appears to have a mental illness for which immediate observation, care and treatment in a hospital is appropriate and which is likely to result in serious harm to himself or herself or others. Upon the request of such qualified psychiatrist, peace officers, when acting pursuant to their special duties, or police officers, who are members of an authorized police department or force or of a sheriff's department shall take into custody and transport any such person. Upon the request of a qualified psychiatrist an ambulance service, as defined by subdivision two of section three thousand one of the public health law, is authorized to transport any such person. Such person may then be admitted in accordance with the provisions of section 9.39 of this article

(As amended L.1989, c. 723, § 8.)

Historical and Statutory Notes

1989 Amendment. L.1989, c. 723, § 8, made provisions gender neutral, and deleted reference to section 9.39 relative to the definition of the term "likelihood to result in serious harm".

Effective Date of Amendment by L.1989, c. 723; Expiration. Amendment by L.1989, c. 723, eff July 24, 1989, and to expire July 24, 1994, pursuant to section 21 of L.1989, c. 723, set out as a note under section 31 27

§ 9.57 Emergency admissions for immediate observation, care, and treatment; powers of emergency room physicians

A physician who has examined a person in an emergency room or provided emergency medical services at a general hospital, as defined in article twenty-eight of the public health law, which does not have an inpatient psychiatric service, or a physician who has examined a person in a comprehensive psychiatric emergency program shall be authorized to request that the director of the program or hospital, or the director's designee, direct the removal of such person to a hospital approved by the commissioner pursuant to subdivision (a) of section 9.39 of this article, if the physician determines upon examination of such person that such person appears to have a mental illness for which immediate care and treatment in a hospital is appropriate and which is likely to result in serious harm to himself or others. Upon the request of the physician, the director of the program or hospital or the director's designee, is authorized to direct peace officers, when acting pursuant to their special duties, or police officers, who are members of an authorized police department or force or of a sheriff's department to take into custody and transport any such person. Upon the request of an emergency room physician or the director of the program or hospital, or the director's designee, an ambulance service, as defined by subdivision two of section three thousand one of the public health law, is authorized to take into custody and transport any such person. Such person may then be admitted in accordance with the provisions of section 9.39 of this article.

(As amended L.1989, c. 723, § 8.)

Historical and Statutory Notes

1989 Amendment. L.1989, c. 723, § 8, added provision relating to the examination of a person in a comprehensive psychiatric emergency program by a physician, deleted reference to definition of the term "likelihood to result in serious harm" contained in section 9.39, and made provisions gender neutral.

Effective Date of Amendment by L.1989, c. 723; Expiration. Amendment by L.1989, c. 723, eff. July 24, 1989, and to expire July 24, 1994, pursuant to section 21 of L.1989, c. 723, set out as a note under section 31 27

§ 9.59 Immunity from liability

(a) Notwithstanding any inconsistent provision of any general, special or local law, an ambulance service as defined by subdivision two of section three thousand one of the public health law and any member thereof who is an emergency medical technician or an advanced emergency medical technician transporting a person to a hospital as authorized by this article, any peace officers, when acting pursuant to their special duties, and any police officers, who are members of an authorized police department or force or of a sheriff's department, who are taking into custody and transporting a person to a hospital as authorized by this article, and any employee of a licensed comprehensive psychiatric emergency program, specially trained in

OFFICE OF THE
COMMISSIONER

DEPARTMENT OF MENTAL HEALTH,
MENTAL RETARDATION AND ALCOHOLISM SERVICES
93 WORTH STREET
NEW YORK, N.Y. 10013
212-334-2081
FAX: 212-566-6256

November 6, 1992

TO: Luis R. Marcos, M.D.

FROM: Rita Duffy RD

SUBJECT: Involuntary Commitment Statutes

The following is a summary of existing New York Statutes that govern the involuntary commitment of mentally ill and those person suffering from alcoholism or substance abuse.

I. <u>Statutes Governing New York State Emergency Commitment of Mentally Ill Persons</u>.

<u>Article 9 of the Mental Hygiene Law</u>.

Mental Hygiene Law Article 9 governs the hospitalization, including, the involuntary hospitalization, of mentally ill persons.

Definitions set forth in MHL §9.01 provide that:

"in need of care and treatment" means that a person has a mental illness for which in-patient care and treatment in a hospital is appropriate.

"in need of involuntary care and treatment" means that a person has a mental illness for which care and treatment as a patient in a hospital is essential to such persons's welfare and whose judgment is so impaired that he is unable to understand the need for such care and treatment.

"likelihood to result in serious harm" or likely to result in serious harm" means (a) a substantial risk of physical harm to the person as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that the person is dangerous to himself or herself, or (b) a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm.

§9.27 Involuntary Admissions on Medical Certification.

MHL §9.27 authorizes involuntary admission upon certification by two physicians that the individual is mentally ill and "in need of involuntary care and treatment." The examining physician must consider alternate forms of care and treatment besides involuntary hospitalization. MHL §9.27(d). Mental Hygiene Legal Services (MHLS) must be notified immediately of a patient's involuntary admission, MHL §9.29(a), and must inform the patient of his statutory rights. MHL §29.09(b)(2). Written notice must also be given to the patient's nearest known relative, and up to three additional persons designated by the patient, no later than five days after admission. MHL §9.29(b).

An individual admitted pursuant to §9.27 may be retained without court authorization for up to sixty days. MHL §9.33. However, during the sixty days retention the patient, relative or friend, or MHLS may request a hearing on the question of the need for involuntary commitment. MHL §9.31 (a). Such a hearing must be held within five days of the request. MHL §9.31(c).

MHL §9.27 also provides that the fact that a mentally ill person is also an alcohol or substance abuser does not preclude commitment for a mental illness. MHL §9.27(h). This language is repeated in the other Article 9 commitment provisions discussed below.

§9.37 Involuntary Admission on Certificate of a Director of Community Services or His Designee.

MHL §9.37 authorizes involuntary admission upon certificate of a director of community services or his designee of persons who have "a mental illness for which immediate inpatient care and treatment in a hospital is appropriate and which is likely to result in serious harm to himself or others." The need for immediate hospitalization must be confirmed by a staff physician prior to admission. MHL §9.37(a). Such a patient may not be involuntarily retained beyond 72 hours unless an additional staff physician certifies the need for retention. The procedural safeguards relating to admissions pursuant to MHL §9.27 (notice, hearing, review, judicial approval of continued retention) apply to MHL §9.37 admissions.

§9.39 Emergency Involuntary Admissions for Observation, Care and Treatment.

MHL §9.39 provides that the director of a qualified hospital may receive and retain for up to 15 days any person alleged to have a mental illness for which immediate observation, care, and treatment in a hospital is appropriate and "which is likely to result in serious harm to himself or others." Retention cannot extend beyond 48 hours if the original physician's finding

of need for emergency admission is not confirmed within that period by a second medical opinion. MHL §9.39(a). Notification must be given to MHLS and certain designated individuals, any of whom may request a hearing which must be held no later than five days afterthe request is received. Upon expiration of the 15 days, if the patient does not choose to remain hospitalized on a voluntary basis, he must either be discharged or admitted as an involuntary patient pursuant to MHL §9.27.

§9.40 Emergency Observation, Care and Treatment in Comprehensive Psychiatric Emergency Programs.

Section 9.40 of the Mental Hygiene Law authorizes the director of any designated comprehensive psychiatric emergency room to receive and retain for a period not to exceed seventy-two hours, any person alleged to have a mental illness for which immediate observation, care and treatment in such program is appropriate and which is likely to result in serious harm to the person or others.

§9.41 Emergency Admissions; Police Authority.

Sections 9.41 of the Mental Hygiene Law authorizes the police to take into custody any person who appears to be mentally ill and is conducting him or herself in a manner which is likely to result in serious harm to self or others, as defined in §9.01. Such officer may direct the removal of such person to any §9.39 designated hospital.

§9.43 Emergency Admissions; Courts Authority to Issue Warrants.

Section 9.43 of the Mental Hygiene Law authorizes a court when informed by a verified statement that a person is apparently mentally ill and is acting in a manner which is likely to result in serious harm to self or others to issue a warrant directing that such person be brought before it. If that person is brought before the Court, based on the evidence presented before it, the Court may issue a civil order directing his or her removal to any §9.39 designated hospital.

§9.45 Emergency Admissions, Powers of Directors of Community Services.

Section 9.45 of the Mental Hygiene Law authorizes the director of community services or his designee to direct the transfer of a person to a §9.39 designated hospital, pursuant to a report by a parent, spouse. or child of the person, a licensed physician, health officer, peace officer or police officer that such person has a mental illness for which immediate care and treatment in a hospital is appropriate and which is likely to result in serious harm to self or others, as defined in Section 9.39.

II. Emergency Services for Intoxicated Persons. Article 21 of the Mental Hygiene Law.

The Mental Hygiene Law does not provide the same alternatives concerning emergency admission for intoxicated persons that it does for mentally ill persons. In fact, only one section of the Mental Hygiene Law, §21.09 addresses this situation.

§21.09 provides that a person who appears to be incapacitated by alcohol to the degree that he or she may endanger self or other person or property may be taken by the police, or by the director of community services or designee, to an alcoholism facility for immediate observation, care, and emergency treatment, or if no alcoholism facility is available, to any other place authorized by the director to give emergency treatment.

Mental Hygiene Law §21.09(d), provides that a person found by an examining physician to be incapacitated by alcohol to the point that the person may endanger himself or other persons or property may be involuntarily retained up to 24 hours, or until he is not so incapacitated. Subdivision (f) states that a person may not be retained for more than 24 hours without consent. There is no express right to a hearing in that section, but MHL §33.15 provides for obtaining a writ of habeas corpus.

III. Emergency Services for Substance Abusers Article 23 of the Menal Hygiene Law.

New York is one of four States that expressly excludes dependence upon or addiction to any substance such as alcohol or drugs from its definitions of mental illness or mental disorder (MHL §1.03(20)). Consequently, there is no authority in New York State to involuntarily commit drug dependent persons under general "mentally ill commitment laws". It should be noted that twenty-four states and the District of Columbia have specific detailed provisions for the involuntary civil commitment of drug dependent persons; eleven states have limited provisions; and an additional eleven states include substance and alcohol abuse in their definition of mental illness and utilize the general "mentally ill commitment laws" for persons suffering from these disabilities.

The Mental Hygiene Law includes only one provision which addresses the hospitalization of a substance abuser. Section 23.01(b)(3) authorizes a Court to issue a warrant to bring an alleged drug dependent person before it for a determination whether there are reasonable grounds to order him to undergo a medical examination at a designated facility.

However, under §23.05(b) of the Mental Hygiene Law, it is specified that "Participation in a substance abuse program is voluntary." Consequently, if a person is compelled to undergo a medical examination, and is found to be chemically dependent, he or she cannot be required to participate in a substance abuse program.

In summary, the Mental Hygiene Law contains a number of provisions to involuntarily transport and hospitalize mentally ill persons. (Article 9) However, the law provides but one procedure to transport intoxicated persons and specifically excludes involuntary treatment for substance abusers.

RD:jg

cc: William Martin

Form OMH 471B (1-89)

State of New York
OFFICE OF MENTAL HEALTH

REQUEST BY AN EXAMINING PHYSICIAN TO TAKE INTO CUSTODY/TRANSPORT A MENTALLY ILL PERSON

SECTION 9.27 (i) MENTAL HYGIENE LAW

PART A REQUEST FOR CUSTODY AND TRANSPORTATION OF A MENTALLY ILL PERSON BY A PEACE OFFICER

Pursuant to the authority granted to me under Section 9.27 (i) of the Mental Hygiene Law, I,

____________________ M.D., hereby request ____________________
(Name of Examining Physician) (Name & Badge # of Peace/Police Officer)

to take ____________________ into custody and transport this person to
(Name of Person)

____________________.
(Name and Address of Hospital)

I have examined this person and have certified that he/she is mentally ill and in need of involuntary hospitalization. This person has also been certified as mentally ill by another examining physician and an application for admission has been completed.

____________________ M.D., __________ __________
(Signature) (Time) (Date)

____
(Location/Address)

PART B REQUEST FOR TRANSPORTATION OF A MENTALLY ILL PERSON BY AN AMBULANCE SERVICE

I, ____________________ M.D., request, and ____________________
(Name of Examining Physician) (Name of Ambulance Service)

is hereby authorized under Section 9.27 (i) Mental Hygiene Law to transport ____________________
(Name of Person)

to: ____________________.
(Name and Address of Hospital)

I have examined this person and have certified that he/she is mentally ill and in need of involuntary hospitalization. This person has also been certified as mentally ill by another examining physician and an application for admission has been completed.

____________________ M.D. __________ __________
(Signature) (Time) (Date)

____
(Location/Address)

APPLICATION FOR INVOLUNTARY ADMISSION
ON CERTIFICATE OF A DIRECTOR OF COMMUNITY
SERVICES OR DESIGNEE
Section 9.37 Mental Hygiene Law

Person's Name (Last, First, M.I.)

III GENERAL INFORMATION

A. Mental Hygiene Legal Service

The Mental Hygiene Legal Service is an agency of the New York State Supreme Court which provides protective legal services, advice and assistance including representation, to all patients admitted to psychiatric facilities. Patients are entitled to be informed of their rights regarding hospitalization and treatment, and have a right to a court hearing, to be represented by a lawyer, and to seek independent medical opinion.

There is a Mental Hygiene Legal Service office in many psychiatric hospitals. Where there is no office at the hospital, a representative of the Service visits periodically and frequently. Any patient or anyone in his or her behalf may see or communicate with a representative of the Service by telephoning or writing directly to the office of the Service or by requesting someone on the staff of the patient's ward to make such arrangements for him or her. The Mental Hygiene Legal Service representative for this hospital may be reached at: ____________

B. Reimbursement

The patient is legally responsible for payment for the cost of care. Additionally responsible are the patient's spouse and in some cases the parents of a patient under the age of 21. Also legally responsible are the committee, guardian, or trustee of a trust fund established for the support of the patient, or any fiduciary or payee of funds for the patient.

Charges may be waived or reduced when there is inability to pay. Any person who applies for a waiver or reduction of charges must cooperate in a financial investigation to determine ability to pay.

STATE AND FEDERAL LAWS prohibit discrimination based on race, color, national origin, age, sex or disability.

PART A — APPLICATION FOR ADMISSION

I hereby request that ____________ (Name of person) be admitted to ____________ (Name of Hospital).

This request is made due to the behavior and/or specific acts described below:

____

____

____

Under the penalty of perjury, I attest that the information supplied on this application is true to the best of my knowledge and belief.

Signature of Director of Community Services or Designee	Official Title

Address	Date Mo.	Day	Year

PART B — CUSTODY/TRANSPORTATION BY A PEACE OFFICER *(OPTIONAL)*

I hereby direct, under the Mental Hygiene Law, that peace/police officers of ____________ (Department/Location) take the above-named person into custody and transport him/her to the above-named hospital.

Signature of Director of Community Services or Designee	Date Mo.	Day	Year	Time Hr	Min	A.M. / P.M.

PART C — PHYSICIAN'S CONFIRMATION OF NEED FOR IMMEDIATE HOSPITALIZATION

I am a physician on the staff of the above-named hospital providing services for the mentally ill. I hereby confirm the following (Check one).

☐ That the above-named person has been referred upon the application and certification of a Director of Community Services or Designee who is a physician and the above-named person is in need of immediate hospitalization

☐ That the above-named person has been referred upon the application of a Director of Community Services who is not a physician; that I have examined the above-named person and determined that he/she has a mental illness for which immediate inpatient care and treatment in a mental hospital is appropriate and which is likely to result in serious harm to self or others and, that hospitalization can reasonably be expected to improve the person's condition or at least prevent the person's deterioration.

Physician's Signature	Date Mo.	Day	Year	Time Hr	Min

State of New York
Office of Mental Hea

EMERGENCY or C.P.E.P. EMERGENCY ADMISSION
(Sections 9.41, 9.45, 9.55 and 9.57 Mental Hygiene Law)

Custody/Transport Of A Person
Alleged To Be Mentally Ill To A Hospital Approved
To Receive Emergency or C.P.E.P. Emergency Admissions

Person's Name (Last, First, M.I.) ____________________

Sex ____________ Date of Birth ____________

Address ____________________

I. §9.41 Mental Hygiene Law | **Custody/Transport By Certain Peace Officers and Police Officers**

I, ____________ (Name), a Peace Officer/Police Officer of ____________ (Department/Location),

hereby acknowledge that I have taken into custody ____________ (Name of Person), who appears to be mentally ill and is conducting him/herself in a manner which is likely to result in serious harm to him/herself or others.

A. I have removed or directed the removal of this person to ____________ (Name of §9.39 Hospital/C.P.E.P.*).

OR

B. I am temporarily detaining this person at ____________ (Location), a safe and comfortable place, pending examination or admission to ____________ (Name of §9.39 Hospital/C.P.E.P.*). I am notifying ____________ (Director of Community Services) or ____________ (Health Officer) of ____________ (City) or ____________ (County) of this detention/removal.

(Signature of Peace Officer/Police Officer) ____________ Title/Badge Number ____________ Mo. ___ Day ___ Yr. ___ Hr. ___ Min. ___

II. § 9.45 Mental Hygiene Law | **Request By A Director of Community Services or Designee**

I, ____________ (Name), am the Director of Community Services for ____________ (City or County).

OR

I, ____________ (Name), am the designee of the Director of Community Services for ____________ (City or County).

It has been reported to me that ____________ (Name of Person) has a mental illness for which immediate care and treatment in a hospital is appropriate and which is likely to result in serious harm to him/herself or others.

This information was reported to me by ____________ (Name), who is:

- ☐ a licensed physician
- ☐ a licensed psychologist or social worker currently responsible for providing treatment services to the person
- ☐ the health officer
- ☐ a peace or police officer
- ☐ the spouse of the person
- ☐ the child of the person
- ☐ the parent of the person
- ☐ the adult sibling of the person
- ☐ the committee of the person

I hereby direct, under the Mental Hygiene Law, that peace/police officers of ____________ (Department/Location) take this person into custody and transport him/her to ____________ (Name of §9.39 Hospital/C.P.E.P.*).

OR

I hereby request, under the Mental Hygiene Law, that ____________ (Name of Ambulance Service) transport this person to ____________ (Name of §9.39 Hospital/C.P.E.P.*).

Signature of Director of Community Services or Designee ____________ Mo. ___ Day ___ Yr. ___ Hr. ___ Min. ___

Form OMH 474A/476A (1-91) page 2

Custody/Transport Of A Person Alleged to be Mentally Ill To A Hospital Approved to Receive Emergency Admissions	Name (Last, First, M.I.)

III. § 9.55 Mental Hygiene Law	Request By A Qualified Psychiatrist (MAY NOT Be Used for Custody/Transport of a Person to a C.P.E.P.)

I, ______________________, M.D., a qualified psychiatrist*, am supervising or providing treatment for ______________ (Name of Person) at ______________ (Name of Facility), a facility licensed or operated by the Office of Mental Health which does not have an inpatient psychiatric service. I have examined this person and am of the opinion that s/he has a mental illness for which immediate observation, care and treatment in a hospital is appropriate and which is likely to result in serious harm to him/herself or others.

I hereby direct, under the Mental Hygiene Law, that peace/police officers of ______________________ (Department/Location) take into custody and transport this person to ______________ (Name of §9.39 Hospital**)

—OR—

I hereby request, under the Mental Hygiene Law, that ______________ (Name of Ambulance Service) transport this person to ______________ (Name of §9.39 Hospital**).

*A qualified psychiatrist means a physician licensed to practice medicine in NY state, who: is a diplomate of the American Board of Psychiatry and Neurology or is eligible to be certified by that Board, or who is certified by the American Osteopathic Board of Neurology and Psychiatry or is eligible to be certified by that Board.

Signature of Psychiatrist	Mo	Day	Yr.	Hr.	Min.	☐ AM ☐ PM

IV. § 9.57 Mental Hygiene Law	Request By Emergency Room Physician (MAY NOT Be Used for Custody/Transport of A Person to a C.P.E.P.)

I, ______________________, M.D. have made an emergency room examination of or have provided emergency medical services for ______________ (Name of Person) at ______________ (Name of Hospital), which does not have inpatient psychiatric service. It is my opinion that this person has a mental illness for which immediate care and treatment in a hospital is appropriate and which is likely to result in serious harm to him/herself or others.

I hereby request that the hospital director direct the removal of such person to a hospital approved by the Commissioner of OMH under MHL Section 9.39.

Signature of Physician	Mo	Day	Yr	Hr	Min	☐ AM ☐ PM

Based on the above request, I hereby direct under the Mental Hygiene Law that peace/police officers of ______________________ (Department/Location) take into custody and transport this person to ______________ (Name of §9.39 Hospital**)

—OR—

Based on the above request, I hereby request under the Mental Hygiene Law that ______________ (Name of Ambulance Service) transport this person to ______________ (Name of §9.39 Hospital**).

Signature of Hospital Director/Designee	Mo	Day	Yr	Hr	Min	☐ AM ☐ PM

**A hospital approved by the Commissioner of OMH under MHL Section 9.39 as maintaining adequate staff and facilities for admitting patients on an emergency basis

COMMUNITY SERVICES

Deinstitutionalization efforts in New York State have shifted the main focus of services to mentally retarded, developmentally disabled, and mentally ill citizens away from the institutional setting and into the community, requiring a range of community-based programs. Unfortunately, the development of the community services which were supposed to follow these patients out of the institutions has consistently fallen short of the demand. Such services, generally provided by nonprofit or not-for-profit organizations and regulated by the Office of Mental Health (OMH) and/or the Office of Mental Retardation and Developmental Disabilities (OMRDD), can include transportation, recreation, vocational training, education, and employment assistance. Funding comes from a variety of State, local, and private sources.

Community residences are a fundamental part of the community-based system of services. Such residences emphasize intensive treatment, interaction, and rehabilitative therapy in an attempt to successfully reintegrate the disabled into the community. As outlined in a 1987 Senate report, community care is not only philosophically sound, it can also be cost-effective without hindering the quality of care if implemented appropriately. As of July 25, 1991, there were 24,035 persons in community residences under OMRDD's auspices, including intensive care facilities. During FY 1991-92, it is estimated there will be 8,300 OMH and OMH-regulated operational community residence beds which served community residence clients, many of whom were in transitional (short-term) placements.

INVOLUNTARY AND EMERGENCY ADMISSIONS

Sections of the Mental Hygiene Law which pertain to involuntary admission to psychiatric institutions based upon the "likelihood to result in serious harm" are often misconstrued to mean that a mentally disabled individual must exhibit violent behavior in order to be eligible for involuntary admission to a hospital. Provisions of the Mental Hygiene Law pertaining to emergency admissions for immediate observation, care, and treatment define the likelihood to result in serious harm as: "substantial risk of physical harm to him/herself as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that he/she is dangerous to him/herself; or substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm."

The courts on occasion have interpreted New York's Mental Hygiene Law to permit involuntary confinement of a mentally ill person who poses a threat of physical harm to him/herself as the result of his/her failure to meet the essential needs of health and safety. Physicians who are unfamiliar with the case law, however, have expressed concern regarding the legal criteria for involuntarily confining such persons because present statutory language regarding dangerousness is specific only as to violence or suicide. The large number of apparently mentally ill and often deinstitutionalized persons unable to care for themselves and entering the ranks of the homeless has added to the concern over involuntary commitment standards. The Senate passed a measure to clarify what "in need of involuntary care and treatment" means in the Mental Hygiene Law (S. 2183, Passed Senate, 1991).

The need for emergency psychiatric services has grown more intense as increasing numbers of mentally ill people reside in the community. At a February 8, 1989 public hearing on psychiatric emergency care in New York City, officials cited increased demands on the system by acquired immune deficiency syndrome (AIDS), drug abuse, the homeless, and an aging population, which threatens to collapse the mental health system. An agreement made between OMH and New York City officials in 1989 to work together to define responsibilities and solve the crisis has succeeded in keeping the hospital psychiatric bed occupancy rate below 100% since the Summer of 1989. In addition, the Legislature in 1989 passed a measure creating Comprehensive Psychiatric Emergency Programs, designed to provide a full range of psychiatric emergency services within a defined geographical area, to address the issue (Chapter 723, L. 1989).

1991 ANNUAL REPORT
N.Y. STATE SENATE STANDING COMMITTEE ON MENTAL HYGIENE

Expanding Nurses' Roles in Psychiatric Emergency Admissions

S. 4412-B
Chapter 309
(Spano)

Adds registered professional nurses to the list of persons who may report to a director of community services that a person in the community may have a mental illness for which emergency psychiatric care may be necessary, thereby enabling the director to order such person's removal to a facility for treatment. Effective September 13, 1991. (Mental Hygiene Law)

Transportation of Person with Mental Illness by Ambulance

A. 6647
Chapter 357
(same as S. 4112, Spano)

Authorizes ambulance services as defined in the Public Health Law to transport persons who require involuntary psychiatric hospitalization upon the written request of the local director of community services or his/her designee. Effective July 15, 1991. (Mental Hygiene Law)

IMPORTANT BILLS

Definition of Necessity for Involuntary Care for Mental Illness

S. 2183
Passed Senate
(Spano)

Adds to the definition "in need of involuntary care and treatment" to include a person who has a mental illness and because of their mental illness is not capable of surviving in freedom or is helpless to avoid the hazards of freedom through his/her own efforts or with the help of willing family members or friends, even without recent overt conduct evidencing substantial and present risk of serious physical harm. (Mental Hygiene Law)

MENTAL HYGIENE FINANCE

New York State administers services to the mentally disabled through the Department of Mental Hygiene, which encompasses the Office of Mental Health (OMH), the Office of Mental Retardation and Developmental Disabilities (OMRDD), and the Office of Alcoholism and Substance Abuse (OASA), which is further divided into the Division of Alcoholism and Alcohol Abuse (DAAA) and the Division of Substance Abuse Services (DSAS). Funding mechanisms for services to the mentally disabled are provided at the federal, State, and local levels, and providers compete for funds with a variety of other human services. Emphasis has been placed on providing services in the community and away from overreliance on inpatient care, resulting in parallel service systems which need to be clarified, coordinated, and integrated. While the focus is away from institutionalized care, the remaining inpatient population tends to need the most intense services, and requires adequate and appropriate staff to meet their needs. In order to provide quality services to all mentally disabled clients, both inpatient and community services need continual administrative and fiscal improvements to integrate services within the entire system and to strengthen and the quality of care. A significant 1989 measure authorized the New York State [illegible] (MCFFA) to issue [illegible]

TUESDAY, NOVEMBER 4, 1986

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Science Times

The New York Times

To Expert Eyes, City Streets Are Open Mental Wards

A Psychiatric View of Broadway

Anne McGrath, a mental health worker, travels Upper West Side streets trying to gain the trust of "clients." She begins by offering a bag of food.

At 87th Street, an old toothless man wearing a baseball cap answers all inquiries with a gibberish that seems to combine every European language, from Swedish to Spanish.

On the island between 82d and 83d Streets, a woman wearing a garbage bag for a skirt accepts the sandwich and asks the worker for a pair of slacks, which are brought to her.

At 78th Street, a woman in her 60's pokes through a garbage can. Offered food, she strikes a dignified pose, walks across the street, and reaches into another garbage can.

At 72d and Broadway, a jovial woman in her 50's sits on a bench. She says she cannot talk now because she is on television; she starts singing "The Rose of Piccardy."

In front of Juilliard, a frantic, pacing man, wrapped in a grimy blanket, takes the sandwich and stalks away without breaking stride.

In front of Lincoln Center, a man in his 30's, with matted hair and beard lies on a bench. He takes a

Schizophrenics spur a new field of street psychiatry.

By DANIEL GOLEMAN

BROADWAY from Columbus Circle through the West Side is filled with new condominiums and well-dressed shoppers come to sample the sparkling pleasures of gourmet delicatessens and designer boutiques.

But seen through the eyes of a mental health worker, Broadway is a very different street. The swank and style recede, and a bent old woman in a filthy coat, fishing a slice of bread from the garbage can by Zabar's,

First of two articles about the homeless mentally ill.

and a man wrapped in a grimy blanket, huddled on the sidewalk by Lincoln Center talking earnestly with no one, come into focus.

These are the clientele of a team of health workers who cruise the Upper West Side, searching out those whose confusion, delusions and despair have driven them to a life on the streets.

This is the Broadway polite eyes avoid, an open psychiatric ward where those with severe mental illness find asylum of sorts in a bench or doorway. Broadway, with its busy traffic and mall-like traffic islands with benches, seems to be one of those public spaces that invites the mentally ill to set up housekeeping. And what is happening there is typical of many other streets and parks in cities throughout the country.

To look upon this Broadway is to see the city with new eyes. The images that leaped out block after block were revelations to me — even though as a psychologist I had tals and had seen every sort of schizophrenic — as I traveled with some of the workers the city depends on to lure the deranged in for treatment.

There were disabilities more florid than I had seen before: people lost in the utter apathy that schizophrenia can breed and others fighting through a paranoid world of delusional villains out to ensnare them. These disorders are found in abundance in mental hospitals, but there medications blunt their full force. On Broadway the diseased mind is free to torment its victim relentlessly.

My guides through this netherworld were the staff of Project Reachout, a group whose responsibility is the mentally disturbed on the streets of the Upper West Side and in Central Park. The group is one of a handful working in the city.

Project Reachout, a service of the Goddard-Riverside Community Center, a nonprofit charitable organization, is widely viewed as a leader in what might be called street psychiatry, a specialty that hardly existed five years ago, before the mentally ill became homeless in such numbers. Today, of the estimated 45,000 homeless in New York City, at least a third are thought to suffer mental illness.

The mentally ill on the city streets are people that the system has failed. They cannot, by law, be forced into treatment unless they are so dangerous that life is at risk — and very few are ever that dangerous. Many have been in and out of mental hospitals for years, in a revolving door that gives them care until their symptoms subside, then releases them to drift back to the streets.

An increasing number have never had any help at all for their mental problems. And, in ever-growing numbers, they have thoroughly insinuated themselves into the major boulevards, a silent witness to the heartlessness and befuddlement that has created no better alternative for them.

There is much that the mental health workers can offer: Government stipends for the mentally disabled, medical care, psychiatric help, a place to live. But the people in the streets are so disorganized, so frightened and wary, so isolated from human contact, that they are worlds away from these benefits.

The workers' challenge is to engage them in some way and then, very slowly, to build a bond of trust strong enough that they will come in for help. The effort is akin to coaxing a wary fawn to come near for food; force, or too aggressive an approach, will fail here. Success depends on gentle patience and the instincts of the heart.

Indeed, more often that not, the first time the workers approach a potential client, they are rebuffed. "We use sandwiches as bait," Anne McGrath explained as the van for Project Reachout began its morning round. The sandwich is in a brown paper bag, along with juice, a Famous Amos cookie — donated to the project — and a slip of paper with the address and telephone number of the office, and an offer of help.

The paranoid may see the sandwich as part of a plot; the regressed and withdrawn psychotic may be too timid or out of touch to take help. The woman who had retrieved bread from the garbage can by Zabar's, for instance, pulled herself into a dignified huff and marched across the street. There, she found the remains of a pizza in another garbage can.

It often takes weeks before the offer of a sandwich is accepted, weeks more before there is conversation, and months before an actual visit to the office.

479 Street Clients Monthly

Project Reachout has recently averaged each month 479 street people it is in contact with regularly — people who day after day, unless they wander elsewhere for a time, are on a bench or sidewalk, or perched on a rock in the park. An additional 120 or so people are approached just once, never to be seen again. And, in any given month, according to Diane Sondes, the project's director, about 25 percent of the street clients will finally accept the invitation to come into the project office, where they receive anything from a cup of coffee and a shower to a room, financial aid and psychiatric care.

The van's first stop on this particular morning is a Jamaican woman in her 30's who has spent the better part of a year on a bench in the mall that divides Broadway near 98th Street. The woman, Ms. McGrath tells me, is so confused and apathetic that last winter, when she lost several toes to frostbite, she did not even know she *needed medical help*. The Reachout workers called in Project HELP, a roving mental health team with a psychiatrist who can commit people whose mental illness endangers their life. The woman was committed, spent three months in city and state psychiatric wards and then, as often happens with the homeless, was released to a shelter. Instead of going there, though, she came straight back to the bench. She considers it a safe refuge.

As we approach her, the woman *barely turns to look*; when she speaks her face is expressionless. From Ms. McGrath she gets another sandwich and makes another promise to come in, a promise she will not keep — at least not yet.

Pernicious Negative Symptoms

Her apathy is a common hallmark of schizophrenics who are not plagued by vivid hallucinations but are too confused to do much for themselves, and so overwhelmed by apathy that they do nothing anyway. Recent research on schizophrenia has emphasized the pernicious nature of these so-called "negative" symptoms, including the loss of all motivation and the muting of feeling. From a psychiatric viewpoint, she might be

diagnosed as a schizophrenic of the "disorganized" type, because of the absence of systematic delusions and the blunted emotions she displays even when she tells, in a monotone, of being evicted from her tiny apartment.

Traveling with the Reachout team as it searches out its clients makes clear just how destructive those negative symptoms are to the schizophrenics on the street. The woman's pattern is repeated time and again in others, their apathy and lethargy shrinking their lives to ever smaller orbits, with ever fewer efforts to care for themselves.

To the public, such people may seem perennial eyesores, somehow to blame for their pathetic circumstances; through the psychiatric lens it is clear they are victims of the subtler symptoms of schizophrenia.

In the traffic island between 82d and 83d Streets we find a woman who wears a plastic garbage bag for a skirt, a large wool pullover and a flashy green knit hat. She is talkative, mostly complaining about the frustrations of trying to get her Social Security checks. She has been camped on that island on and off for almost 18 months, from the day she was evicted from her small room in the hotel just across the street. She is determined to get her revenge, and until then nothing will move her from that spot.

Too Wary to Go In Office

At times, the woman has angrily threatened people who dared to cross Broadway over "her" island. On this day, in a different mood, she asks Ms. McGrath for a pair of pants and some socks, and Ms. McGrath brings them later. Although the Reachout team has worked with the woman since she appeared on the island, the woman came by the office just once, and then was too wary to come in the door.

Her argumentativeness and her angry fixation on revenge, along with the apparent absence of hallucinations, mark her as a paranoid. The paranoids on the streets are among the most difficult to help, their suspicion making them steer well clear of everyone. They are most wary of those who dare approach them, even with help.

At 72d Street, sitting on the sidewalk leaning against a bank, is a woman in her 50's, whose elegant, though filthy, clothes bespeak a better past. She says almost nothing, but as she takes her sandwich, an insect touches on it and flies away, prompting her to tear off that part of bread and throw it away. Her hand remains frozen in midair for a full half-minute.

In the past, the worker tells me, the same woman has been seen inside the bank, agitatedly tearing up the deposit slips and literally tearing her hair out. At other times, she stares at a tree, unmoving, for hours. The alternation between stupor and excitement marks the woman as a catatonic, a type of schizophrenic whose most extreme symptoms are rare among hospital patients because medications suppress them. Because she lives on the streets, her symptoms run rampant.

Further down the street in front of Lincoln Center we encounter a man in his early 30's, with matted hair and beard, who lies on a bench on a small traffic island, watching the cars stream by. His is an isolated spot, the perfect place: No one comes there, and, judging by his demeanor and tone, he wants no contact.

The man takes a sandwich with a suspicious glare and responds to the offer of help if he will come into the office with an "O.K." that says "leave me alone."

"You've got to know when to back off," says Mike Mastrogiovanni, the worker, who explains that it took weeks of offering before the man would even accept a sandwich.

That is part of the art of those who work trying to build trust with the deranged of the streets. Through daily contacts with these people, the Reachout workers and others like them are building an expertise that was virtually unknown four or five years ago. Although their patients have severe mental illness, the psychiatric workers of the streets have none of the luxuries of hospital psychiatry — medications, large staffs, even a building to work in.

Who Is Helping

Only parts of the city have outreach programs for the mentally ill. The main programs, some of which operate only from mobile vans, are:

PROJECT REACHOUT. Covers 59th Street to 110th Street, all of Central Park to the Hudson River. 589 Amsterdam Avenue at 88th Street, basement. 595-3066.

MIDTOWN OUTREACH. Covers 34th Street to 59th Street, from Fifth Avenue to the Hudson River. 620-0340.

PROJECT HELP. Manhattan below 34th Street. Also has mobile unit with a psychiatrist for those homeless of immediate danger to themselves or others. 227 Madison Street 374-4062

LENOX HILL OUTREACH TEAM. Covers 59th to 96th Street, Fifth Avenue to East River. 331 East 70th Street. 744-5022.

PROJECT HOME. Covers parts of Brooklyn, from Brooklyn Heights. 718/596-5500, extension 369.

Lost in a Private World

"I was sure the world had ended and started over, that it was the Year Two, and people were being held prisoner in all the buildings and subways," said Robert, recalling the eighteen months he spent roaming New York City streets, plagued by voices in his head and bedeviled by wild delusions. Although he is under psychiatric treatment and is calm now, Robert's memories of those months are vivid still.

"I was nervous all the time and walked from Canal Street up Broadway to 116th Street, almost running like an animal; while I walked I heard people's voices — Ho Chi Minh, Genghis Khan, and a Chinese gangster named Charlie Hen," said Robert.

"I would chant as I walked. In my mind I was 'running the gauntlet,' being persecuted by Islam. For a while I worshipped the Standard Oil Building as a symbol of jealousy; I thought it was a space center — it sort of looks like a space ship."

For those months, Robert was lost to the world. He spoke to no one and never asked for help or money. Occasionally people would give him a dollar or two, which he immediately spent on cigarettes and coffee.

"I was psychotic then, but I'm on medication now," he said. "When I think about it now, it doesn't seem real, but the delusions were all very real to me then. I suffered a lot."

At 42, Robert seems bright and personable today. But when he was first spotted striding along Broadway by the workers for Project Reachout, "he was a wildman," in the words of Judy Pritchett, Assistant Director of the project. "He was scary-looking, with matted, wild hair and beard, and filthy clothing."

Robert remembers that, in those days, he wore two pairs of pants, several sweaters, and two overcoats, no matter the weather. He never took a shower; he felt "sealed" in his clothes.

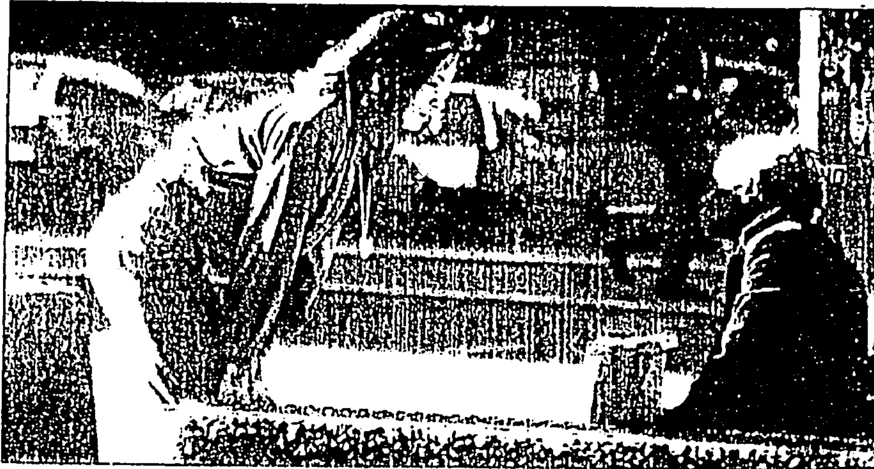
Robert ate whatever he could find in garbage cans, food he thought was left there for him "by the deities." A big problem was where to go to the bathroom; twice he defecated in the street, but, he says, "Ho Chi Minh made fun of me."

Robert's mental map of the city combined his delusions, such as a "lake of fire," with more practical landmarks, including public rest rooms and drinking fountains. Wherever he went, he carried a sleeping bag he found in the garbage; he slept in several favorite spots, particularly near the Carousel in Central Park, a place near both drinking fountains and public bathrooms. "I never worried about whether it was safe," he says.

Those eighteen months of madness on the streets were one of many such episodes in Robert's life. His first hospitalization was in Glen Oaks Hospital on Long Island, when he was seventeen, and he has gone from mental hospital to the streets many times since.

In Robert's mind, the Goddard-Riverside Reachout worker who approached him to offer a sandwich and juice was a wealthy industrialist who owned a chemical factory. Robert thought that the man was Mr. Goddard, and that he had come to recruit him for a medical research project at his factory, which was named Goddard-Riverside. The first time Robert came to the Project office and got medication from a psychiatrist, he thought it was all part of the research, which he was willing to assist.

"When I was on the streets, I was more interested in my delusions than in what was actually going on," says Robert. "They were much more interesting."



The New York Times/Keith Meyers

Anne McGrath of Project Reachout talking with a homeless mentally ill woman on Broadway. "We use sandwiches as bait," Ms. McGrath said of efforts to engage the homeless in conversation.

Movement for Asylums Recalled

They rely instead on patience, flexibility and intuition. If things continue as they are, this is a craft that will be needed more and more, as psychiatric services are redesigned to meet what amounts to a crisis. This is a moment in the history of psychiatry parallel to the 18th-century emergence of the first asylums for the mad, a movement that sought a humane refuge for the mentally ill who then roamed the streets. Now, as then, they are in need of a more protected haven, of psychiatric care, and of someone trustworthy who can help them manage the small details of daily living that are now just too overwhelming.

On any given day on this strip of Broadway, there are an estimated 80 to 100 mentally ill homeless people, about 30 of whom will have contact with the Reachout workers. In the days I traveled with the workers, the most prevalent problem seen, by far, was schizophrenia in all its varieties — including the catatonic, the disorganized, the paranoid.

But the most common sort of schizophrenia that I saw seemed to fall in the "undifferentiated" category. The victims suffer a mix of delusions, hallucinations — in the form of voices in their minds — and incoherence, and are, in general, so disorganized they can barely care for themselves.

A large number of the schizophrenics seen on the streets are in a phase of the illness in which their more obvious and bizarre symptoms are less noticeable. The negative symptoms dominate: social withdrawal, a gross deterioration in personal hygiene and grooming, indifference even to their own plight, apathy.

Studies have found that there are as many deteriorated alcoholics on the streets as schizophrenics, and to the untutored eye the two groups may seem the same. Indeed, some schizophrenics will take to drinking to quiet the voices that plague them, in a desperate "self-medication." The Reachout workers will, on first sighting, check to see if an alcoholic is not actually mentally ill; the pattern of alcohol and drug abuse among the schizophrenics on the street is increasingly common. Alcoholics, though, have their own programs, centering around detoxification treatment.

There are, of course, other mental disorders that bring people to the streets, notably acute depression, which sometimes can mix with psychosis. A handful of the mentally ill seen on the streets were people for whom the sudden onset of such a depression led to their precipitous fall to homelessness.

Those who work with the homeless mentally ill say the city law that allows people to be taken forcibly to city shelters when the temperatures fall to freezing will be of little help beyond offering sheer survival. The large city shelters are, for the mentally ill, no refuge. "Being told you have to go to a city shelter is terrifying to someone who believes the streets offer a safe home," said Judy Pritchett, assistant director of Project Reachout.

"Fort Washington armory has 900 men on a good day," she said. "It's the mentally ill there who are most vulnerable, who get robbed or beaten, or even raped."

Before I embarked on this journey, the homeless seemed more or less to be all of a kind. Now, though, I see the stark difference between those who roam the streets out of poverty and those who suffer an affliction of the mind that denies them a better choice.

Waiting for a Rescue

I am thinking, for instance, of that nameless woman in her 20's who even now is undoubtedly still sitting on that bench in Central Park where she first appeared 10 weeks ago. Stylishly dressed, her long black hair always neatly combed, her well-packed suitcase by her side, the woman only recently held a job in the city as a secretary, had an apartment with roommates. But now she sits waiting for a rescuer — a television announcer she believes to be her "real" mother — to come to the park and take her home. The woman with the suitcase will not move, nor will she accept any help; she clings stubbornly to her fantasy of rescue.

But, then, there is the man who had sat in the middle of a baseball field since last May, so depressed and listless he would not move out of the rain. Then, one day just last week, the Outreach workers found him crying, for the first time.

"Why are you crying?" Margarita Lopez, the worker, asked him.

"I don't know," he said.

And, at that, Ms. Lopez started crying, too.

The next morning, the man showed up at the door of the Reachout office and accepted, for the first time, an offer of help.

Next Week: The Successes.

TUESDAY, NOVEMBER 11, 1986

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Science Times

The New York Times

For Mentally Ill on the Street, a New Approach Shines

Therapy revolves around medication, caring people and structured day.

By DANIEL GOLEMAN

ROBERT was at a cooking class baking a cake when he saw Timothy walk by. Robert came out of the kitchen to shake Timothy's hand. "You're moving into a good place," Robert said. "You'll like it here."

For both, that simple welcome marked the end of what seemed, a year ago, an impossible journey. Just last fall Robert spent his days frantically pacing the streets of New York, tormented by voices only he could hear; Timothy huddled in a pile of garbage at the bottom of a stairwell, sure he was being pursued by the Mafia.

Now Timothy was moving into his own room at the St. Francis Residence, a home for the mentally ill who have been rescued from desperate existence on the streets.

The residence embodies what seems one of the few truly workable answers for the thousands of mentally ill relegated to the streets when state mental hospitals were emptied before effective treatment alternatives were established.

In an era in which the most common responses to the problem are indifference or despair, it represents a new partnership between modern psychiatry and older humanitarian traditions.

As one follows those workers who roam the city coaxing into treatment the mentally ill of the streets, the outlook for success seems more hopeful, even as the notion of "success" is drastically amended. After all, how complete a return to life can be achieved by the woman who spent 22 years under the delusion she was a traffic officer, toiling

Second of two articles about the homeless mentally ill.

countless days urgently directing the cars that passed by her favored corner?

Experts in the field recognize that the homeless mentally ill, if offered the best of care, would fill a range of niches. Some would return to productive life; others would still face lifelong inability to perform the smallest daily tasks. Such a range of needs and possibilities, the experts are saying, demands an equivalent spectrum of services.

These suggestions have been adopted as the official policy of the American Psychiatric Association. Proposals similar to those of the association are contained in a report, commissioned by the National Institute of Mental Health, on the New York City's homeless mentally ill.

A central concept in both sets of of proposals is "supportive housing." That phrase embodies a concept of many layers of support. Mental health workers must make sure that their clients eat, take their medicine, keep appointments, work their way through bureaucratic red tape, get training in basic social skills and find work when possible. The clients' condition must be monitored and psychiatric help sought when necessary. The total vigilance of a caring family has to come into play. In some instances, it means that when a client heads off for a new job he is accompanied by a guardian who will take over if the client fails.

This kind of treatment, once called "milieu therapy," seemed like a good idea with no place to go twenty years ago. Today, it is finally gaining acceptance.

It is being applied, for the first time with people whose plight has seemed so hopeless

and the reviews are all good so far. The key has been to combine the compassion of nonprofessional guardians, who bear most of the day-to-day burden with a tight link to professional psychiatry, which is called in as needed.

A Year on the Road Back

Jan. 23, 1985. Mental-health workers find Timothy huddled in a pile of garbage in a stairwell on West 68th Street. He says the Mafia is after him and laughs oddly. From his confused account, it appears that he has been hiding in garbage for at least two months. He resists efforts to move him to a shelter, preferring the stairwell.

March 4. After several false starts, Timothy is finally brought into the office of Project Reachout for treatment. One drug, then another is tried. He is put on a regimen of Prolixin, an anti-psychotic drug that diminishes agitation and delusions.

March 11. Meanwhile, a psychiatrist records improvement in Timothy's mental condition: his thinking is clearer; he is more alert, feeling better about himself. The patient starts to take showers.

March 19. For the first time, Timothy expresses interest in washing his clothes.

April 10. He agrees to leave the stairwell behind, accepting a tiny hotel room from the project.

May 19. He starts working in the kitchen at Fountain House, an organization that helps chronic schizophrenics to take part in society again.

Sept. 10. After project workers apply in his behalf, he receives his first Government disability payment.

Sept. 25. He begins work as an messenger at Manufacturers Hanover Trust bank offices. A project worker initially accompanies him to take over if he fails.

Oct. 29. He moves into a room of his own at the St. Francis Residence. There is a cable hookup for the color television he hopes to get. The room is newly painted. On the floor by the closet is a blue plastic bucket containing three pairs of filthy shoes and six umbrellas, mementos of his street days.

The New York Times

Through a painstaking process over a year, Timothy was rescued from the street and prepared for a job.

These settings exist now, though most were established only recently, but there are far too few. In New York City, the St. Francis Residence, as well as a program run by Fountain House and one called The Heights in Washington Heights are widely regarded as among the best.

Early data on how they work are beginning to emerge. In recent research, the St. Francis Residence was found to be six times more effective than the prevailing facilities — including state mental hospitals and shelters — in keeping the most seriously disturbed of the homeless mentally ill from drifting back to a life on the streets.

Most of the mentally ill on the streets suffer from schizophrenia, a serious mental disorder whose most prominent symptoms include delusions, auditory hallucinations and confusion. For some, schizophrenia is a lifelong condition whose symptoms alternately worsen and improve. For others, a single psychotic episode is followed by complete remission.

The new approach means creating a surrogate family including someone who will help the schizophrenic past the obstacles of agencies that offer stipends but only to people with an address, a birth certificate or identity card. Some of the other stumbling blocks include finding the agency's office in the first place or filling out a 16-page application.

Such help is all the more essential because the rules of most social service agencies trap the homeless mentally ill in a Catch-22 as bizarre as some of their own delusions: many programs for the mentally ill will not help them because they are homeless; most programs for the homeless will not help them because they are mentally ill.

Until that hurdle is overcome, the schizophrenic is out of reach of the relief psychiatry can offer. In most cases, anti-psychotic medications can calm the more flamboyant symptoms: voices in the head that never stop, delusions of persecution or grandeur, incoherence and helplessness in the face of life's smallest demands.

"The improvements the right medication can bring to what seem like hopeless cases on the street is surprising," said Katherine Falk, an assistant professor of psychiatry at New York University who heads a group of psychiatrists who have volunteered to help the homeless mentally ill.

But once those florid problems are muted, negative symptoms often remain. These include a withdrawal from human contact that can lead to complete isolation, peculiarities such as collecting odd bits of junk, oddities of speech and thought, lack of interest in caring for oneself and pervasive apathy.

Robert, the man who spent 18 months walking Broadway from Canal Street to 110th Street, hearing the voice of Ho Chi Minh, no longer is haunted by voices now that he receives medication. But he is beset by lethargy that often makes it difficult even to leave his room at the St. Francis Residence.

Some find their more obvious symptoms, such as delusions, persist in less severe form. The woman who directed traffic for so many years, for example, no longer insists she is a traffic officer. But she holds to the belief that she is an Italian who emigrated to this country just four years ago — despite the fact that she was born and raised in New York City.

But once the fog of mental illness starts to lift, the changes can be startling. For instance, a man who spent six months roaming the city at night and dozing all day in a Central Park ballfield finally accepted the offer of help from the mental health workers of Project Outreach who had been bringing him food. Within a week of his coming to the office, he had himself volunteered to help out preparing lunch at a church soup kitchen.

But even when their major symptoms abate, many of the most impaired schizophrenics need people who truly care to watch them day after day, to see that they take their medication and to call in psychiatric help if the illness returns.

The need for such concerned companionship was brought home last

The New York Times/[illegible]

Emily Frank, a nurse, dispensing mediation at the St. Francis Residence. At the same time, residents are given their daily spending money.

ment for mental illness was apparently assaulted in the sparsely furnished Jersey City apartment where he lived alone. For fifteen minutes he cried for help, yelling, "Somebody help me! Get them off me!" Then he ran naked into the street, screaming, "Mommy, Mommy."

When a police sergeant tried to help him, the deranged man panicked, grabbed the sergeant's gun and shot him dead.

Such fragile people also need someone to keep an eye on the small details of life: to oversee how Government stipends are budgeted and spent; to see that medical, Social Security, and psychiatric appointments are kept, and that rent is paid. And when red tape snags, they need an advocate with the resilience to speak up in their behalf and see that their legal rights are protected.

Supervision and advocacy are not enough, though. The schizophrenics who have been brought from the streets may also need help in renewing the habits of human life that can atrophy in their private world.

"Living indoors is a huge change for someone used to lighting fires to keep warm and sleeping anywhere that looks inviting," said Edward Geffner, executive director of the Manhattan Bowery Corporation, one of the groups most active in outreach programs that direct the homeless mentally ill toward help.

Some five decades ago similar

munity residential centers that were then being touted as an alternative to the huge state mental hospitals, but which never materialized, even as the worst wards of the large hospitals were closed.

Over the years the idea floundered — with rare successes here and there — as half-hearted attempts failed, or as the concept was twisted and misapplied.

Now, though, there are places it works.

In recent days I accompanied Timothy — his name has been changed to protect his identity — when he moved into the St. Francis Residence.

Last January, when a phone call brought him to the attention of the workers at Project Reachout, Timothy had spent two months huddled in a heap of garbage in the stairwell of a brownstone on West 6[illegible]th St., hearing voices telling him his life was threatened by the Mafia.

Timothy shunned public shelters, and insisted he needed a job, not a psychiatrist. But months of patient efforts eased Timothy out of his stairwell and into psychiatric care.— His bizarre ideas faded. Then he was lucky enough to be accepted into a program at Fountain House, a combination clubhouse and job training center for the mentally ill whose places, far too few for those who need them, are awarded by lottery. Through Fountain House, Timothy got a job as a messenger at a bank.

The day he moved into his own small room at the St. Francis Residence, Timothy, who is still painfully shy and who mumbles when he talks, said he was, at last, very happy.

Timothy's journey from a garbage heap to a job and room of his own shows the possibilities for those apparently hopeless schizophrenics one sees — or tries to avoid seeing — huddled on the city's streets.

With such disturbed people, though, the very nature of success has to be reconsidered. "Lots of our people on medication are still like a toned-down version of their crazy selves," said Mike Bush, a staff member at the residence. "Their voices may continue, but they've learned to ignore them. We have some people who sit mumbling to themselves, but when you ask them what just happened on TV, they answer you right away."

One man who had been homeless for years, and had all that time worn a heavy wool overcoat, continued to wear the coat after he moved into the St. Francis Residence. For months the staff suggested that he remove it. He finally did one hot summer day.

"For us, that was an improvement," said Father John McVane, one of the Residence's directors. "We take the most fragile of the homeless and create a home for them with supporting services. Once they come here, we expect they'll stay with us."

One of the most important of these services occurs in the morning, when most of the residents come to the office for their daily "M & M," money and medication. All the residents qualify for Social Security disability stipends or other Government support; most checks are sent to the Residence, and, after the monthly rent is taken out, the residents are given their spending money each day, a few dollars at a time.

At the same time, they receive their medication, so the staff can be sure they take it. And then many residents simply watch television, attend a cooking or art class, go out for a cup of coffee — or go to one or another psychiatric treatment program.

It is this partnership with psychiatry that enables the residence to run so smoothly. Staff members help the residents reopen to life as much as possible, but they are not psychiatrists. Before a schizophrenic can be admitted to the residence, his condition must be stabilized by psychiatric treatment. And if his condition dramatically worsens, he will be transferred to the psychiatric unit at Bellevue Hospital, with which the residence is linked under a special arrangement.

Father McVane is cautious about expanding the St. Francis program, which already has two buildings and is adding a third. He said he feared careless growth would mean loss of contact with "the members," all of whom he knows personally. Then, too, there is the danger of duplicating the form of the residence while losing the spirit that seems so essential to its success.

In a recently completed study, Dr. Frank Lipton, director of the psychiatric emergency unit at Bellevue, studied a group of homeless schizophrenics who had been brought in by the police because they were threatening other people or in danger of suicide. Some had been homeless for as long as five years.

After treatment at Bellevue, half the group were discharged to the usual settings, ranging from state hospitals and city shelters to adult homes. And half the group, assigned at random, were sent to the St. Francis Residence. A year later, the difference between the groups was dramatic.

Those sent to the St. Francis Residence spent an average of 28 nights of the following year homeless again; most of the small number who left the residence did so in the first few weeks. For those sent elsewhere, the number of homeless nights during that year was 121.

"The beauty of St. Francis is that everyone there is watched," said Dr. Lipton. "If something starts to go wrong, it will be picked up early."

One surprising advantage of such programs is their frugality. The cost of hospitalizing a psychiatric patient in a city hospital is $500 to $800 a day, according to Dr. Luis Marcos, vice president for mental hygiene services of the Health and Hospitals Corporation. In a state mental hospital the cost is $150 each day. In a community home, such as the St. Francis Residence, it is $15 per day.

But some of those retrieved from the streets are too disturbed for such a living arrangement, even after receiving psychiatric care. And others require much less supervision.

What is needed is a network whose elements would range from mobile outreach teams that include psychiatrists — such as one run by the Manhattan Bowery Corporation in its Midtown Outreach program — to humane housing like the St. Francis Residence to job placement programs like the one at Fountain House.

According to Diane Sonde, the director of Project Outreach on the Upper West Side, many more people could be brought off the streets almost immediately if there were enough workers to contact them, enough proper places to bring them and enough caring people to help manage their lives.

New York City boasts some of the nation's finest programs and facilities for the homeless mentally ill. One of the best and largest is the St. Francis Residence.

It houses 215 people.

In the entire city, there are just 2,020 beds in such supervised residences; the state plans to add 5,240 — by 19[illegible].

And, by the best estimates, there are at this moment roaming the

Who Is Helping

Only parts of the city have outreach programs for the homeless mentally ill. The main programs, some of which operate only from mobile vans, are these:

PROJECT REACHOUT. Covers 59th Street to 110th Street, all of Central Park to the Hudson River. 593 Columbus Avenue. 595-3066.

MANHATTAN BOWERY MIDTOWN OUTREACH. Covers 34th Street to 59th Street, from Fifth Avenue to Ninth Avenue. 620-0340.

PROJECT HELP. Manhattan below 34th Street. Also has mobile unit with a psychiatrist for those homeless of immediate danger to themselves or others. 227 Madison Street. 374-4082.

LENOX HILL OUTREACH TEAM. [illegible] East 70th Street.

PROJECT HOME. Covers parts of Brooklyn. 101 Joralemon Street, Brooklyn Heights. (718) 596-6600, extension 300.

Supervised residences are also available. Some are only for the homeless mentally ill, while others integrate these people in general low-cost housing. Among those thought to be outstanding are these:

ST. FRANCIS RESIDENCE. 125 East 24th Street, 477-4700; 155 West 22d Street, 620-6465.

FOUNTAIN HOUSE. 425 West 47th Street. 582-0340.

THE BRIDGE. 483 Amsterdam Avenue. 724-1200.

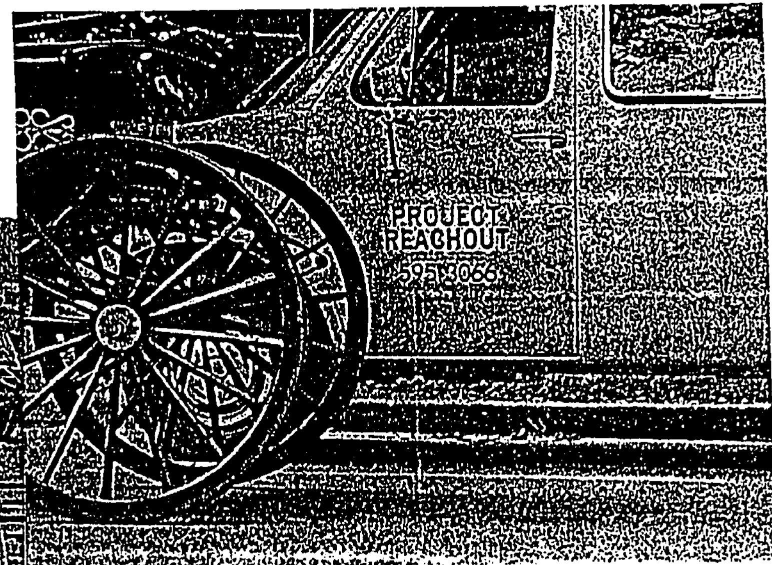
THE HEIGHTS. 530 West 178th Street. 927-0062.

[illegible]

GODDARD-RIVERSIDE COMMUNITY CENTER'S

PROJECT REACHOUT

(212) 595-3066



September 1986

Photos by Faye Ellman

Services and Advocacy for the Mentally Ill Homeless

What we are...

Project Reachout is a mobile outreach program providing services to the mentally ill homeless on Manhattan's Upper Westside from 59th to 110th Streets—including Central Park. Established in 1979, it is sponsored by Goddard Riverside Community Center and funded largely by State CSS (Community Support Services) funds which are administered by the New York City Department of Mental Health. At present, our project has a total staff capacity of 20 people—13 of whom provide direct outreach services.

How we do it...

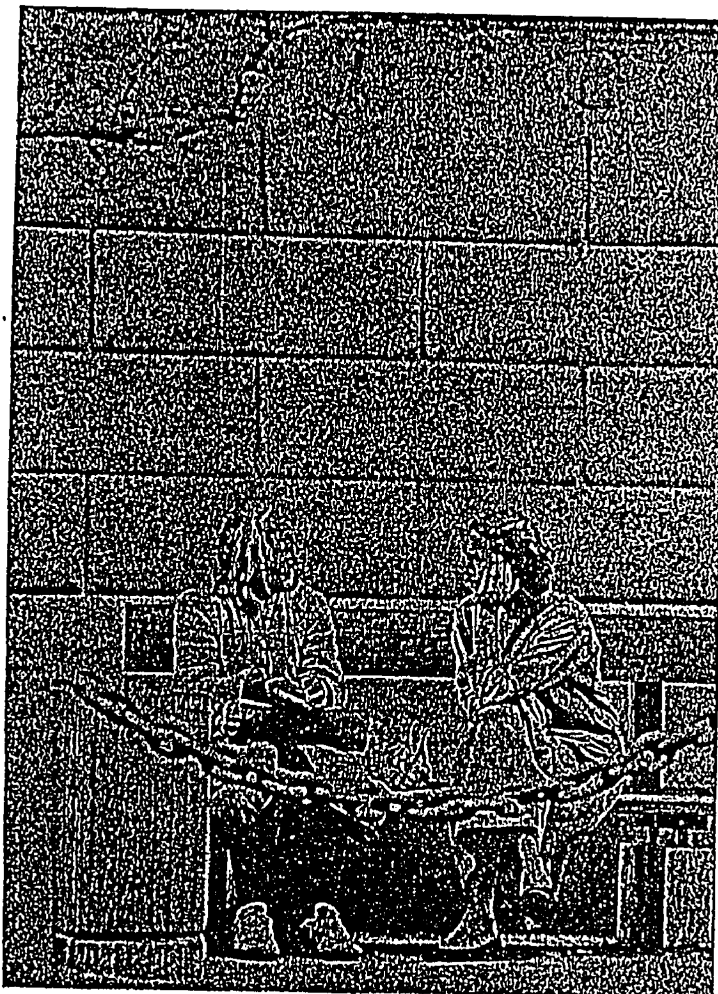
Project Reachout outreach teams go out twice daily in vans—initially to gain the trust of mentally ill persons living in the streets. We do this by providing them with food, clothing and blankets. A brown paper bag containing a sandwich, juice and dessert is our "engagement" tool. We also offer showers, medical and psychiatric services, financial assistance, temporary shelter plus a welcoming place to come and sit and have a cup of coffee in our modest office space. Our long range goal is to secure permanent housing, most often in a neighborhood SRO (single room occupancy) hotel or one with supportive services such as the St. Francis Residence. To that end, we help them secure entitlements (welfare or social security disability), we assist with money and medication management and other activities of daily living. When appropriate, we refer them to drop-in centers or day treatment programs in the neighborhood.

Those we've helped...

Project Reachout has provided services to people ranging in age from seventeen to eighty-four, with 35% over 50 years of age. Prior to their life on the street, many had spent years in and out of psychiatric hospitals, most had lived in single room occupancy hotels or other low rent housing. Others had lived with parents or spouses until they died, and became homeless when they were no longer able to maintain their jobs and apartments on their own.

More about us...

Project Reachout provided services to 3,096 *different* individuals last year. More were males than females, 71% had major psychiatric problems and 15% had both psychiatric and substance abuse problems. Over 24,000 sandwiches were distributed. This past summer we had contact with an alarming number of homeless people—greatly outnumbering those of previous summers. In the month of August alone the team on the street saw a total of 397 individuals—of those 123 were "new" to the outreach team. The Central Park team saw a total of 383 individuals—of those 183 were "new" to the team.



If you would like more information about the Project please call us at (212) 596-3066.

Mailing address:
593 Columbus Avenue
New York, N.Y. 10024

Office location:
88th Street and Amsterdam Avenue
Northeast corner—at the bottom of the driveway

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Fear Returns to Sidewalks of West 96th Street Along With Homeless Man

By EBEN SHAPIRO

For the residents of West 96th Street, the quiet of summer was shattered last week with the news that Larry Hogue was back on the streets.

Since 1985, Mr. Hogue, a homeless man who the police say becomes violent when he smokes crack, has been a frightening fixture for the residents of the Upper West Side neighborhood.

Mr. Hogue has been arrested nine times since 1972, for offenses ranging from assault to attempted murder when he pushed a young girl in front of a school bus on Amsterdam Avenue. He was acquitted of the murder charge after a trial in 1988 and has not been convicted of any crimes serious enough to keep him off the street for longer than a year.

'A Constant Nightmare'

Prosecutors say that Mr. Hogue, 48 years old, is mentally ill because of a head injury sustained when he served in Vietnam. And on Sunday, after being arrested for scratching a car with a knife, he was taken to Bellevue Hospital Centerfor psychiatric tests.

But people in the neighborhood fear that he will soon be back. "The neighborhood is living in absolute terror," said Lisa Lehr, a longtime resident of West 96th Street. "There is no question that there is a homicide waiting to happen," said Mrs. Lehr, who is an auxiliary police officer and has been active in efforts to get Mr. Hogue off the streets.

Residents, police officers, and even advocates for the homeless say that Mr. Hogue has become a terrifying symbol of the difficulty of getting a mentally ill and dangerous person off the streets.

A Waiting Game

Diane Sonde, director of Project Reachout, a program for the homeless on the Upper West Side, said the situation was not uncommon. "It is a constant nightmare that's not fair to anyone, the client or the community," she said. "There needs to be something on the books that covers these people."

The Legal Aid Society, which has represented Mr. Hogue in the past, had no record of representing him in the latest case.

The District Attorney's office has taken a keen interest in Mr. Hogue's case, and assigned a high-level prosecutor to monitor the case.

"How can a society get itself in a position where all you can do is wait for a fellow to commit a more serious crime?" said Paul Shechtman, the prosecutor. "He seems to have fallen through every crack in the system."

"A person can only be hospitalized involuntarily if two doctors agree that the person presents an imminent danger to himself or a danger to society."

Mr. Shechtman said the problem is that Mr. Hogue, who has been briefly committed several times, only presents a danger to himself or society when he is high on cocaine. After a few days in jail, when the drugs clear his system, Mr. Hogue is calm and eligible for release, he said. "You have the worse of vicious cycle," said Mr. Shechtman.

The latest round of problems began last week, when Mr. Hogue was released from an eight-month sentence he received after smashing a car window with a part of a stone bench that he ripped out of a lobby of an apartment building. Just as he did after other short prison terms, Mr. Hogue returned home to 96th Street. Most of the time he lives in doorways from West End Avenue to Central Park West, but favors the blocks between Columbus and Amsterdam, the police said.

He quickly ran into trouble. He was picked up on Saturday for acting in a manner that would endanger him or others, the police said, and was later released. On Sunday, he was arrested for scratching a car with a large knife. He was arraigned Monday in criminal court and was ordered to be held in Bellevue to undergo psychiatric tests. The results from the tests will be presented at a hearing on Sept. 21.

By all accounts, Mr. Hogue presents a menancing figure on the streets. He is 6 feet tall and weighs well over 200 pounds, the police said. Captain Liugi Iocco, who heads the 24th Precinct, said: "He's a big individual. He is very threatening."

The captain said Mr. Hogue was an aggressive beggar who had assaulted several people though none seriously. He also has been arrested for setting fires and breaking church windows, the police said. He has been sentenced to prison six times since 1984, with the terms ranging from five days to a year.

Residents Feel Frustrated

Captain Iocco said his officers and residents were getting increasingly frustrated by the inability to keep Mr. Hogue off the streets.

"He's been in the system so many times, it's hard to explain why he is still out there," he said.

Mrs. Lehr and others are worried that nothing will be done about Mr. Hogue until he commits a serious violent crime.

Law enforcement officers say Mrs. Lehr's concerns are valid. "He has the potential to be dangerous," said Captain Iocco. "This thing is driving me crazy. For three years, we've been chasing this guy all over town."

Mrs. Lehr doesn't feel completely safe, even with Mr. Hogue locked up for the moment. "This happens each time," she said. "We have a sense of déjà vu."

Associated Press

Larry Hogue, a homeless man who prosecutors say is mentally ill, has frightened many residents on the Upper West Side with his history of violent crimes.

AUGUST 29, 1992

West Side Homeless Man Is Tentatively Ruled Ill

He Should be Committed, Psychiatrists Say

By CELIA W. DUGGER

Psychiatrists evaluating Larry Hogue, a homeless man who has frightened Upper West Side residents with his irrational, occasionally violent outbursts, have tentatively concluded that he is mentally ill and should be committed to a mental hospital for treatment, state mental health officials said yesterday.

The case drew wide attention this week after it was reported in The West Side Spirit. Mr. Hogue's long presence in the neighborhood has raised questions about why law enforcement and mental health authorities did not move more quickly to get Mr. Hogue off the streets or make sure he received proper help.

Yesterday, an official in the Manhattan District Attorney's office said Mr. Hogue got out of jail earlier this year because the bail was mistakenly set too low. And the state mental health commissioner said a Veterans Administration hospital that released Mr. Hogue earlier this year may have interpreted state law on the involuntary commitment of mentally ill people too stringently.

Mr. Hogue, 48 years old, was arrested Sunday and charged with scratching a car with a knife, the latest in a string of run-ins he has had with the law since 1972. In the most serious case, Mr. Hogue was convicted of pushing a 16-year-old girl in front of a truck in 1988 and sentenced to a year in jail for recklessly endangering her life.

Screaming and Begging

For many people who live around West 96th Street, Mr. Hogue's favorite haunt, he has become a figure of dread and a symbol of one of the most aggravating facets of city life: dealing with mentally disturbed street people.

He wanders aimlessly, yelling at strangers or aggressively begging, and he is especially threatening when high on crack, say the police and residents.

Jeff Agrest, father of the girl who was pushed in front of the truck, said he moved his law practice and his family upstate because the city does not protect his family from men like Mr. Hogue. "This guy is street garbage," Mr. Agrest said. "He's a crack head."

Mr. Hogue's court-appointed lawyer, Noel Ziegler, could not be reached for comment yesterday.

Mr. Hogue is now undergoing psychiatric tests at Bellevue Hospital in Manhattan. Lorinda Klein, a spokeswoman for the city hospital, declined to comment on his case. But Richard Surles, state Commissioner of Mental Health, said members of his staff have talked to a psychiatrist working for Bellevue.

Brain Injury in Vietnam

That psychiatrist, he said, told state officials that the preliminary finding is that Mr. Hogue is mentally ill and will need continuing treatment. Mr. Hogue's mental illness is also compounded by a brain injury he sustained while serving in the military in Vietnam. Mr. Surles said the state would accept him as a patient if a judge orders his commitment at a hearing scheduled for Sept. 21.

This January, he was arrested for throwing a brick through the windshield of a 1987 Oldsmobile. At that point, there was a widespread outcry from residents afraid that Mr. Hogue would quickly be back on the streets. That drew the attention of Paul Shechtman, counsel to the Manhattan District Attorney, Robert M. Morgenthau.

The psychiatrists found Mr. Hogue competent. While he was awaiting his court date, he accumulated enough money from his veterans benefits to bail himself out of jail.

Mr. Shechtman said Mr. Hogue's release was "probably my fault" for not having asked that the bail be set for a higher amount.

Not long after he bailed himself out, Mr. Hogue was picked up by the police and taken to St. Luke's-Roosevelt Hospital Center, which then transferred him to the F.D.R. Veterans Administration Hospital in Montrose, N.Y.

"Within two weeks, the drugs were out of his system and he was back to being relatively docile," Mr. Shechtman said. The hospital then released Mr. Hogue.

Alan Malter, assistant chief of psychiatry at the Montrose hospital, said state law is so stringent that a person can only be committed to a hospital against his will if he is an imminent danger to himself or others. Mr. Malter gave as examples a person who is assaulting other people or walking in front of onrushing cars.

But Mr. Surles, state commissioner of mental health, said the law is more flexible. The court will accept as evidence the person's violent history, as well as the psychiatrist's judgment that the person could hurt himself or others, he said.

After Mr. Hogue got out of the V.A. hospital, he pleaded guilty to throwing a brick through the car windshield and was sentenced to eight months in jail. He was released Aug. 14, and arrested a week later for scraping a car with a knife.

Mr. Shechtman said Mr. Hogue was acting much more bizarrely this week than he did when he pleaded guilty in the broken-windshield incident earlier this year.

"He was shouting about my involvement in the Kennedy assassination," Mr. Shechtman said. "What he was saying was sufficiently irrational that I was moving, somewhat flipIy, for a psychiatric evaluation for the reasons Mr. Hogue himself had just articulated."

Threat Only on Crack, Man Flouts Health System

By CELIA W. DUGGER

Peering from their apartment windows, the residents of West 96th Street have watched Larry Hogue's slow descent into madness. At first, he was just another shambling homeless man who muttered to himself, slept barefoot in the snow and ate from the garbage.

But over the years his behavior became more bizarre. He stalked a teacher as she walked her fawn-colored Akita, and threatened to roast and eat the dog. He dragged a raggedy chair into a busy intersection, leaned back as if he were reclining in a chaise longue and munched a bagel as cars swerved around him.

He jumped on the hood of a red Jetta and banged on the windshield as a terrified woman tried to pull out of a parking space. He heaved rocks through the vaulted stained-glass windows of a landmark church. He knocked a schoolgirl into the street, where she was almost struck by an onrushing truck.

Like Typical Horror Movie

Dozens of times, police officers in the 24th Precinct deposited Mr. Hogue in psychiatric emergency rooms or jail cells, but each time, like some horror movie cliché, he returned to his old haunts.

Mr. Hogue is among the growing ranks of mentally ill people who are also addicted to drugs. His scary collision with the Upper West Side, a bastion of upwardly mobile liberalism, has not only tested the tolerance of residents, but has also offered an unusually detailed look at the failure of the mental health system to help people like Mr. Hogue or protect the public, say his psychiatrists, mental health experts and city officials.

Although he is an extreme case, Mr. Hogue represents the sometimes dangerous fusion of two trends: the deinstitutionalization of the mentally ill and the rise of cheap crack cocaine.

Community Care and Money

Since the 1950's, when there were almost 90,000 patients in New York State mental hospitals, the state has greatly shrunk that population. The goal was community care, which critics charge has never been adequately provided. Even in the last five years, under grinding budget pressure, the number of patients has been almost halved, from 20,000 to 11,000. Critics say the state policy has left the city to cope with the consequences.

Thousands of those living on the outside, especially the homeless, have turned to crack and other street drugs that give an anguished mentally ill person a way to feel intensely alive, unlike prescribed medications that can deaden sensation, doctors say.

The disastrous results can be found in one staggering statistical leap: In 1985, 20 percent of the psychiatric patients discharged from public city hospitals were dependent on drugs or alcohol. Last year, 41 percent had a "dual diagnosis" of mental illness and substance abuse.

Men and women like Mr. Hogue cycle in and out of hospitals and jails. Programs to treat their complex problems are still relatively scarce, officials say. Under state law, people cannot be hospitalized against their will unless they are legally considered dangerous to themselves or others. And mental hospitals, under the gun to reduce costs, often release them when they stabilize, researchers say. But once they leave the hospital, the drug addiction often reasserts itself, fueling the patient's sickness.

"There's an enormous pressure to get people out of hospitals because they cost a lot of money," said Elmer Struening, an epidemiologist at the state-sponsored Psychiatric Institute. "They stay in the hospital until they simmer down. Then they are discharged."

Dr. Gregory A. Miller, right, who has treated Larry Hogue, the homeless man who has plagued an Upper West Side neighborhood, is skeptical that changes in state law would solve such problems.

'He Was Pushed Through the Cracks'

This was the pattern with Mr. Hogue. He became psychotic when he smoked crack, so the police took him to an emergency room. From there he was transferred to a state hospital. Then after he calmed down, he was discharged to start the destructive cycle again — even though his records indicated he probably would be back to the hospital again. Mr. Hogue is now under psychiatric evaluation at Bellevue Hospital Center.

"Larry didn't fall through the cracks," said Michael Powell, a psychiatrist who saw Mr. Hogue at least a dozen times at St. Luke's-Roosevelt Hospital Center in the 1980s. "He was pushed through the cracks."

The portrait of Mr. Hogue that emerges from interviews with doctors, mental health officials, the police and residents of 96th Street is of a man whose troubles appear to have begun in Vietnam. He was struck in the head by a propeller blade and suffered damage to the frontal lobe of his brain.

Mr. Hogue, now 48 years old, first went to jail and a state psychiatric hospital in 1972. Over the next two decades, he was in and out of state hospitals about 30 times — not counting many other stays in the psychiatric wards of Veterans Administration hospitals, officials say. He also served jail terms ranging from five days to a year for crimes of criminal mischief, gun possession and attempted robbery, among others.

He first turned up on the Upper West Side in the mid-1980's. No one seems to know why he made the undistinguished blocks of 96th Street between Amsterdam and Central Park West his home base.

Lisa and David Lehr moved there from the New Jersey suburbs in 1985 and spotted Mr. Hogue in the first hour. In winter, Mrs. Lehr set out meals of cheese, crackers and milk for him. Sometimes, when he slept shirtless and barefoot on a grate, she covered him with a wool blanket.

But he deteriorated as crack unhinged his sanity. A disabled veteran, Mr. Hogue received about $36,000 a year in benefits, officials say, but did not spend the money on shelter. Instead, residents say, he collected cash from a bank and spent much of it to buy crack and other street drugs.

Mr. Hogue crouched behind cars, sneaking from one to another, with his arm outstretched and his finger pointing like a gun, perhaps, residents thought, in a flashback to Vietnam.

He seemed to have a special grudge against cars. He set fires under them and stuffed rags in their gas tanks. He ripped off side-view mirrors, then wandered into the street and shaved with a knife as he gazed at his reflection.

When the police took Mr. Hogue to St. Luke's, Dr. Powell said, the nurses and doctors there would sigh and say, "Oh, God, it's Hogue again." Dr. Powell, the director of the psychiatric emergency room there from 1977 to 1990, said: "He just ran people ragged because he was such a pain in the neck. We were uncomfortable restraining the guy, but if you didn't he was constantly into stuff."

Dr. Powell said Mr. Hogue suffered from the brain injury, crack addiction and a psychiatric illness that was hard to disentangle from the other problems. The doctor said he believed that Mr. Hogue needed long-term hospital care, but never got it because of the pressure to empty state hospitals.

Mr. Hogue was the kind of patient who could make life miserable on a hospital ward, the doctor said — an added incentive to discharge him. "He's ungratifying to work with," Dr. Powell said. "He ruins your stats because he stays forever. Every time he breaks something, there's an investigation. He's very high overhead, so they export the problem to the streets."

Shoved Schoolgirl In Front of a Truck

In 1988, a 16-year-old girl was walking home from her private school

when Mr. Hogue came shadow-boxing through the intersection of 93d Street and Amsterdam Avenue, punched her in the stomach and pushed her in front of a Con Edison truck, said her father, Jeff Agrest, a real-estate lawyer.

The truck driver, who stopped in time, chased Mr. Hogue and the police took him to a hospital. Mr. Agrest, enraged, wanted to press charges, but said the police and the District Attorney's office told him not to bother because of Mr. Hogue's mental state.

But the girl's mother, Susan Agrest, who had been a Newsweek correspondent for many years in the city, called the Manhattan District Attorney, Robert M. Morgenthau, her husband said. Mr. Hogue was subsequently indicted on attempted murder charges.

"Morgenthau's not frightened of an angry father, but of a reporter with access to ink," said Mr. Agrest, so disgusted by the incident that his family moved upstate.

Mr. Morgenthau said through a spokesman he had no memory of Mrs. Agrest's intervention. At the trial, Mr. Hogue contended he had just bumped into the girl. A jury convicted him of reckless endangerment and he was sentenced to a year in jail.

When Mr. Hogue, inevitably, showed up again at St. Luke's Hospital after his release from Rikers Island, Dr. Powell, aware of the truck incident, was worried that Mr. Hogue would kill someone. The doctor said he wrote to the head of a Veterans Administration Hospital and warned him not to let Mr. Hogue go again if he was readmitted. The doctor also took the case to court and Mr. Hogue was involuntarily committed to the Manhattan Psychiatric Center, a state hospital on Wards Island.

"I did not want to be on the cover of The New York Post as the guy who let him go," he said.

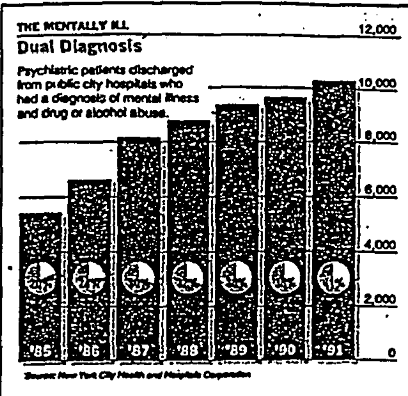
But the revolving door kept spinning. "When this guy's drug problems clear, his psychosis seems to disappear," said Robert Spoor, spokesman for the state Office of Mental Health. "When a person's condition no longer requires hospitalization, we discharge him."

Alan Maker, assistant chief of psychiatry at the V.A. Hospital in Montrose, N.Y., where Mr. Hogue was treated, declined to comment on the case, but speaking generally about the issue, he said: "How long can a person be kept against their will when their psychiatric condition is stabilized? Ninety days? A year? Five years?"

On Jan. 5, Mrs. Lehr, an auxiliary police officer and community advocate, saw Mr. Hogue bolt across 96th Street, carrying a slab of stone.

"With incredible fury, he rammed it through my car window," she said. "It not only shattered the glass, it bent the frame."

Mrs. Lehr pressed charges and went to The Manhattan Spirit, a



neighborhood paper, which published a cover story headlined "The Wild Man of West 96th Street."

On a cold dreary morning this February, about a dozen residents climbed into a police van and went to the state hospital on Wards Island to meet with Mr. Hogue's medical team.

'Cooperative' Inside, Furious on Street

"The psychiatrist explained to my amazement that Larry was calm and cooperative and so they put him on the street," said Joyce Wouthers, a board member at the First Church of Christ, Scientist, whose windows Mr. Hogue had broken. "My mouth was hanging open."

At the time, Mr. Hogue was still in jail, but in May he bailed himself out with his veteran's benefits, went out of control and was taken back to St. Luke's, which sent him to the V.A. hospital, which released him a couple of weeks later.

He pleaded guilty to breaking Mrs. Lehr's car window and was sent to jail. But in mid-August, he was back on 96th Street.

On Aug. 17, Mrs. Lehr said, a police van followed him to his bank, and from there to a crack house. He was not arrested.

On Aug. 18, Mrs. Lehr said, she saw him walking down the street with a screwdriver in one hand, an ice pick in the other and a machete in his back pocket.

On the afternoon of Aug. 22, the police took him to St. Luke's after he started jumping on the hoods of moving cars. The next morning, a neighbor told Mrs. Lehr in disbelief, "This is not 'Nightmare on Elm Street,' but Larry's back."

On Aug. 23, Andrea Kerzner-Torgovnik, a schoolteacher, went to the window. She said Mr. Hogue was circling her red Jetta, appraisingly touching the side-view mirrors, when he pulled out a long knife and scraped it along the side of the car.

In earlier years, he had threatened her dog and scared her 8-year-old son, Max, so badly that he was afraid to ride his bike on the street. This time, she pressed charges.

"Until he does something horrible, he's not going to be taken off the streets," she said.

The case has ignited a debate about the adequacy of state laws to involuntarily commit a person like Mr. Hogue. It also raised questions about why the Veterans Administration gave Mr. Hogue a sizable pension, apparently with no strings.

Given Mr. Hogue's violent history, the state's Commissioner of Mental Health, Richard C. Surles, now says Mr. Hogue is likely to be committed to long-term care. A hearing is scheduled for Sept. 21 in State Supreme Court in Manhattan.

The city's Mental Health Commissioner, Luis R. Marcos, says he believes state law should be changed to allow involuntary hospitalization for drug addiction, as well as mental illness.

But Gregory A. Miller, a psychiatrist who treated Mr. Hogue periodically at St. Luke's between 1990 and this summer, is skeptical that changing the law would make any difference. The system is so overburdened, he said, that even mentally ill addicts who beg for help often do not get it, much less those who resist treatment.

"What this boils down to," he said, "is that we as a society have decided to ignore the problem and then get mad when someone is out on the street."

Judge Orders Mentally Ill Manhattan Man to Remain in Hospital

By CELIA W. DUGGER

Larry Hogue, a mentally ill man whose aggressive behavior has terrified many Upper West Side residents, was ordered held in a state hospital against his will yesterday by a judge who ruled that Mr. Hogue was likely to abuse crack, refuse treatment and become psychotic and dangerous if he was released to the streets yet again.

The judge ruled after a state psychiatrist testified that Mr. Hogue, who is being held in Creedmore Psychiatric Center in Queens, is "a disaster waiting to happen."

The case of Mr. Hogue has become a widely publicized test of whether state laws on involuntary commitment of the mentally ill are adequate to cope with the growing numbers of mentally ill drug addicts on the streets of New York.

Repeatedly Taken Off the Street

Mr. Hogue, a Vietnam veteran, suffers from a manic depressive illness that is worsened by drug abuse, said the state psychiatrist, Kusum Kathpalia. He has been taken off the streets more than 30 times only to be released when the drugs have cleared his body and his behavior improves. He then returns to the street and the abuse of drugs that worsens his manic depressive illness.

At issue is the delicate balancing of Mr. Hogue's individual rights and his demands for liberty against what the residents of West 96th Street — his favorite haunt — consider their right to live in tranquillity, free from the repeated harassments of a deranged man.

The law says a person can be hospitalized against his will only if he is an imminent danger to himself or others.

A clash of individual liberty with community rights.

State Supreme Court Judge Cosmo J. DiTucci made it clear how thin the line was between committing a mentally ill person and releasing him when he said yesterday that he would reconsider his decision if Mr. Hogue admitted that he was a mentally ill drug abuser and promised to seek outpatient care. Mr. Hogue is "almost eligible for release," the judge said.

Mr. Hogue can petition for his freedom in 60 days. The state can then ask the court to commit him for six more months.

State mental health officials said the judge's decision supported their contention that state law was broad enough to involuntarily commit a person like Mr. Hogue, even though he was a peaceable person who passed his days playing chess as long as he was hospitalized and locked away from street drugs.

State officials have maintained that psychiatrists and lawyers have often interpreted the law too narrowly. For example, in Mr. Hogue's case, they say, hospitals released him once the drugs cleared from his system and he became calm. But the hospitals could have presented evidence that Mr. Hogue's sober hospital stays were always

Associated Press

Larry Hogue, a mentally ill Vietnam veteran, was ordered held in a state hospital against his will.

followed by drug abuse and psychosis once he was released.

"The judge's decision shows that when proper medical evidence is presented, Mr. Hogue falls well within the framework that courts can use to retain him involuntarily," said Peter A. Durfee, a deputy counsel for the state Office of Mental Health.

Robert Spoor, a spokesman for the state Office of Mental Health, said, "More and more, we're recognizing the broader interpretation of the law."

But New York City's Mental Health Commissioner, Luis R. Marcos, said the law was still so murky that doctors were often reluctant to recommend the involuntary commitment of patients whose mental illness was set off by drug abuse. He believes the law should be modified.

Mr. Hogue's lawyer, Catherine Kerrigan, with Mental Hygiene Legal Services, declined to comment on the case.

During the hearing at Creedmore hospital in Queens, Mr. Hogue angrily denounced the psychiatrists, prosecutors and residents of West 96th Street for conspiring against him.

He denied the testimony of one of the residents, Lisa Lehr, that he had masturbated in front of children, slept on the yellow line in the middle of 96th Street, set fires and threatened to kill her as he clutched a machete in one hand and an ice pick in the other.

'A Bunch of Lies'

"Ms. Lehr is part of the 96th Street Ku Klux Klan," Mr. Hogue said. "That's a bunch of lies by rich 96th Street people out to railroad me. I fought in Vietnam for this country. For those people to make me out to be a bad person, that's immoral."

Mr. Hogue's son, Shawn Sells, testified that he was willing to have his father live with him and his three young children in their apartment in Bridgeport, Conn. Mr. Sells said he was not working and would be

Continued on Page B2

Mentally Ill Jailed on No Charges, Survey Says

By PHILIP J. HILTS
Special to The New York Times

WASHINGTON, Sept. 9 — A survey of American jails has found that more than half regularly hold people with serious mental disorders on trivial charges or no charges at all.

"We were shocked to find that 29 percent of the jails we asked admitted to holding people in jail with no charges at all, solely because they are mentally ill," said Dr. Sidney Wolfe, director of the Public Citizen Health Research Group, a Washington health advocacy group that conducted the survey of 1,391 local jails, the first of its kind.

The group said an additional 23 percent of jails acknowledged holding people who have serious mental disorders on minor charges like disorderly conduct or vagrancy.

Lack of Treatment Cited

When jails added people with major mental disorders who are suspected of committing more serious crimes, the figure rises to more than 86 percent, the group said.

It is illegal in 35 states to hold the mentally ill without charges except on a brief and emergency basis. In eight states and the District of Columbia even emergency detention in jails is prohibited. Jailers say they often have no alternative because of the absence of emergency mental health treatment or reliable local treatment programs.

Thus, said Dr. Wolfe, the jails are actually the nation's largest mental institutions. A separate survey by the group found that the Los Angeles County Jail has become the nation's largest mental institution.

Dr. Wolfe's group, along with the National Alliance for the Mentally Ill, a support group for the mentally ill, sent questionnaires to all 3,353 local jails in the United States. About 41 percent of the jails responded, representing more than 60 percent of the 430,000 people in jail in the United States.

The report said that about 30,000, or 7.2 percent of all those now in jail, are manic-depressive or schizophrenic or have other serious mental disorders.

The survey had the support of the American Psychiatric Association, and the American Jail Association helped in carrying it out.

'The Ever-Broadening Net'

"Jail administrators are alarmed at the increasing rate in which the mentally ill are being caught in the ever-broadening net of the criminal justice system and booked into the nation's jails for extensive lengths of time," the jail association said in a statement. "Jail has become the substitute institution of our neglect."

Dr. Joseph T. English, the president of the American Psychiatric Association, said jailing the mentally ill is a "shockingly widespread misuse of the nation's correctional system." The situation has developed over the years, as state mental hospitals have been emptied by a series of legal and mental health reforms. Many of those in the state institutions were receiving poor treatment, and many did not need to be there but could be treated effectively by out-patient services.

The breakdown in the system occurred when the community mental health system began to replace the state hospitals. The report said a primary cause for the failure is that there are too few centers and that they have inadequate funds to follow their patients closely.

James Finley, director of government affairs for the National Council of Community Mental Health Centers, the trade association representing community mental health agencies around the country, said that government provides three-fourths of the financing for community treatment, and that this money has been reduced as the Federal Government and many state governments struggle to close their budget deficits. The report listed 13 recommendations to help solve the problem.

Among the main recommendations, said Dr. E. Fuller Torrey, a psychiatrist who is an author of the report, are passing laws that would make it illegal in all states to hold the mentally ill without charges; shifting funds from mental health programs to jails to care for the mentally ill, and requiring mental health professionals as a condition of licensing to do two hours of pro bono work a week at public mental health centers.

Homeless, Insane and on Crack

A Danger to Themselves and Others

By CELIA W. DUGGER

EVERY now and again a heinous crime or bizarre act by a homeless mentally ill person shocks the public and inspires a spasm of governmental concern about the shoddy state of mental health care for the poor. It is a cycle of mindfulness and forgetfulness that plays out in cities across the country.

The issues were back in the spotlight in New York City last week after an 80-year-old churchgoing woman was beaten to death with a pipe by a mentally ill drug abuser who lived in a nearby shelter.

The killing caused Gov. Mario M. Cuomo's administration to announce Thursday it would step up efforts to find and hospitalize mentally ill shelter residents who are dangerous. The state dispatched a psychiatrist, social worker and nurse to the shelter where the suspect lived and found three severely ill people who agreed to go to a city hospital.

But many of the professionals who work daily with the mentally ill in shelters and on the streets say the state's action is just one small stitch in a tattered safety net. Thousands of mentally ill drug abusers enter New York City hospitals each year in crisis. The problem isn't so much getting them to the hospital, doctors and caseworkers say, it's knowing what to do with them once they are there.

The growing problem of patients who are mentally ill chemical abusers, or MICA's in the shorthand of city officials, has caught an already overwhelmed community mental health system flat-footed. Between 1985 and last year, the proportion of mentally ill patients discharged from New York City hospitals who were also dependent on drugs or alcohol doubled, to more than 40 percent. The system is not geared to

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Philip Greenberg for The New York Times

Christopher Battiste, center, described as homeless and mentally ill, was charged last week with bludgeoning to death an 80-year-old woman in New York City.

A Danger to Themselves and Others

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help them. At the state level, drug treatment and mental health care are divided in two different bureaucracies. Treatment programs for mentally ill addicts are sparse, and state hospitals often do not have properly trained staff.

"People's problems are not compartmentalized the way agencies are," *said* Nancy Wackstein, executive director of the Lenox Hill Neighborhood Association, which works with the homeless mentally ill. "The mental health system does not want to deal with addicts. They'd rather have pure psychoses or neuroses."

The ground for the disastrous spread of drug abuse among the homeless mentally ill was laid over the last several decades in New York and other states. Prodded by court rulings on the rights of mental patients, as well as the availability of new drugs to treat them, governments deinstitutionalized the vast majority of the mentally ill, but they failed to deliver on promises to develop enough group homes and outpatient clinics.

No one knows how many homeless mentally ill there are in this country. Estimates for the homeless alone range from the 1990 Census's disputed 250,000 to between 1 million and 3 million estimated by their advocates. One quarter to a third of that is thought to be mentally ill. In New York City, the state estimates that 000 homeless are mentally ill; advocates say the figure may be double that.

Crack and the Homeless

In New York City in the 1970's and the early 1980's, even the number of flophouses and shabby single-room-occupancy hotels that had once housed the mentally ill living outside locked hospital wards dwindled as owners renovated them for more prosperous tenants.

By the early 1980's, it became apparent that growing numbers of mentally ill people, predominantly schizophrenics, were living in doorways and on stoops. In 1982, a homeless woman who refused to leave her cardboard box froze to death in Manhattan. Out of the reach of caseworkers who could oversee their medication, the homeless mentally ill grew sicker.

So in the mid-1980's, when crack became widespread and cheap, the homeless mentally ill were often eager customers, looking for a way to medicate themselves and to escape their torment, psychiatrists say.

For a decade now, a New York City program called Project Help has operated as a kind of 911 *service for* the homeless mentally ill, with psychiatrists empowered to hospitalize people who are a danger to themselves or others. The vast majority of people it picks up are not attacking others; they are simply not taking care of themselves. They have ulcerated feet, tubercular coughs, emaciated bodies.

Once the patients are stabilized in the hospital, there is often no place for them to go, said Sam Tsemberis, director of Project Help. There are simply not enough supervised group homes. The state estimates that each bed costs about $60,000, and another $14,000 to $28,000 a year to mainta

But even many of the supervised apartme being developed especially for the mentally will not accept people who have recently us drugs or have a criminal record.

"They want people who have been substan free for six months or a year," Mr. Tsembe said. "No one is like that on the streets. Peo are drinking, or smoking crack."

The Chaos of Shelters

Nor will many of the mentally ill brave t often fearsome city shelters. For almost a de ade, city officials have promised to develop sp cialized *shelters for the mentally ill,* but so far has not happened on a large scale. Instead, ma mentally ill people are sent to larg dangerous armory shelters whe they are often preyed upon by dru dealers and thugs. The cacophono and chaotic open areas where the sleep with hundreds of others ca exacerbate their illnesses, doctor say. The suspect in last week's slay ing lived in just such an armor *shelter* in the Bronx, a makeshi home to 700 men.

State Mental Health Commissione Richard C. Surles acknowledge there are deep structural problems i the system. "A tragedy comes alon; and there's a flurry of attention for : while," he said. His departmen needs more resources to cope witl the underlying causes of the trage dies that catch the public eye, he said

"There's a huge concentration o community mental health clinics ir midtown," Mr. Surles said. "Bu there are very few in Bedford-Stuyvesant, East Harlem and the South Bronx. I need a new generation ol specialized clinics. I need bette trained staffs in the hospitals to deal with difficult patients. I need more than double the number of intensive case managers I now have in New York City."

Only a fraction of this is included in the budget recently proposed by Governor Cuomo. He is advocating closing three state hospitals and investing $43 million in community services. Dr. Surles said most of that new money would be spent on housing for the mentally ill, not on clinics, case managers or hospital staffs. Sometimes, he said, he is unsure whether he is running a housing agency or a mental health one.

"So much of this comes back to money," he said.

Dith Pran/The New York Times

The Franklin Avenue Armory in the Bronx is a makeshift home to 700 men, many of them mentally ill.

Danger of Mentally Ill Homeless To Be Re-evaluated in New York

By SARAH LYALL

The Cuomo administration said yesterday that it would begin sending state mental health workers into New York City's homeless shelters in an effort to identify residents who are dangerously mentally ill and place them in state mental hospitals, in some cases against their will.

The policy, which was ordered by the State Mental Health Commissioner, Dr. Richard C. Surles, came in response to the case of a mentally ill homeless man who drifted in and out of homeless shelters and was charged with bludgeoning an 80-year-old Bronx woman to death on Sunday near the shelter where he sometimes lived.

But the move was the latest twist in a long-running struggle over how best to handle the thousands of mentally ill patients who have been left to roam the city's streets and crowd its shelters since the state began closing its mental hospitals 30 years ago. The state has pledged to create residential programs to treat them in neighborhoods, but has fallen far short of its promises.

The policy was immediately attacked by the New York Civil Liberties Union, which said that involuntary hospitalization might well violate the rights of homeless people.

And advocates for the mentally ill argued that while the program may identify and treat some extremely sick people, it does not deal with the deeper reasons that lead to thousands of New Yorkers flowing in and out of mental hospitals, jails, shelters and the streets. [News analysis, page B2.]

Yesterday, as residents of the neighborhood near the shelter mourned the slain woman and accused the city of failing to protect their area, the first two three-member teams of mental health workers, each made up of a nurse, a social worker and a psychiatrist, entered the Franklin Avenue shel-

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Danger of Mentally Ill Homeless Comes Under Scrutiny

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ter and conducted a preliminary evaluation of its mentally ill residents. The shelter, one of the city's largest, was the on-again, off-again residence of Christopher Battiste, the suspect in the slaying.

Dr. Surles said that the state did not yet have the authority to move people from the shelters into state hospitals, and would work out the details with the city by next week. He added that he did not know how many people would be committed to hospitals under the policy. "It could be one person; it could be 100 people; it could be 1,000 people — I don't know," he said.

Pointing Fingers

For as long as there has been a problem, the state and the city have tried to blame each other.

"I'm not going to blame anyone, but I'm personally outraged," said Dr. Surles, proceeding to ask why Mr. Battiste had slipped through the cracks in the city's vast shelter system.

"You have a multitude of city agencies — H.H.C., H.R.A., and the city mental health department," he said. "We give the city huge amounts of money for outreach teams. I'm here in Albany and I don't know the magnitude of the problem down there, but this is the end of it for me."

But Angelo Castillo Jr., a deputy commissioner at the city Human Resources Administration, which is responsible for administering the city's homeless shelters, said the city has always been hamstrung in its ability to deal with its mentally ill homeless population.

Policy Called Overdue

He said that the state should be responsible for people like Mr. Battiste, and that he was pleased with the new policy. "I'm glad that they've finally agreed to do what is needed," he said. "This is long overdue and should have been done years ago. I just hope that this doesn't end up being a revolving door, because many of these people need long-term care."

Advocates for the homeless attacked the state's plan, saying that it was a desperate measure that underscored the state's failure to provide permanent housing for the mentally ill homeless. The state says there are about 8,000 mentally ill homeless people; advocates say the figure is from 13,000 to 15,000.

The state has built only 345 of the 1,888 units it promised to construct for mentally ill homeless people in New York City, said Mary Brosnahan, executive director of the Coalition for the Homeless.

"This plan is a classic smokescreen," she said. "The blood is on the Governor's hands and he's looking for a quick-fix solution."

Ms. Brosnahan also said that while it is on a smaller scale, the state's plan represented a throwback to an earlier era, when mentally ill people were placed in sprawling state hospitals to languish until they died. With the advent of drugs that could treat people suffering from schizophrenia and other mental illnesses, the state released thousands of people from the hospitals in the 1960's and 1970's.

"The assumption was that these people could live active and safe lives outside in the community," she said. "But this is turning the clock back and locking the folks up again."

Dr. Surles said that over the next few weeks, the teams of workers would systematically visit all the city's homeless shelters, starting with the 13 men's shelters, to determine the magnitude of the problem.

Separate Area for Some

The teams will evaluate only those residents that the shelter staff considers mentally ill and possibly dangerous, like those residents placed in the Franklin Avenue shelter's "yellow zone" for the mentally ill, he said.

Some of the residents could be taken to psychiatric emergency rooms in city hospitals for further evaluation, he said. Others could be committed directly to state-run hospitals, like Creedmoor Psychiatric Center in Queens, where officials say there is enough space for more patients.

Under state law, people can be involuntarily committed to state mental hospitals if they are considered dangerous to themselves or others. Under the current system, mental health officials are not allowed to take them from the shelters to the state hospitals, but can only refer them to psychiatric emergency rooms for evaluation.

If someone objects, as did Larry Hogue, the 48-year-old homeless man known for terrorizing the residents of West 96th street, he is entitled to a court hearing. In Mr. Hogue's case, the judge ruled that he could be involuntarily committed. Mr. Hogue is now undergoing treatment in Creedmoor, where each patient costs the state $105,000 a year.

No Treatment Follow-up

Before the slaying on Sunday, Mr. Battiste, who is 33 and has a long criminal record, had been treated for psychiatric problems in city hospitals at least twice in the last two months, city officials said. Although doctors who treated him recommended that he enroll in a drug-treatment program, he never followed up and instead went back to the Franklin Avenue shelter.

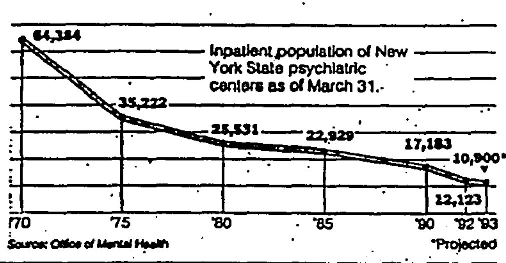
There, he was placed in the shelter's "yellow zone" for mentally ill and violent residents, where even in the rough shelter world he was considered dangerous. Although shelter officials knew of his problems, no one ever followed up on his treatment.

To carry out the new policy, the state is asking the city to grant it these powers: the ability to go into shelters unannounced and the ability to transport mentally ill people to emergency rooms or state hospitals on the spot. "We want a major overhaul in the way the state relates to the city shelter system," Dr. Surles said.

Norman Siegel, executive director of the New York Civil Liberties Union, said the new policy raised a host of questions. "The standard is that you have to be in imminent danger to yourself or others, based not on speculation but on actual conduct," he said. "The state better be very careful, because homeless people have rights, too."

MENTAL HOSPITALS

A Decline in Patients



Source: Office of Mental Health *Projected

The New York Times

A Debate Unstilled

New Plan for Homeless Mentally Ill Does Not Address Larger Questions

By CELIA W. DUGGER

In moving to identify and hospitalize violent mentally ill residents of New York City shelters, state officials are taking a small step to improve coordination in a fragmented, overwhelmed mental health system.

News Analysis

The new policy is not a return to institutionalizing the mentally ill on a large scale. Instead, it is a limited initiative to deal with the fears aroused by the latest horror story out of the mental health system: the fatal beating Sunday of an 80-year-old woman by a mentally ill man from a Bronx shelter.

The new effort may find some extremely sick people and commit them to state mental hospitals. But experts and advocates for the mentally ill argue that it fails to grapple with the deeper reasons that lead to thousands of New Yorkers cycling in and out of mental hospitals, jails, shelters and the streets.

In response to changing attitudes and laws regarding the mentally ill, the state has cut the number of patients in mental hospitals from almost 90,000 in the 1950's to about 11,000 now. And even that number will shrink to about 9,700 by 1994 under Gov. Mario M. Cuomo's new budget proposal.

The need is in the streets; the money in the institutions.

Old System Keeps Money

But politics has kept the state from shifting enough resources from mental hospitals to services in the communities where mentally ill people now live. Many largely empty hospitals have remained open because community leaders, lawmakers and unions have fought the closings.

"Historically, the dollars have remained locked in the institutions and did not go into community mental health," said David Rothman, a professor of social medicine at Columbia University College of Physicians and Surgeons.

This year, Governor Cuomo has proposed closing three mental hospitals and pumping $43 million more into community mental health. State officials say the Cuomo administration has invested heavily in housing with special services for the mentally ill. But advocates say more hospitals should be closed and maintain that Governor Cuomo has failed in his overall promises to reform mental health services.

As the number of mentally ill people living outside hospital wards has grown, two other trends have enormously complicated their ability to survive independently. First, in the 1970's and 80's, the stock of single-room-occupancy hotels that traditionally provided the mentally ill with a cheap place to stay disappeared as developers upgraded the properties. And then, in the mid-1980's, the wildfire spread of inexpensive crack cocaine in the city ensnared growing numbers of often inadequately medicated mentally ill people in drug addictions that exacerbated their illnesses.

The result of these forces is often apparent on the streets. Without stable housing where caseworkers and doctors can care for them and make sure they stay on their medications, the mentally ill get sicker and too often end up living on sidewalks and in doorways.

For the most part, psychiatrists and social workers say, the homeless mentally ill are not dangerous and are much more likely to be preyed upon than to be predators themselves.

Sick and on Their Own

Too often, both state and city hospitals effectively release mentally ill people to the streets or homeless shelters, where they have difficulty getting treatment and housing.

The state's Mental Health Commissioner, Richard C. Surles, said state hospitals never discharge patients to the streets. But Diane Sonde, director of Project Reach Out, which works with homeless mentally ill people on the Upper West Side, said state hospitals commonly let people out on day passes, and they never go back.

"I can show you a person in our lounge now who got out of Manhattan Psychiatric Center on a day pass six weeks ago," she said.

Ms. Sonde said her organization often has trouble finding treatment for homeless clients and depends on psychiatrists who volunteer their time. "We often can't get people psychiatric care from the community clinics," she said. "They're full and have long waiting lists."

The state's latest effort to cope with the problem of disturbed, occasionally violent homeless people has not calmed the debate but has instead led to a new bout of finger pointing between city and state officials over who is to blame for the tragic breakdowns in the system that have periodically flared into public view over the past decade.

A City-State Debate

Commissioner Surles criticized the city for failing to act aggressively enough to involuntarily commit mentally ill people who are a danger to themselves or others. "For some reason, the people in the city continue to want to say that the law is a problem," he said.

The new policy of sending teams into shelters to identify violent people grew out of the sense, he said, that "people are getting lost out there. And I've got to do something aggressive to change the way we do business. For some reason we aren't reaching cases of people who are threatening to others."

But the city's Mental Health Commissioner, Luis R. Marcos, said much of the problem lies with the state. The state has two separate bureaucracies that deal with mental health and drug abuse, making coordinated efforts to deal with mentally ill addicts difficult to implement, he said.

Added to that, he said, state commitment laws are fuzzy about whether people can be involuntary committed if their mental illness is set off by drug abuse. Dr. Marcos said he wants the law clarified, and he called the state's move into city shelters "a Band-Aid approach."

"The state," he said, "can't have it both ways, continuing to downsize the hospitals without investing enough in community services, while blaming city doctors for not institutionalizing more people. I mean, really."

February 3, 1993
N.Y. Times

State Told To Free Man In Hospital

Homeless Man Said To Harass Residents

By RONALD SULLIVAN

Larry Hogue, the homeless man who residents of the Upper West Side accuse of terrorizing them and their neighborhood, was ordered released from a state mental hospital yesterday on the grounds that he was not mentally ill and only had what a judge described as an "attitude problem."

But the release order, by Justice Richard Rutledge of State Supreme Court in Queens, was effectively stayed for five days while the state Attorney General, Robert Abrams, files an emergency appeal of the order with the Appellate Division of State Supreme Court.

State lawyers who fought Mr. Hogue's release from Creedmoor Psychiatric Center in Queens quoted Justice Rutledge as saying that Mr. Hogue apparently did not have a mental illness and thus could not be kept involuntarily committed by the state any longer.

"What he has is an attitude problem," the judge said, according to the state lawyers. Justice Rutledge could not be reached for comment last night.

Release Called Disservice

Mr. Abrams denounced the judge's statement, calling it an "insult to the community." In a statement, Mr. Abrams described the order releasing Mr. Hogue as a "'disservice to the community he has terrorized for the past few years."

The ruling, Mr. Abrams said, "flies in the face of testimony from experts that Mr. Hogue's behavior becomes frightening and dangerous when he fails to take medication, and assertions by residents of Manhattan's Upper West Side that he spends his government disability checks on crack."

Justice Rutledge was apparently convinced during a four-hour hearing yesterday that Mr. Hogue had regained his mental composure during nearly two months of involuntary confinement and that he had agreed to live with his son in Connecticut.

Mr. Hogue's commitment nearly two months ago underscored a growing fear in New York City over the potential danger posed by some mentally ill homeless people whose illnesses are worsened by drug use and who grow violent when they fail to take medications.

That fear was heightened last month when Christopher Battiste, the homeless drug addict who has been in and out of shelters, prisons and psy-

Menacing Recalled

The killing increased the demands by many residents for a tougher policy for the violent mentally ill who become more dangerous when using drugs.

Lisa Lehr, a West Side resident, said Mr. Hogue had terrorized her neighborhood since 1985, with his violence increasing sharply in the last 18 months.

Roaming an area centered on West 96th Street, residents said, Mr. Hogue would menace pedestrians, often striking some of the older ones; attempt to set fires to cars and trash cans; expose himself, and throw heavy objects like stone benches through plate glass windows. Most often, he was arrested for disorderly conduct or some other minor offense and released.

All told, he has been arrested nine times since 1972 and has served six terms in prison ranging from five days to a year.

At his hearing in court yesterday, Mr. Hogue, who is 48 years old and a stocky six feet tall, testified that his problems began when he was a soldier in Vietnam, and that he suffered "flashbacks" that were prompted by his exposure to the toxic chemical, Agent Orange.

Social workers testified that Mr. Hogue's son in Connecticut had agreed to take him in and that Mr. Hogue's former wife had agreed "to look in after him."

But Dr. Kussim Kathpolia, the psychiatrist who treated Mr. Hogue at Creedmoor, testified that Mr. Hogue "does have a mental illness" and that if he was released he would revert to his destructive behavior.

IE NEW YORK TIMES METRO THURSDAY, FEBRUARY 4, 1993

Business as Usual For Shelter Teams

State's Plans for the Mentally Ill

By LYNDA RICHARDSON

Dr. James Farrar and his team of state mental health workers recently weaved their way through the echoing corridors of the Bellevue Men's Shelter before settling into a conference room with a stack of manila files on 12 homeless men.

Soon, the team began summoning the men themselves. A few waited nervously outside the closed steel door.

The team, in this instance composed of a psychologist, a psychiatrist, a social worker and a nurse, looking at men identified by shelter workers, was doing nothing new. For the last 12 years, the team has been a mobile triage unit conducting weekly visits in the city's sprawling shelter system to make psychiatric evaluations on homeless men. Sometimes the team simply helps a resident get a prescription or offers a recommendation for entry into a group home. But at other times, it deems a person in need of immediate hospitalization and seeks to have him taken from the shelter.

Amid public outrage over the death of an 80-year-old woman in the Bronx, who the police say was killed by a homeless man who spent much of his life bouncing between mental institutions and shelters, the state announced last week that it would send more teams into the city's 25 single-sex shelters and it would give the teams more authority to take action against those they decide are dangerous. The teams usually consist of three people: a psychiatrist, a social worker and a nurse.

Richard C. Surles, the State Mental Health Commissioner, said the state would take other steps to make sure that the mentally ill did not become a danger to the public, including better training of shelter workers and more inspection of conditions in the shelters. He said he hoped the teams would help to pinpoint the most volatile residents.

Despite Commissioner Surles's urgent tone, nothing much had changed last week, and the only state team

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Despite Plans for Homeless,

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screening the mentally ill in the shelter system went about its business as usual.

In the conference room on the third floor of the Bellevue Men's Shelter, members of the team gently questioned each man, then listened patiently and watched for signs of trouble. Two men muttered about suicide. Another man in his 30's was hearing "voices" and expressed homicidal thoughts. "Ever hear the devil tell you what to do?" he quietly asked a visitor, feigning a boxer's swipe in the air.

By midday, 3 of the 12 men had gone voluntarily by ambulance to the psychiatric emergency rooms of the city-run Bellevue Hospital.

The scene was repeated at more than half a dozen shelters last week, as the state mental health team did what it always does on routine rounds.

Big Step or Stunt?

Some city officials and advocates of the homeless began to question last week whether the big pronouncement made in Albany was merely a public-relations stunt. The announcement, they said, the latest twist in a long-running dispute over how best to handle thousands of mentally ill patients who have been left to roam the city's streets and crowd its shelters since the state began closing its mental hospitals three decades ago, didn't amount to much.

Norman Siegel, the executive director of the New York Civil Liberties Union, said the state was once again ducking its larger responsibilities to provide more community care by offering a program "that the state has actually had in effect for some time."

"Without the resources to treat these individuals," Mr. Siegel said, "this is just a hollow gesture which diverts attention from the state's continuing refusal to honor its promise to provide 'community mental health services.'"

At the city's Human Resources Administration, which is in charge of the shelter system, Angelo Castillo Jr., Deputy Commissioner, said that he sensed no heightened urgency from

The latest in a dispute over treating the mentally ill.

the state. "I've been calling my folks to say, 'Are things better now with this response?' and they say, 'What response? Things are pretty much the same.'"

'A Series of Changes'

Commissioner Surles said on Friday that things would indeed change but that he was still trying to determine the magnitude of the problem. "A whole series of changes" would be announced this week, Mr. Surles said.

"I'm still not sure what we want to do permanently," he said. The Commissioner said there would be two teams, instead of one, fully operating in the shelters by this week, and that he intended to redefine their role.

In a move intended to hasten the hospitalization of the dangerously mentally ill, Mr. Surles said the state-employed psychiatrists on the two teams would get legal authorization from the city to transport mentally ill people who seem to be dangerous to psychiatric emergency rooms or to state mental hospitals, immediately and forcibly, if necessary.

Under the current system, state mental health officials are not allowed to take people from the shelters directly to state mental hospitals, but may only request emergency personnel to take them to psychiatric emergency rooms in city hospitals for evaluation, he said.

Mr. Surles also said he wanted more systematic training of the shelter staffs to recognize mental illness, more inspections of the shelters, and mental-health services made available in 9 of the 13 men's shelters that lack them, possibly through contracts with volunteer community agencies.

Ted Hernitche, the deputy shelter director at Bellevue Men's Shelter, asks about the homeless men who can't be reached by the psychiatric teams: "What do we do with the ones who don't want help?"

It's Business as Usual

What to Look For

lembers of Dr. Farrar's team said / looked for signs of bizarre beior, which could include extreme ation, like standing in corners and ·ing into space; muttering to no , and getting into fights. The shel- staff is trained by the team to ke similar assessments.

There are things that may be hard :valuate but look different," said Taormina, the psychiatric social ker. "We all have a sense of what trange."

urrent state law says people must a danger to themselves or others ore they may be involuntarily nmitted.

o get someone forcibly commit- Mr. Taormina said, "The team uses the criteria it has always d, which is based on dangerous- s at the present. If he is not ap- ring bizarre and not appearing gerous, if the guy is functioning . at the moment, what can you do? : say, 'Stay with it.' You can't ly throw him in the hospital."

t Bellevue, the members of the e team and the shelter staff greet- one another warmly. In many :s, they have known one another years. In the dimly lighted hall- outside the conference room, e of the homeless men, at times ompanied by their caseworkers, in to line up shortly after 9 A.M. nterviews that would last from an · to an hour and a half.

A Nervous Wait

anding against the wall, Wilfred om got jumpier the longer he ed.

wanted it over real fast," said 2-year-old man, who has slept on streets and in trains for the last years. "A lot of guys on the wall · telling stories about some guys ; to the hospital and it was scary- ne up."

ke the other men, Mr. Sessom ed to sit down for the evaluation. r than cajoling and sometimes ing, officials said there is little can do to force shelter residents : in the interview chair.

-. Sessom said his caseworker d him to go because she felt he i't being open with her. He said e of the men in the shelter believe he is mentally ill because he giggles a lot, cracks jokes and exercises frenetically. But he said his only problem is his eagerness to leave the shelter. The state team evaluates men such as Mr. Sessom to insure that they are ready for specialized housing programs.

While he was being interviewed, Mr. Sessom said he was trying to figure out where the psychiatric social worker, Mr. Taormina, was leading with his questions. Had he killed somebody? "No." Did he want to kill somebody? "I smiled and I said, 'Yeah,' and he said, 'That's a joke?' I said, 'Yes, that is. I hope you didn't take that seriously.' "

Mr. Sessom said he was surprised that the social worker got him to reveal his private shame, the one he had not told his caseworker: that he had not graduated from high school. After the evaluation was over, Mr. Sessom looked relieved. "I guess he said I was all right," he said with a giggle, before disappearing within the warren of rooms and hallways.

Trouble Ahead

When a man in his 30's walked in and talked of hearing voices, the team saw trouble immediately. "I need some help," he said to a visitor, speaking with an unfocused stare. "This shelter is getting on my nerves. These people are making me real snappy. I snap. I hear the voice."

The man was taken to Bellevue Hospital, where doctors felt he was not dangerous and returned him to the shelter that day, state officials said. He was re-evaluated by the state team on Thursday and volunteered to be hospitalized at the state-run Manhattan Psychiatric Center.

Officials at Bellevue Men's Shelter said the man who heard the devil was not the kind who caused the most alarm.

"Those are the easy ones," said Ted Hernitche, the deputy shelter director. "They're crying out for help. The question is, What do we do with the ones who don't want help? What about the ones whose psychosis is not as easily defined and seen?"

N.Y. TIMES APRIL 7, 1993.

Who Will Turn Violent? Hospitals Have to Guess

By ELISABETH ROSENTHAL

Early on a Monday morning in the Columbia-Presbyterian Medical Center emergency room, nine psychiatric patients with recent histories of violent behavior lounged on stretchers and armchairs, awaiting a doctor's decision about who would be committed and who discharged. One man had threatened to murder his girlfriend and another, hearing voices urging him to kill a prostitute, had grazed a woman's neck with a knife. A 51-year-old woman, while high on crack, had tried to place her young niece in the oven for being disobedient.

"The normal complement after a weekend," said Dr. Ellen M. Stevenson, who is in charge of the hospital's psychiatric emergency services. "The knife and gun club. The crack. The threats. The temper tantrums gone bad."

All nine patients had been living in an "extended observation area" just off the emergency room for two or three days, undergoing observation, testing and treatment. Now, in a tiny windowless command center next door, half a dozen workers were busily making telephone calls to gather information to help them decide which patients were dangerous enough to warrant stripping them of civil liberties and keeping them in the hospital against their will.

They were trying to sort out whether violent words represented innocuous outbursts or serious threats; which voices urging someone to kill were private madness and which might lead to homicide.

Unfortunately, predictions about who will be violent are often made on the basis of limited information, and even more limited science, leading to a sometimes mediocre batting average, researchers say. But as a practical matter doctors in psychiatric emergency rooms must commit or discharge potentially violent patients every day.

And so now researchers have been working on new strategies: Developing lists of personality traits and social factors that correlate with a predisposition to violence so psychiatrists may identify patients who are statistically at risk, the same way cardiologists use risk factors to predict which patients are vulnerable to heart disease.

Dredging of the Past

At Columbia's innovative program, where patients can be held for up to three days, the strategy includes extensive dredging of the person's past for patterns of violence, instead of relying primarily on interviews with the patient. The new method has allowed the emergency room staff to make far better determinations about violent potential, Dr. Stevenson said. There is tremendous pressure to improve since, rightly or wrongly, the courts and public have frequently held therapists accountable for a patient's violent acts.

"When it comes to predicting violence, our crystal balls are terribly cloudy," said Dr. John Monahan, professor of law, psychol-

Continued on Page C12, Column 1

Who Will Turn Violent? Doctors Seek Commitment Guides

Continued From Page A1

ogy and legal medicine at the University of Virginia, who is directing a study about violence in the mentally ill for the John D. and Catherine T. MacArthur Foundation. "The research indicates that clinicians are better than chance at predicting who will be violent, but they are far from perfect. The problem is there is no standard procedure and the field lacks a solid research base for knowing which factors to rely on."

One recent study in The Journal of the American Medical Association found that among 357 mentally ill emergency room patients who psychiatrists had predicted would be violent, 53 percent indeed committed violent acts in the next six months. But among a group of patients who were judged not to represent a threat, 36 percent committed violent acts. The groups were similar in terms of the patients' backgrounds and the types of mental illnesses represented.

Devoting More Time To Investigation

Dr. Charles W. Lidz of the University of Pittsburgh, who led the study, said he was somewhat surprised that the psychiatrists' predictions were as good as they were, given the lack of a scientific system for making the determinations. And he pointed out that patients who were judged to be nonviolent tended to commit offenses that were much less serious. But a public weary of living in fear may not be comforted by the fact that one in three patients released from emergency rooms as nonviolent will go on to harm, even if the harm is only shoving or pushing.

Scientists at several universities have identified numerous factors they believe are most likely to coexist with a predisposition to violence. Among them are poor ability to control anger, crack use and failing to take prescribed medications.

In addition, psychiatrists say they are spending far more time delving into a patient's background and current social situation, since patients who seem calm and composed under the doctors' scrutiny may turn from Jekyll to Hyde in outside-world situations. Such scrutiny may take longer than the 12 to 24 hours that many states allow doctors to hold patients against their will, which is why the pilot program at Columbia-Presbyterian was set up. The hospital had to get special dispensation from the

Crystal balls for violence are cloudy.

New York Mental Health Commissioner to hold patients for up to three days before initiating full commitment.

During that time, a team of psychiatrists, nurses, social workers and drug counselors not only interview each patient, but also try to reach anyone who can describe the patient's behavior in the outside world: family members, ex-spouses, teachers, landlords or parole officers.

"This is not just an interview, it's hours and hours of very thorough phone work to piece together a picture of a person's day," Dr. Stevenson said. "We seem to be making the right decisions. But we could never do it in eight hours or a day."

Psychologists and psychiatrists have long taken issue with the public perception that the mentally ill are, as a group, somehow more dangerous than the average person. Psychologists point out that many types of mental illness leave people with low

Marilynn K. Yee/The New York Times

Dr. Ellen M. Stevenson, psychiatric chief of Columbia-Presbyterian emergency services.

energy levels or feeling withdrawn; and, even when hearing voices, such patients are extremely unlikely to commit violent acts.

Still, large statistical studies have reliably shown a link, albeit a weak one. And the connection gets far stronger in certain subgroups of psychiatric patients, like those with certain types of delusions — and those who are patients in emergency rooms.

A Stronger Link To Drugs or Alcohol

"There is some association between mental illness and violence, but it's not nearly as strong as the link to drugs or alcohol," said Dr. Dale McNiel, director of psychological services at the Langley Porter Psychiatric Institute of the University of California at San Francisco. The potential for violence is multiplied when

want doctors "to say whether an individual is or is not dangerous, when that responsibility should lie at the judge's bench, not in the consultation room."

The traditional method that psychiatrists use for assessing violent potential is disarmingly simple: they ask the patient if he or she has any intent to hurt others or himself. The doctors say this brings a surprising amount of information to the surface: patients respond with plans to murder neighbors or weapons hidden in handbags.

But today the questions asked are much more probing. "We are very direct about asking patients about violence, violent fantasies and access to weapons," Dr. Stevenson said. "And certainly the patient's statement about intentions is important. But it's hardly the only one."

4 Types of Factors

new risk factors and to determine how important they are.

Dr. Monahan's group is looking at these four types of risk factors:

¶Those involving the patient, which may include the ability to control anger or to respond to threats nonviolently.

¶Those involving the patient's past, including a history of arrest or failure to keep appointments for psychiatric treatment.

¶Those involving the patient's social context, including living arrangements or family structure.

¶Those involving a patient's disorder, like delusions or fantasies about violence.

Dr. McNiel and his colleague Dr. Renee Binder have developed a screening checklist for use by therapists at Langley Porter in San Francisco to see which patients possess some of the qualities that correlate with a heightened potential for violence. It includes questions about recent aggressive behavior, a history of

since they have found that violenc
often the byproduct of combinin
person who is predisposed to viole
and a particular situation. For ex
ple, the schizophrenic man at Col
bia who had threatened to murder
girlfriend was found to have an
tremely stressful family situati
while in the emergency room, he l
group counseling with his family
his girlfriend.

But therapists acknowledge t
there are many constraints on a d

Seeking time bombs amon the troubled.

tor's ability to complete the task.
example, although a history of
lence is probably the strongest
dicter of risk for future viole
emergency room staff often ca
get access to arrest records, in s
cases because of time constraint
bureaucratic reasons and in ot
because of concerns for civil rig

"The amount of informatior
often quite limited and varies a
from jurisdiction to jurisdiction,"
McNiel said.

Decisions Can Take Days or Just Hours

At the University of California
tors make an effort to make a d
sion on commitment or releas
about three hours, although they h
the capacity to keep patients
about a day. At Columbia-Presby
an, where many patients in the
chiatric emergency room pre
high risks of violence, psychiat
started the three-day extended ob
vation unit so that evaluations c
be more thorough.

Many acknowledge the civil li
ties issues inherent in keeping pe
for days against their will withou
safeguard of a formal commitm
Commitment procedures vary wi
from state to state but freque
require that at least two doctors
cur on the detention and allow
tients some form of legal appeal w
in 48 to 72 hours. But the doctors
that society may have to compror
on civil liberties if it wants be
protection. And they point out
some patients who would be com
ted if psychiatrists had only e
hours to render a judgment are
home without commitment afte

3/23/93

Helping the Mentally Ill Return to the World

Bellevue's Program Is a Model of Discharge Planning in Caring for the Homeless

By LYNDA RICHARDSON

Reba Cherry used to lash out at people on the streets when she felt cornered. In a psychotic daze, she was assaulted by her own hallucinations. But the 36-year-old mentally ill and homeless woman was calm, cheerful and medicated enough on a recent Monday to be discharged from Bellevue Hospital.

Armed with a one-week supply of an anti-psychotic drug, three sets of clothing and discharge papers that spelled out after-care treatment, Ms. Cherry was escorted from the hospital's 18 West unit to a supervised single-room occupancy hotel in Chelsea where medical attention and counseling were waiting.

Ms. Cherry's first steps into the real world were more sure-footed than those of many mentally ill homeless people who are released from New York City hospitals, advocates for the mentally ill say. Unlike Ms. Cherry, most get little more than a slip of paper with no solid services behind it, advocates say, and many end up joining the estimated 10,000 mentally ill people in the city who have no place to live but in huge, forbidding shelters or on the streets.

Procedures Inconsistent

As the debate churns over a recent ruling in a lawsuit aimed at forcing the city to provide housing for homeless mentally ill people once they leave hospitals, Bellevue's 18 West ward provides a model of discharge planning in the complex world of care for the homeless mentally ill, city officials and advocates for the mentally ill say. But in hospitals across the city, and even within one hospital, like Bellevue, the discharge procedures are rarely consistent, and in some cases nonexistent, they say.

A showdown may come in mid-April when the ruling by the State Court of Appeals takes effect. The city said that its discharge procedure is effective and that it planned to continue discharging mentally ill homeless people as usual. But advocates for the homeless say the city will face a contempt of court proceeding if it continues to discharge people without safe housing and mental-health services.

"The city is doing what we were trying to stop them from doing," said Mary Brosnahan, executive director of the Coalition for the Homeless.

At Bellevue, the 18 West unit treats some of the city's most chronically ill homeless patients. The special 28-bed ward accepts only people brought in by Project Help, a city-run program that seeks to hospitalize the dangerously mentally ill homeless, against their will if necessary, and eventually find appropriate places for them to live.

"It is a model program and it shows that it can be done," said Luis R. Marcos, New York City's Mental Health Commissioner. "Unfortunately, we don't have similar programs throughout the system. That's not the way it is in other city hospitals or in other wards at Bellevue, either."

When the 18 West unit at Bellevue was created six years ago, it received seven additional staff members and $300,000 more than the other psychiatric wards, Mr. Marcos said. The unit's extra money, its special sense of mission and its link to a network that tracks the homeless mentally ill has given it an advantage over other wards, the commissioner said.

Even on one floor of Bellevue Hospital, the discharge planning is often starkly inconsistent in psychiatric units. On a recent Thursday, a 35-year-old schizophrenic being treated in the hospital's 18 South unit was only given a list of single-room occupancy hotels upon his discharge. The homeless man returned to the same East Side street corner where health-care workers picked him up.

He was released without any discharge plans and no effort was made to have a court decide whether he should stay hospitalized, said Dr. Samuel Tsemberis, director of Project Help.

"It's horrible," said Dr. Tsemberis. "The unit didn't try to detain him, knowing the guy had a history of trying to leave hospitals at the first chance."

Dr. Tsemberis and other community health-care workers say it is rare that efforts are made by city hospitals to place the homeless mentally ill into housing or to maintain contact with the community agencies that referred them to hospitals.

Returning to the Streets

The mentally ill homeless are often discharged with a written referral to a city shelter, but most refuse to go and many return to the streets, according to community care agencies that responded to a questionnaire sent out by the city's Office of Mental Health last year. The groups also found that many patients were placed back on the streets without hospital staffs notifying the agencies that referred them to hospitals. Seldom do hospitals call to arrange discharge plans, they said.

> Most ex-patients get little more than a slip of paper with nothing behind it.

"All too often patients are discharged with plans that fall through because they are unrealistic or just plain poor to begin with," said Diane Sonde, the director of Project Reachout, a nonprofit agency that provides help to mentally ill homeless people.

At Bellevue Hospital, officials said their policy has always been to provide proper discharge plans for every patient, not only in the 18 West unit.

But every day, the products of failed discharges in the mental-health-care system find their way to a drop-in center for the homeless in the old school of St. Agnes Church on East 44th Street near Grand Central Terminal.

'It's Not Easy'

There they are able to get a shower, a hot meal, a change of clothing or a nap curled up in a chair.

"It's not easy for them to stay on course," said Dr. Tsemberis of Project Help. "These people need help to make sense of their lives."

L'Tanya Smith, a 34-year-old homeless woman, has shown up at the drop-in center every day since Feb. 1. On that day, she said she left the 18 East psychiatric ward of Bellevue Hospital after a two-week stay with only a referral slip to get drug treatment at a community health clinic.

The woman, who has been in and out of mental institutions for several years, had been offered an adequate discharge plan but rejected it, a hospital spokesman said.

But Dr. Tsemberis said that Ms. Smith's experience pointed to a lack of follow-up and government responsibility and that more coordination was needed between the city's hospitals and community care providers.

"As far as 18 East is concerned, her case is closed until she comes back again," Dr. Tsemberis said. The 18 West unit at Bellevue, where Ms. Cherry was treated and discharged, was created in 1987 as a joint project between Project Help, Bellevue Hospital and Rockland State Psychiatric Facility in Orangeburg as a means of tracking patients after their discharge from city hospitals.

Can Challenge Commitment

Homeless people are first evaluated where they are found by city psychiatrists for Project Help. If they are found to be a danger to themselves or others, they are taken to Bellevue's emergency room where they are evaluated again and informed of their right to challenge their commitment.

Patients who are admitted are placed in 18 West. But because the unit is usually full, overflow patients are also taken to the hospital's other adult psychiatric wards where the homeless now are estimated to fill at least half of the beds.

The patients usually stay in 18 West for about 30 days. When they are released, about 50 percent are placed in community-based residences. About 40 percent go to the state mental hospital, and a smaller number are reunited with family members or released if ordered by the court.

Edward Keating/The New York Times

Reba Cherry, a homeless woman who was treated in the psychiatric ward of Bellevue Hospital, was released with antipsychotic medication, clothing, discharge papers and housing at a single-room occupancy hotel in Chelsea, where medical care and counseling awaited her.

Despite their best efforts, hospital officials say they too sometimes feel hamstrung by the system in which they work.

"We have seen patients slip through our fingers because of court rulings, patients who have in some cases come to bad end, either in the legal system or deteriorating on the streets," said Dr. Robert Levy, a psychiatrist and unit chief on 18 West.

"The system is a very erratic patchwork, depending on the given hospital, the given doctor, the idiosyncracies of the judges," he added. "The concept of danger to oneself and others is interpreted differently by

Despite her sketchy history, hospital staff members said they knew enough about her past from Project Help records to know her possibilities.

Ms. Cherry had not responded effectively to medication before, but doctors at 18 West decided on a long-term trial with an expensive new drug called Clorazil. They discovered over the course of five months that the drug seemed to be the glue that held her together.

Social workers began filling out housing applications. They chose St. Frances Residences, which has a medical and social work team and a

DEPARTMENT OF MENTAL HEALTH,
MENTAL RETARDATION AND ALCOHOLISM SERVICES
93 WORTH STREET
NEW YORK, N.Y. 10013
212-334-2081
FAX: 212-566-6256

LUIS R. MARCOS, M.D.
COMMISSIONER

November 9, 1992

Phyllis Harrison-Ross, M.D.
Director
Department of Psychiatry
Metropolitan Hospital CMHC
1900 Second Avenue, Rm. 4M3
New York, New York 10029

Dear Phyllis:

As you know, clinicians in psychiatric emergency rooms often express their lack of clarity about the legal provisions for emergency care and treatment to individuals who suffer from substance-induced mental disorders and are dangerous to self and/or others. This confusion is understandable given the current mental hygiene law which expressly excludes substance abuse from its definition of mental illness (MHL Sec. 1.03 (3) (20)).

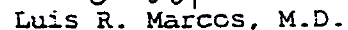
Compounding the problem, the mental hygiene law separates the provisions of care to the mentally ill (MHL Sec. 9.39) from the provisions of care to substance abusers (MHL Sec. 23.01 (b) (3)). Specifically, it excludes emergency involuntary treatment for substance abusers.

I would like to propose an amendment to the mental hygiene law which adds "substance-induced mental disorders" to the current emergency admissions for immediate observation, care and treatment provisions. Enclosed please find two documents for your consideration. The first is a legal analysis of the statutes governing this area and the second is a copy of the current mental hygiene law pertaining to this issue.

I am especially interested in your thoughts about this matter as well as your support. Please contact me at your earliest convenience to discuss this initiative.

I look forward to speaking with you.

Best regards,



Luis R. Marcos, M.D.

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