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Making decisions under constraint: A case study

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MAKING DECISIONS UNDER CONSTRAINT: A CASE STUDY

by

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Abstract

MAKING DECISIONS UNDER CONSTRAINT:

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Adviser: Professor Herbert D. Saltzstein

This study, based on the grounded theory approach, explored how members of one outreach team made decisions to involuntarily hospitalize individuals judged to be at risk of danger to self or others due to mental illness. From observation and interview material gathered over a one-month period, a conceptual framework of decision-making under constraint was proposed. Both legal criteria for involuntarily hospitalization (i.e., danger to self or others due to mental illness) and the system of care for homeless mentally individuals is framed in person-level categories and need-based language. However, decisions made by outreach workers on the street are based on intersecting person, group, system, and situational realities, and are framed in help-based language. Decisions to designate were based on risk and filtered through individual worker's beliefs about the capability of the help system and their own need to help. Ultimately, however, people were transformed into categories that matched legal and system criteria.

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CHAPTER I

INTRODUCTION

The Problem and Proposed Solutions

Since the early 1980s, the numbers of disheveled, dirty, and aimless people, seemingly without reason, have increased on the streets, stirring ambivalent public reactions of pity, disgust, and fear (Rivlin, 1986; Shipp, 1986). Pressure has been brought on public officals to "do something" (e.g., Egan, 1993). As in the past, mental health professionals have been called upon to handle the problem. In New York City, for example, a network of professionalized social services has evolved to address the problem of the homeless, including "specialized" groups of the homeless such as those with mental disabilities, and to deal with problems created by the impact of homelessness on the larger community (Lovell, Richmond, & Shern, 1994).

In order to receive services within the network, the homeless must first be classified into "policy-relevant" groups (Lovell, 1992). A key component in classification of people into appropriate categories for particular services is the homeless outreach team (Nasper, Curry, & Omaru-Otunnu, 1992). According to procedure manuals, outreach teams, traditionally funded by government mental health departments, link the "hard-to-reach" homeless to services by assessing homeless persons' problems and needs and making

referrals to programs where additional evaluation occurs (e.g., Alpert & Greer, 1990).

Assuming that the person assessed is willing to accept services (Dennis, Buckner, Lipton, & Levine, 1991), he or she might receive entitlements, trauma support, shelter, supported housing, a case manager, admission to a mental illness facility or substance abuse program, or emergency medical or psychiatric hospitalization (Drake, Osher, & Wallach, 1991). When a homeless individual is not willing to accept services and that person is determined to be a danger either to himself or to others because of mental illness, then an involuntary hospitalization, or designation, might be ordered by a psychiatrist on, or called by, an outreach team (Tsemberis, Cohen, & Jones, 1992).

Judgments of Mental Illness and Danger

Legal mandate requires that a person meet criteria of both mental illness and danger to self or others in order for a psychiatrist on a specialized outreach team to prescribe hospitalization. Both judgments of mental illness and danger are difficult to make under the best circumstances and those made in the street are confounded by contextual issues (Cocozza & Steadman, 1985; Prins, 1986; Snow, Baker, & Anderson, 1988; Wright, 1988).

The difficulty of making assessments of mental illness

in street populations is evident in epidemiological research. Current estimates of mental illness among the homeless, based on studies employing standard instruments validated for use with this population, are roughly one-third (Dennis, Buckner, Lipton, & Levine, 1991). However, estimates culled from early epidemiological studies designed to provide a description of the so-called "new" homeless (Rossi, 1990) in the early 1980's ranged from 2% to 90% depending on the sampling strategies, measurement techniques, or conceptual definitions used (Fischer & Breakley, 1991).[1] Determinations of danger, which in many cases imply a prediction of future conduct, are equally subject to interpretive problems (Steadman, 1976),

Although it is a crucial part of service planning and delivery, little is known about how assessments of homeless persons' problems and needs are made by outreach workers in street settings. According to an evaluation of service programs operating in 1986 and 1987, assessments appeared to rely heavily on clinical or intuitive judgment (Hopper, Mauch, & Morse, 1989). Inherent weaknesses in intuitive judgment by both lay and professional persons are well-known

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[1] Snow, Baker, and Anderson (1988) note that, under at least some definitions (such as those that equate "demoralization" with mental illness), nearly all homeless people would be considered mentally ill and by other conceptualizations (such as the ability to survive at all under such adverse conditions being equated with mental health) none of them would be.

(e.g., Fischoff, 1976; Kahneman, Slovic & Tversky, 1982; Ross, 1977).

Research on social and cultural influences on psychiatric diagnosis has shown that such diverse factors as personality and experience of the psychiatrist, social class of both the patient and of the psychiatrist and the social distance between them, ethnic and cultural background (usually discussed as important in terms of their effect on definitions of normality and abnormality), prejudices, religious or political affiliations, and even suggestion, all affect clinical judgments (Baldwin, Floyd & McSeveney, 1975; Conover & Climent, 1976; Helman, 1990; Temerlin, 1968; Wilkinson, 1975).

Moreover, the context in which diagnosis takes place appears to affect decisions about patients' problems (Emerson, 1983; Rosenhan, 1973). For example, judgments of incompetency required for involuntary hospitalization were found to be affected by organizational and administrative factors as well as patients' symptomatology (Haney & Michieulutte, 1968; Mendel & Rapport, 1975). And, mental health professionals may be over-cautious when making predictions of danger (Prins, 1986).

Limitations in the ability to make informed assessments may also be compounded by the ambiguous information available about the homeless person during an encounter (Brickner, 1990; Lovell, Barrow & Struening, 1992; Susser,

Conover, & Struening, 1990) and the often "insane" conditions under which assessments occur (Snow, Baker, & Anderson, 1988). For example, behavior resulting from delusional thinking might instead be a situationally adaptive defense -- motivated either by fear or by cleverness -- in response to a threatening physical or social environment (Fox, 1987). Likewise, aggressive behavior, not always synonymous with danger, may result from psychoses, stressful conditions, situational contexts, interpersonal conflicts, and/or a wide array of organic disorders (Shah, 1977).

Consequences of Assessments

Assessments of problems and needs that "miss the mark," including overdiagnosing as well as under-estimating mental illness by service providers and policy planners, is problematic both at a policy and individual level (Wood & Valdez, 1991). Overdiagnosing mental illness may deflect attention away from other problems, such as medical or social-economic problems (Rosenberg, Solarz, & Bailey, 1991), which tend to be discounted, or ignored (Snow, Baker, & Anderson, 1986). Discounting may result in ineffective planning for and referral to services (Kiesler, 1991; Rochefort & Cobb, 1992), at the least, or, more seriously, failure to recognize a serious, life-threatening illness. On the other hand, mental illness is a serious and

legitimate concern among homeless individuals as they face the many additional stressors of life on the streets and it is equally important that mental health problems are not ignored (Bachrach, 1986; Goodman, Saxe, & Harvey, 1991; Helman, 1985; White, 1982).

Over-associating danger with mental illness and mental illness with homelessness may result in unnecessarily shunning and stigmatizing the homeless. Homeless people are reluctant to use services when they don't believe that these services meet their needs or when they feel that by doing so they may end up even worse off than they were before they entered into the service system. Such people have been labelled "service-resistant" by providers but different perceptions of need and differential focus on the root of problems appear to lie at the heart of the issue of under-utilization (Morrissey, Gounis, Barrow, Struening & Katz, 1986; Morse & Caslyn, 1985).

When the decision becomes about whether to involuntary hospitalize an individual, the ambiguity of the decision takes on ethical significance -- suspension of an individual's rights -- an individual who is already taxed by disenfranchisement and an overwhelming panoply of problems. As resources dwindle and the rights of the individual become subordinate to the larger community, it is most often the "marginals," of whom the homeless, the poor, and the "different" are historic examples, whose rights become

subordinate. Psychiatric institutionalization carries the benefit of removing undesirables from the street so that the rest of society can feel safe (Scull, 1977) while they are being rehabilitated (Rothman, 1971). Unfortunately, this may also deplete the need for community-based options and divert resources away from other solutions to the problems of homelessness.

Research Plan

Despite the essential nature of these issues, I am aware of no systematic study that has focused on the processes by which assessments of homeless individuals are made in practice. This research was an attempt to address that gap by developing and refining a conceptual framework of decision making about homeless persons' problems and needs that was empirically grounded in the actual experiences of outreach workers who make decisions. Specifically, the framework would address how outreach workers make decisions to involuntarily hospitalize, for further evaluation, homeless street persons determined to be a danger to self or others due to mental impairment.

The specific research question upon entry to the study was, "How do team members make the decision to take someone to the hospital against their will (to "designate" the person)?" Because of the legal criteria that specify the conditions under which involuntary hospitalization can occur

(i.e., danger due to mental illness), it was proposed that outreach workers would have to make two determinations: (1) Is the person a danger to self or others? (2) Is the person mentally ill? Moreover, mental illness must be causally related to danger. The study addresses how these judgments were made and explores whether these judgments constitute the core components of decisions to designate.

CHAPTER II

METHODOLOGY

Methodological Framework

At the most basic level, assessment is a process of human judgment that involves actively acquiring and using information about the homeless person. This process is guided by information, prior beliefs and values the assessor already has and is affected by the target's behavior as well as the situational context in which assessment occurs (Carroll & Payne, 1976). Therefore, one research approach would be to investigate the cognitive processes involved in making assessments and to explore how motivational or informational factors produce systematic violations of normative inferential principles (e.g., heuristics or misattributions; Kelley, 1967, 1971; Kahneman & Tversky, 1973; Reiss, Levitan, & Syzsko, 1982; Schustack & Sternberg, 1981).

In this type of investigation, exploration of target and information variables should offer insight into the assessment process at an individual level. As stated earlier, the behavior of homeless individuals can be a product of factors occuring within the person (Drake, Osher, & Wallach, 1991; Wright & Weber, 1987) as well as the circumstances in which behavior occurs (Fox, 1987; Snow, Baker, & Anderson, 1988). Thus, situational factors should

also be considered. Prior information, such as a mental illness diagnosis, may focus the attention of the service provider on a psychiatric interpretation and he or she may seek information to support that hypothesis (e.g., Arkes & Harness, 1980; Baumann, Cameron, Zimmerman, & Leventhal, 1989; Shaklee & Fischoff, 1982).

Moreover, pre-existing beliefs of the observer (consisting of both general models relating to the behavior under consideration and specific prior beliefs about the target person) are important because they influence the way in which behavior is identified and integrated (Trope & Higgins, 1993). Training, experience, and interpretive models of the observer (e.g., illness models, Eisenberg, 1981; Engel, 1980; models of helping and coping, Brickman et al., 1982; or attributional models, Kelley, 1972; Carroll & Payne, 1976) should be considered.

Whereas it is extremely important to integrate social cognitive concepts into studies in applied settings, especially in important social issues such as homelessness (Toro & Warren, 1991), preliminary exploration into the way decisions to designate were made revealed some problems in applying a cognitive/individual approach in a regression model even when situational factors were taken into account.

First, the team was embedded in a service system for homeless and homeless mentally ill people in the City and had a unique position of legal and medical responsibility

within that network. The team accepted referrals from other outreach teams, other service organizations, the police, and private citizens. The assessments they made appeared to be enmeshed in a complex web of system and group interaction in addition to operating on an individual level. It was essential to explore how system- and group-level variables influenced individual decisions (see Hirokawa & Johnson, 1989, for a discussion of research on group processes).

Second, it was apparent that this exploration must take place in the context in which decisions occur, as they are occurring. This approach would allow individual-level variables to be revealed as they are brought to bear on the the decision-making task (Newell & Simon, 1972). Moreover, meanings that outreach workers apply to decisions may be products that arise during interactions (Blumer, 1969). Qualitative methods that emphasize validity, including participant observation and in-depth naturalistic interviewing, well known in sociological and anthropological research (e.g., Glaser & Strauss, 1965, 1967), were best suited to understanding how the world was experienced and defined from the actor's own perspective, and in capturing this process of interpretation.

The tools of this method consist mainly of generation of categories and terminology from a thorough review of field notes taken during participant observation and/or interviews and protocols. Use of the constant comparative

technique throughout data collection and analysis enables the researcher to discover and describe "what is going on" when decisions to designate are made and to develop hypotheses that are "grounded" in the data (Strauss, 1987; Strauss & Corbin, 1990). This seemed a necessary first step in understanding how decisions were made in complex environments.

Subjects and Sources of Data

The non-random selection of subjects was consistent with grounded theory methodology. Comprehensive data were collected from a sample chosen for theoretical relevance. In other words, subjects were selected because they were "experts" in the area of inquiry. Qualitative methodologists suggest that it is beneficial to understand a single setting and only then to decide upon additional settings to study (Taylor & Bogdan, 1984).

Practical consideration also guided the selection of subjects. The researcher was given a unique opportunity to study the decisions made by the outreach team responsible for involuntary hospitalizations within the services network in a large northeastern urban region (the City). By mandate, the outreach team (referred to throughout this paper as the Team) specifically targets mentally ill homeless people and includes psychiatrists and nurses as well as social workers (Cohen & Sullivan, 1990). The Team

was initiated by a city hospital agency in 1982 after, according to one account (Tsemberis, personal communication, May, 1993), a city commissioner was unable to negotiate a timely removal from the streets of a homeless woman badly in need of medical care.

Then existing law required two physicians to sign a short-term involuntary treatment order (STIPSO) so that an individual could be hospitalized. In the interim, about 72 hours, the woman died. Under the new Mental Hygiene Law, the Team became the only agency in the City legally empowered to involuntarily remove homeless people from public spaces if determined to pose a threat to themselves or to others as a result of mental impairment (Katz, Sabatini, & Codd, 1993), and transport them, with police assistance, to psychiatric facilities for further evaluation. In addition to emergency transportation, the Team is available to perform evaluations of people determined to be in acute psychological distress by other outreach teams, social service agencies, and private citizens.

The Team's work has not been without controversy, the crux of which revolves around the issue of temporary suspension of individual liberties so that people can be treated. On the night that the initiative was put into place, a woman was brought into the hospital by the evaluation team. The Mayor had been under pressure by

neighborhood groups for some time to remove this woman from the area. She neither wanted to be taken to the hospital nor kept there and called the Civil Liberties Union. The Union operated as advocate for those homeless persons who did not want to be hospitalized because they believed that the City simply wanted to rid the streets of undesirables so that the rich would not have to be inconvenienced (Koch, 1990).

A public argument ensued with each side bringing in its own set of experts to determine the woman's mental stability. A judge ordered her release from the hospital, criticizing the administration for not offering her decent housing. The Mayor appealed and won on the grounds that she was sick and required treatment. The City then sought to require that she take medication but lost this case. She was subsequently released because, it was argued, she could not be treated if she would not take medication.

From 1982 to 1987, the Team was restricted by law to transporting those for whom "inability to meet basic needs for food, shelter, medical care, or safety such that without prompt and adequate treatment death, serious disability, physical injury, or serious physical disease will imminently ensue." Homeless advocates argued that application of this law was dangerous because, by this definition, nearly all homeless people meet the criteria for designation at one time or another. The proponents of extending the scope of

involuntary hospitalizations were pleased, however, when, in 1987, corporation counsel informed the Mayor that the City could also pick up people who "would be a danger to themselves or to others -- not necessarily at that moment, but in the reasonable foreseeable future."

That same year, a new initiative was put into place at a city hospital (the Hospital) when a 28-bed-ward was designated as a special psychiatric unit. Here, individuals could be held for 28 days and discharged to either a state psychiatric hospital for long-term care, to a community residence, to their families, or to their "own care" which in many cases meant back on the street.

Because of the inherent problems involved in psychiatric diagnoses (Wright, 1988) and a look back at the cyclical history of mental illness reform, many people questioned whether initiatives such as this might be consistent with a more general trend toward a "return to asylum" because other alternatives, argued by some as not given a fair chance to succeed (Kanter, 1989; Sullivan, 1992), appeared to have failed (Durham, 1989; Elpers, 1987). Others welcomed the shift, paralleling the progression over the decade from a focus on humanitarian concern to one of public safety and expediency (Durham, 1989; Egan, 1993; Toro & McConnell, 1992; White, 1987), toward preventive confinement.

The research project was approved by the Team's

director and by the other government and private agencies that were involved indirectly in the project (e.g., a transportation agency). Subjects were informed that the research project consisted of an exploration of the assessment process during a meeting between the research investigator, the Team's director, and members of the Team. Specific goals and questions were not disclosed.

Subjects were asked for permission to allow the investigator to accompany them during two or three shifts over a several-week period, to observe and record field notes, and to ask questions about the assessment process. Subjects were then asked to sign an informed consent form that included information about the voluntary nature of the research and about confidentiality of the data collected. In addition, subjects were asked to sign a release for tape recording of selected interviews. Subjects were informed that anonymity of individual team members would be protected by the investigator by the use of a coding scheme that replaced all identifying information in the data and that this coding scheme would be kept in a locked drawer and destroyed after data had been analyzed.

Protection of homeless individuals encountered during the observation and taping period was also discussed during this meeting. The subjects were instructed that, if the question arose, the investigator was to be introduced as a member of the outreach team. All information about homeless

individuals recorded in field notes would be free of identifying data and notes would be destroyed after coding and analyses. Subjects received a $50 consultation fee at the end of the research period.

Each team member was observed during at least one randomly selected 4-hour work shift (one morning and two afternoon week-day shifts, four evening shifts, and two weekend shifts) and in-depth notes were taken of encounters that occurred during that shift. Notes included the geographical location or place where the encounter occurred, characteristics and behavior of the person being assessed, interactions between the outreach worker and the homeless individual, interactions between workers on the team, and interactions between team members and others in the network.

Observation and naturalistic interviews were also conducted with service providers from other agencies (e.g., outreach workers from other teams, service providers from referral agencies) when they were involved in the Team's encounters with homeless individuals. Verbal protocols, a running record of everything a subject says while instructed to "think aloud" during or following a task (Carroll & Payne, 1976), were tape-recorded for later transcription at the end of a shift after the team member was given the following instructions by the researcher:

> A little while ago you came into contact with an individual [remind the subject of the particular case].

> Explain to me in as much detail as possible and in the order in which things happened as best as you can reconstruct it, how you decided what was going on with that person. As you're describing do a few things: Include any information that you used, any information that you wish you had had to use, any decisions you made along the way, any hunches or any intuitions, any feelings that you had. Really, anything that comes to mind and, as I said, do so in the order that those thoughts, information, feelings, decisions, intuitions, considerations, evaluations, etc., came to mind. Tell me what happened without any pauses. Ready? Go.

Subjects were also asked to evaluate the case on several dimensions; presenting problem, attitude toward the interviewer, severity of psychopathology, impairment, and level of dangerousness, and about responsibility for cause and solution to the problem (Karuza et al., 1992). Also, if treatment recommendations or physical condition were not mentioned in the verbal protocols the interviewee was specifically asked about them at this time.

To gain an understanding of the context in which team members operated, interviews, conducted with service and non-service network sources (e.g., transit police officers, directors and staff of business or community non-service agencies, directors of other service agencies and the team's director) as part of a study on services available for homeless mentally ill persons in the City, were included in the analysis (Lovell, Richmond, & Shern, 1994).

During rounds with the team, the researcher remained as unobtrusive as possible. My primary task during this period was to make and record observations. As concepts began to

emerge (and as subjects became more used to my presence), I would occasionally ask questions about those concepts. As the period of study proceeded and hypotheses about categories and their relationships were made, observation and questions became more focused around those analytic questions. The amount of observation and interview material collected, in qualitative research normally determined by the principle of theoretical saturation, or the point where additional data failed to yield new information related to the emerging conceptual framework, was more pragmatic -- the amount of observation done was limited to the amount of time allotted to the researcher to make rounds with the Team. As data analysis proceeded, two meetings were held with the Team's director during which clarification of concepts and their relations were probed. After initial instruction, the verbal protocols were collected with no interruption by the researcher. Occasionally, following verbal protocols I would ask questions to clarify something the subject had said during the protocol.

Data Analysis

The primary task of data analysis was to "make sense" out of the various sources of collected data by following procedural guidelines for discovering, verifying, and formulating grounded theory. Sequential steps of data analyses were not laid out firmly in advance because these

sequences depended on the kinds of data that were available as the research project evolved and on the interpretations of the researcher (Glaser & Strauss, 1967; Strauss, 1987). Moreover, essential procedures were "in operation all through the research project...in close relationship to each other, in quick sequence and often simultaneously" (p. 23, Glaser & Strauss, 1967).

However, as a rule, the earliest phases were more "open" than later phases. The first step was to allow concepts and categories to "emerge" from the data, both during data collection and later when the data were being systematically investigated. As concepts and categories emerged, an indexing system was developed. The purpose of the indexing system was to begin to develop a descriptive language whereby the data were organized and labelled into low-level concepts (the most basic conceptual units) and more abstract concepts that systematically incorporated and connected these basic units. Particular attention was paid to the emergence of conditions, consequences, interactions, strategies, and tactics within the data.

The early phase of analysis offered the researcher maximum flexibility in generating emerging categories. The only requirement at this stage was that, in Glaser and Strauss' terms, the low-level descriptions "fit the data" well. As data analysis proceeded, the researcher "builds up a set of categories each of which is in reference to one or

more instances in the data" (p. 103, Henwood & Pidgeon, 1992). It was during this process of building a set of categories that the low-level categories were systematically integrated into a coherent conceptual account that offered a rich understanding of the data. During later phases, a number of categories that were generated earlier were dropped because they were not very useful and were not related to the core category.

Several routine operations, suggested as aids in the procedure set forth above, all consistent with the method of constant comparative analysis (Glaser & Strauss, 1967), were adhered to during data analysis. The basic premise of constant comparative analysis is that the researcher must always be alert to both similarities and differences that exist between instances, cases, and concepts, so that "the full diversity and complexity of the data is [are] explored." These operations included:

> theoretical saturation of categories (coding of instances until no new examples of variation are found); writing definitions of categories that have achieved saturation; writing memoranda recording all of the analyst's observations during the course of the analysis; linking categories together, often involving the creation of new overarching categories at higher levels of abstraction; and seeking more data where this

appears necessary to elucidate aspects of the emerging theory (p. 103, Henwood & Pidgeon, 1992).

CHAPTER III

DESCRIPTIVE DATA AND TEAM LOGISTICS

Demographics of Team Members

The sample consisted of seven psychiatrists, three social workers, and two nurses. This constituted all staff on the Team, except one psychiatrist, who was on vacation for one month during the period of study, and one nurse, whose primary duties were administrative. Because, as a rule, psychiatrists worked fewer shifts than either nurses or social workers, the method of random sampling of shifts resulted in each psychiatrist being observed during only one shift, one nurse being observed during three shifts, and one social worker being observed during four shifts. At times, inability to re-observe or interview psychiatrists inhibited the researcher's ability to make follow-up inquiries about some concepts. Another problem was that more available data from one social worker and nurse might have given them "more of a voice" in the conceptual framework. As data analysis proceeded, an attempt was made to control for these two problems by presenting unsaturated concepts as "exploratory" and by controlling for over-use of data from the social worker and nurse.

Eight members were female, four were male. All were Caucasian. Ages ranged from 33 to 63. Mean age was 41; the median was 38.5.

Experience working with the homeless ranged from one year to 10 years (M = 4 years) and with mentally ill persons from two to fourteen years (M = 7.5 years). Number of years worked in the social services system ranged from three to sixteen years (M = 6.5 years). Number of years worked for the Team ranged from one to seven years (M = 3.5 years).

Staff were scheduled to work in eight- or four-hour shifts during the day (9am to 5pm) or evening (4pm to 12am) hours. On weekends, staff worked from 12pm to 8pm. During the week, one psychiatrist, one nurse, and one social worker were usually scheduled for the day-shift: On two days, staff consisted of a psychiatrist, nurse, and two social workers. During the weekdays, the team in the field (the team) usually consisted of two members: Composition varied according to the nature of the referral or outreach scheduled that day. For example, if a call came in that required an evaluation for hospitalization, a psychiatrist would be needed. If regular outreach to check on clients occurred, then the nurse and social worker could go out without a psychiatrist.

During the evenings, the team consisted of one psychiatrist and either one social worker or one nurse. On weekends, the team consisted of one psychiatrist and one social worker or the psychiatrist, one nurse and one social worker.

Five staff members (two nurses, two social workers, and one psychiatrist -- the psychiatrist who was on vacation) worked full-time (at least four days) for the Team. One nurse, one social worker, and two psychiatrists worked half-time. The remaining five psychiatrists worked from one evening every week to one evening every two weeks.

When not working for the Team, the staff held positions in other social service agencies or facilities for the homeless and/or the mentally ill. These included two transitional residences for the homeless mentally ill, the Hospital's special psychiatric ward, two state psychiatric hospitals, a public sector clinic for people in shelters, an outpatient psychiatric clinic, a city agency performing psychiatric evaluation services of people in city apartments, two social service agencies for the homeless mentally ill, and the community services program at the Hospital.

Encounters with Homeless Individuals

Thirty-four people were discussed (one person was discussed twice) over 38 hours of observation. The number discussed on each shift ranged from one to nine ($M = 4$). Actions included looking for someone, deciding not to stop and speak to someone, transport to another social service agency, and hospitalization, both voluntary and involuntary.

Specifically, four involuntary and one voluntary hospitalization occurred (three of these encounters were the result of referrals, one from transit police, one from a neighborhood association social service agency, and one from community service police located in a major transportation terminal; one was the result of a call from the team office after one of the office staff had seen a person known to the Team with "a bleeding face;" and one was the result of regular outreach).

Fourteen other cases were discussed as the result of a referral. Of these, the team looked for but didn't find nine people. In two cases, the team told the referral source that they would not be able to come that day. One referral, from community service police in a transportation terminal, resulted in the person being taken to a transitional residence for an overnight stay. In another case, the team went to the referral source's home base but the person had already left by the time they arrived. One referral resulted in an encounter in the loft of private citizens.

Fifteen other cases discussed were not referrals. Of these, two people were not known to the team and were passed by during regular outreach. Seven cases were people who were known before to the team and encounters took place. Four cases resulted in encounters with people who were being

seen for the first time. Two cases were known by the team and looked for during regular outreach but not found.

Thus, even though 34 people were discussed, only 19 encounters actually occurred. These encounters occurred on the street, in major transportation areas, in community service police holding areas, and, in one case, in a private residence.

Interviews and Protocols

Of the nineteen encounters that occurred, five were very brief -- i.e., only a short conversation occurred and no discussed ensued. Fourteen encounters were more lengthy and discussions that followed elicited further questioning of the team members by the researcher. Of these 14 encounters, full verbal protocols were tape-recorded on eight cases.

Seven psychiatrists, three social workers, two nurses, and one community liaison worker from a referring team completed verbal protocols. In the other six cases, abbreviated protocols were taken from two psychiatrists and one social worker.

Verbal protocols (six full and one abbreviated) were taken from more than one person on seven cases allowing comparison between members; (1) psychiatrist, social worker, and community worker, (2) psychiatrist, two social

workers, (3) psychiatrist and nurse, (4) psychiatrist and social worker, (5) psychiatrist and social worker, (6) psychiatrist and social worker, (7) psychiatrist and social worker. The last four were the same psychiatrist and social worker. Six protocols were collected from one social worker.

Demographics of Homeless Individuals in Encounters with Full and Abbreviated Protocols

The sample consisted of two females and 12 (86%) males [of the original 34 cases discussed, nine were female, 25 (74%) male]. Eight were Caucasian (57%), five African-American (36%), and one Hispanic [of 34 cases, 15 were Caucasian (44%), 10 African-American (29%), and two Hispanic -- the referral source did not provide ethnicity in seven unencountered cases].[2]

Eight people were determined to be mentally ill: Of these, one was also diagnosed as retarded, one was diagnosed as having an additional medical problem (abrasions and contusions), and four were considered at risk of danger to self. One person, not judged to be mentally ill, was believed to have a personality disorder. Three people were not judged to be mentally ill but to have alcohol problems.

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[2] In 30 months of operation, the Team identified 1600 patients. Of these, 68% were male, 59% white, 29% black, 8% Hispanic, and 1% Asian (Putnam, Cohen, & Sullivan, 1986).

No judgment could be made about the cause of problem as a result of mental illness or alcohol abuse for two people.

As stated earlier, five encounters resulted in designations. One person was taken to another agency for an overnight stay and then sent back to her hometown the next day. No action was taken on the remaining eight. Five were contacted as the result of a referral (of these three were designated; one taken to another agency; one was "no action").

Day-to-day Operations of the Team

The team operated from a mobile van that travelled throughout the City. The number of homeless people contacted during each shift varied as a function of referrals received and designations made (e.g., a designation, or the involuntary transport of a person to a psychiatric emergency room, required that the team contact a police "task force" to assist in taking the person to the Hospital, a procedure that took anywhere from one to three hours).

The team was accessible by radio and by telephone. Hospital rubber gloves were kept beside the driver's seat. The third seat was used for people transported either to the Hospital or to other agencies and workers did not sit in this seat because of possible contamination from lice or other communicable diseases. The police officer that

accompanied the person to the hospital, however, usually sat in this seat with the homeless individual. Two large plastic bags filled with sack lunches were carried in the van to be distributed to those in need of food. However, food was also used as an engagement tool when someone was being assessed for designation.

The day-to-day operations of the team were highly dependent on how many referrals had come in prior to or during that shift, their nature, and their "immediacy." Assessments were made under variable time constraints. Sometimes there was adequate time to talk at length to a person. At other times there was only time to do a "quick visual."

Operations of the day-teams differed somewhat from that of the night-teams. During the day, team members performed various other duties such as visiting someone in the hospital or at their residence, making inquiries about their needs, and maintaining contact with other service agencies. These duties, with the exception of inquiring about the needs of those seen during regular outreach, were not conducted during the evening or on weekends.

Notes about the contact were taken by a team member following each encounter. If a new client was encountered or if a decision was made to designate, an intake form was completed that included information about the referral source, descriptive and identifying data, presenting

problem, psychosocial assessment, social network and support, mental status exam, medical evaluation, substance abuse, global assessment scale (indicating level of functioning), services provided, and disposition (e.g., involuntary transport, continued monitoring needed, referral to another agency). Any team member, or composition of team members, could complete this form. If the person was taken to the Hospital, a lenthy chart note, describing the rationale for bringing the person to the hospital, was written by the psychiatrist.

Operational System of the Team

The team operated under a variety of requirements that included a legal and medical mandate and a prescribed role within the network of services for the homeless mentally ill. People seen on the street had multiple needs including the need for food, clothing, medical and dental care, decent homes, substance abuse programs, social and job skills training, access to jobs, and opportunities to build self-esteem and self-reliance, all of which required supportive services. Because of their legal and medical mandate to help those at risk of danger to themselves or others due to mental impairment, team members were required to sort through this myriad of need and locate individuals who fell into the dual program-prescribed categories of "dangerous" and "mentally ill," and exclude those who did not.

According to the director, a hospital risk management/quality assurance committee, composed of a psychiatrist and an attorney, reviewed all designations to assure that a "good enough case" was made for bringing the person to the hospital. The hospital was liable if it was not a good enough case. The Team received feedback from the committee, through the Team's regularly scheduled meetings, as to how well they were doing. The Team's doctors needed to justify reasons -- both clinical and legal -- for designation. Therefore, paperwork and explanations for cases consisted of legal and medical rationale that matched the person to hospitalization.

The Team was evaluated on the basis of how many encounters they made, how many people were left on the streets, response time to referral and how well the team was integrated with the referral network (Tsemberis, May, 1993, personal communication). Therefore, it was important to maintain positive relationships with others in the system as well as to have a maximum number of referrals.

The Team had direct access to medical and psychiatric treatment, through the hospital, for those clients believed to meet legal criteria. The Team was also able to provide emergency food, transportation, and referral to other resources for those who did not meet criteria if a person chose to accept those services.

The team was restricted in the type of service it was able to provide, not only as a function of the specific type of help that the team was responsible for delivering -- i.e., hospitalization -- but also by the inadequacies of the city-wide service system for people who are homeless and disabled. Within these constraints, team members did the best they could to help those believed to be in need.

CHAPTER IV

THE ASSESSMENT OF MENTAL ILLNESS AND DANGER

Presentation Overview

In this chapter, the first two observed cases are described and the first phase of analysis presented. As these cases were observed, particular attention was paid to categories, and the relationship between them, set forth in the language of the team's legal mandate -- danger due to mental illness. The guiding questions were: (1) How do team members make determinations of mental illness? (2) How do team members make determinations of danger? and, (3) How do they relate these two categories? Other factors that appeared to impact on decisions to designate were described and organized into low-level and, when appropriate, higher-order concepts. Relationships between concepts were proposed.

Each case is presented in the order in which it was observed. Concepts, and the relations between them, are presented as they are "discovered" by the researcher. By presenting the data in this way, the reader is invited to join in the process by which the researcher began to develop a conceptual framework so that he or she can critically examine the validity of those findings. In succesive chapters, the framework is refined as cases are presented and analysis proceeds.

"Is this Person Mentally Ill?"

During observation of and subsequent review of data from Case 1 (Psychiatrist 1, Social Worker 1), each reference to mental illness was carefully examined to understand how the Team answered the question, "Is the person mentally ill?" These references were then contrasted with those from Case 2 (Psychiatrist 2, Social Worker 2, Social Worker 3).

Case 1 was the result of a referral from community service police in a transportation terminal. The referral had originally been given to another outreach team that works closely both with the police unit and with the Team. The evaluation took place in the police waiting room. This case did not result in designation. Rather, the woman being evaluated was taken to a center for homeless mentally ill persons for an overnight stay and was sent back to her home state the next morning.

Case 2 was also a referral from transit police. In this case, the team travelled to the police office and then out to where the man to be evaluated lived in a shack under the train tracks. The man was involuntarily taken to the Hospital.

When Social Worker 1 responded to the question posed in the verbal protocol after the encounter, "How did you decide what was going on with this woman?," the first reference she made was that she was told by the referral source that the

woman was "mentally ill" and "had left the hospital." Psychiatrist 1 offered another explanation to team members when she was told, in the office, about the referral. She stated, "She may be demented -- she walked out of a nursing home." It appeared that she was reluctant to immediately accept the mental illness diagnosis although she did state, "She'd been in and out of state hospitals."

Thus, two sources of information used by the Team to determine mental illness appeared to be past history of psychiatric hospitalization and the diagnosis offered by the referral source. The determinations of these sources were not automatically accepted, however.

On arrival at the scene, the referral team informed Psychiatrist 1 that the woman's sister had explained a series of actions on the woman's part that strongly suggested a history of mental illness: She leaves the adult home, ends up back at the hospital, takes medication (In the verbal protocol, Social Worker 1 referred to this as "stabilization"), and is discharged to the same adult home where the cycle is repeated.

Social Worker 1 and Psychiatrist 1 reported in respective verbal protocols that the woman was "delusional." Social Worker 1 added that the woman had "paranoid controlling thoughts." Psychiatrist 1 stated, "This is, I think her baseline and while being very delusional she's also quite functional in her own way." These determinations

were made after speaking with the woman for several minutes in the police office and during the ride to the reception center. By the time the woman was questioned by team members, a decision not to designate had already been made.[3]

Talk about mental illness in this case was contrasted with talk and actions by Psychiatrist 2, Social Worker 2, and Social Worker 3 in Case 2, a case that did result in designation. Psychiatrist 2 based his assessment of mental illness on several factors. The first was an inspection of the person's living situation. The second was the man's behavior. The third was a lengthy interview with the person that included questions about his prior psychiatric treatment -- answered in the affirmative -- and exploration of the person's reasons for living under the tracks. Responses included delusional material about working for the government and having been ordered to be there to carry out that work. Psychiatrist 2 also asked questions about substance abuse and organicity. Presence of either of these

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[3] Throughout the rest of the discussion of findings, I have chosen to do two things. First, because all material taken from verbal protocols was in direct response to the question, "Explain to me how you decided what was going on with the person," and after that initial probe can be considered "unsolicited," and because the bulk of verbal data was taken from these protocols, I will usually only describe the source of talk if it comes from another source -- i.e., response to a specific question put forth by the researcher or during discussion between team members that was not in response to the researcher. Second, I will refer to the "researcher" as "I." This will both omit awkward use of language and more clearly reveal my role in the analytic process.

conditions would have ruled out the diagnosis of a chronic psychotic disorder.

Social Worker 2 first referenced his determination about disposition to the referral source. He stated, "It's a good referral source who has some feeling to working these cases with us." He based his assessment of mental illness on the person's living situation, "He was living in a somewhat inappropriate isolated manner," and on the presence of delusional material that was elicited upon questioning by the psychiatrist, "Some delusional material came out that he was working for the government and that there were certain numbers on the tracks that were related to him." Moreover, "his behavior showed impaired, compromised judgment."

Social Worker 3 also first referenced the referral source. She stated, "[The referral] is known to [the Team] and that takes it in a certain direction that the person who's calling you has already made some evaluations." She next considered the timing of these referral calls. (It turns out that another call had been placed by the referral about the same person exactly one month ago). If calls were made about the same time each month, for example, when the person had received a government check that could be used to buy drugs, then the person's aggressive behavior might be a function of drug use and, therefore, a diagnosis of mental illness would be ruled out. Social Worker 2 also referred

to the group process that went into the determination of mental illness. She stated:

> It's just the conversation that goes on in the van on the way out to see somebody. I think that what usually feeds into that is other people we've seen, situations that remind us of experiences other people have had....So a lot of it becomes kind of intuitive and it does become a group decision in that way.

She explained her first instinct, when she saw where the person was living, about whether or not he was mentally ill:

> He seemed pretty well organized but that's my own particular weakness. I have this idea that cleanliness is next to mental health and I know it's not. I'm always impressed with somebody who can keep it together under those circumstances.

However, she based her final assessment of mental illness on the material brought up in interview with the psychiatrist and on the fact that the person assessed seemed to agree that he was mentally ill.

In both cases, the person was judged to be mentally ill. Both were referred cases. However, only one person was designated. The primary difference between these two cases appeared to be judgment about danger to self or others. These two case will be contrasted on this dimension.

"Is this Person at Risk of Danger to Self or Others?"

Social Worker 1 made no reference to danger in the verbal protocol. The only reference that Psychiatrist 1

made was at the end when her statement revealed that she was aware of the potential danger involved in the woman riding alone on the train and wanted to rule this out:

> I questioned her and she knows the train system very well having done this before and I feel completely comfortable that she can make it back there...she's quite functional in her own way and I think that she will have no difficulty getting back there.

The community liason worker from the other team, however, did have some concerns because of "my experience putting mentally disturbed people on public transportation." He stated, "I'm uneasy putting somebody in her condition as delusional as she was and disorganized back on a train, so my reaction was to take her to the hospital."

During my observation of Case 1, I listened as Psychiatrist 1 spoke to the woman in the police office. She asked what medications she had been taking and when she last had a seizure. She asked if she had enough seizure medication to last a few days. She continued to be attentive to possible medical complications in the van on the way to the center, but was not concerned about psychiatric problems impacting negatively on her decision.

In contrast, with the exception of Social Worker 3, protocols, observation notes, and responses to questions in Case 2 were riddled with concerns about danger, both to self and others. Psychiatrist 2 reported that the Team had been called by the police because the man was displaying "disruptive and threatening behavior" and that he was

"lighting fires." According to the psychiatrist, however, he believed that the man posed more of a danger to himself because "he was living in an environment where he was exposed to extreme cold and possible smoke inhalation in this unventilated hut." In addition, "he was periodically quite threatening to police." Psychiatrist 2 concluded, "So, he appeared to be dangerous to self or others based on a long-standing psychiatric condition."

The verbal protocol of Social Worker 2 set up a much more vivid picture of danger, both to others and to self:

> The behavior there struck me that he was isolated in a metal shack in all kinds of weather. He was aggressive. He had threatened the police officer with a shovel, and ready to throw glass on him or, any number of, with knives, so, the level of threat was there. The level of exposure was there and even before seeing the patient it sounded like he was at some degree of risk to self or others.
>
> Now when we drove out to find him he was in a very isolated place which could be dangerous to him. I know that people have been set on fire and attacked. Many homeless people that I know sleep next to doormen or they sleep more of in a public place. His place was very isolated. And he had a smoky fire going in an enclosed area which could actually back up and poison him.

The verbal protocol of Social Worker 3 contained no reference to danger, although she did describe his living situation as "precarious."

A conversation held between team members in the van revealed that the differences in meanings of fire-setting and aggressive behavior might explain the differential references to danger between Social Worker 3 and other team

members. She explained that when she had been told by the police that the man was loud, boisterous, and had been setting fires, she wondered if he had been trying to cook or heat his place and if he might have been aggressive to protect his area. Psychiatrist 2 told her that fire-setting and aggressive behavior were a bit odd no matter why you were doing them.

Thus, a determination of danger to self or others appeared to be the primary judgment in the decision to designate. Even so, I recognized that there existed a relationship between danger and mental illness in that mental illness terms were used in talk about danger.

Relating Danger to Mental Illness

Even though Social Worker 2 stated that the person in Case 2 "was able to support himself," he qualified this by stating that "he was completely ridden with delusions." And, it was these delusions, "of working for the government," that "made him literally chained to a little metal shack unable to free himself, unable to put himself in a room even though he had resources and could have helped himself." His conclusions were that "he was grossly, severely impaired in functioning." According to Social Worker 2, this was true "even though he had a cover story and a set of behaviors that he would say would prove opposite."

Social Worker 3 also connected the man's delusional system with his living situation when she stated, It was clear that he had a pretty well developed delusional system that was keeping him in this really precarious living situation." And, Psychiatrist 2 concluded that the man was "a danger to self or others based on a long-standing psychiatric condition. The man's delusions forced him to live in this hut under the tracks."

Emerging Concepts

Several other concepts, and relations among them, emerged during review of data from these two cases, however, that led me to believe that other influences might also be related to the decision to designate, in part, by affecting the determination of whether the person being assessed was "in danger". Interestingly, these concepts were not a function of the individual being assessed. That is, they were not person or individual categories, such as "mentally ill" or "dangerous". Instead, they were related to the group with which or the system in which the team operated.

Referral source. In each case, by all members, initial references about decisions included information provided by the referral source. This information, according to the community liaison worker, "pre-set" his thinking. According to Social Worker 2, information provided by this "good" referral source enabled him to make a pre-judgment, even

before seeing the individual, that this was someone who was at "some degree of risk to self or others."

Both Psychiatrist 1 and Psychiatrist 2 were attentive to the expectations that the referral source had of the Team. After the initial phone call in Case 1, Psychiatrist 1 stated, "She (the woman) just needs to be taken care of." I inferred that this was a problem that the referral source wanted the team to handle. Psychiatrist 2 stated, "The first thing I did was ask them about was there something more about this patient to get a better sense about what they were expecting from us." During an unsolicited conversation in the van, he stated that he wanted to know, "Why don't they just arrest him?" Social Worker 2 responded, "Is he just a control problem?" Social Worker 3 added, "I think they're afraid of him." In each case, leaving the individual with the transit police was not an option. It was the team's responsibility to decide what action would accomplish two simultaneous goals; "taking care of" the person and meeting the referral's expectations, if those expectations were believed to be appropriate.

Sources of help. It appeared that, in both cases, the team matched the determination, "What do we need to do," against "What can we do?" The team had a limited repertoire of tools available to "take care of," or help the person, and expressed beliefs about the efficacy of those tools.

In Case 1, Psychiatrist 1 also took into consideration

"what others can do." Psychiatrist 2 did this somewhat when he questioned why the person had not been arrested by the police. Arrest was an option available to the police but one they did not choose to exercise. Because the woman in Case 1 had family who were concerned with the outcome of the case and was connected to an alternative source of help -- the adult home and out-of-state hospital -- Psychiatrist 1 had more "tools" to work with. The fact that she also worked at the reception center where the woman would stay overnight awaiting transport back home, additionally increased the help available to Psychiatrist 1. If neither of these sources were available, it may be that this woman would have been judged "at risk of danger to self."

This is exactly what happened when the community liaison worker believed that she was in danger. He did not believe that the system of care (i.e., the family, hospital, and adult-home) in which she had been operating was a viable option:

> The psychiatrist was perhaps right that the Institute that treated her knew her very well but then I thought that maybe a new approach might be good because after talking to her brother-in-law she walked away actually about 15 or 20 times. Somewhere the cycle has to be broken and she was looking for a solution to get away from them.

His response to the question, "Who is responsible for a solution to her problem," indicated that he also believed that this was a woman who could be helped. He answered, "I think with positive thinking and the right counselling she

could live outside an institution." In addition, he believed that the Hospital might be a first step in the woman's regaining control of her life.

Interestingly, whereas neither Psychiatrist 1 nor Social Worker 1 believed that psychiatric problems were a primary part of the woman's predicament at this moment, the community liaison worker did. Moreover, he related the language of "delusional systems" to his explanation about why he believed she was a danger to herself. His determination, in contrast to the members of the Team on this case, brought up the possibility that beliefs about help might focus attention on a particular sub-component of the person's needs. In response to the question, "What is this person's presenting problem, Psychiatrist 1 replied, "Her presenting problem is that she has no place to stay and possible seizures. Psychiatric problems, while severe, are not part of this particular problem."

Thus, from review of the talk of team members in Case 1, I proposed that, in addition to the availability of alternate practical solutions, perceptions of the efficacy of those sources, as well as beliefs about the hospital (the Team's primary tool for help), may have affected the final decision for action.

Social Worker 1 didn't believe that taking the woman to the hospital would really make any difference in terms of helping her because she couldn't be helped within the

present system. She stated, "She would have needed a different kind of help....The system doesn't provide what she wants....(It) provides the medication and meals and very scrutinized activity without really stimulating (people) to grow more and develop ways that they can help themselves."

Of course, it may have been that her beliefs were specific to this particular individual, one who "had been hospitalized so long she had become passive." From this statement, it appeared that there may be a relationship between the kind of person that can be helped and the help available. An observation by Psychiatrist 1 seemed to confirm this interaction. She stated, "It is obvious that this woman has been analyzed up the kazoo and that she has been in treatment forever." She also expressed negative feelings about the hospital. After speaking to the referral source, she stated, "The problem with hospitalizing is that people become resistant to institutions."

In Case 2, the talk of Psychiatrist 2 revealed positive beliefs about the hospital as help. However, it appeared that these positive beliefs were specific to certain kinds of people. In the van, Psychiatrist 2 said that for him the primary question was, "Can we help this person?" He explained that the people who can most be helped are "Axis I lost souls," not people whose problem is drugs.[4] I

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[4] Psychiatrist 2 and Psychiatrist 7 talked almost continually in the van, with little or no prompting, about how decisions were made. They appeared eager to pass on information

inferred that he did not believe that those people should be taken to the hospital. [This may explain why Psychiatrist 2 spent so much time with the person differentiating between symptoms of mental illness and drug abuse and asking about family history of drug and alcohol abuse and his own alcohol and drug use.]

In the verbal protocol, a series of statements by Psychiatrist 2 revealed how important it was to him that the hospital be a good match for this person:

> There was no evidence of recent substance abuse, organicity or things like that. At that point it became apparent to me that he would benefit from hospitalization and was even considering the idea of allowing himself to be hospitalized....Etiology appeared to be a chronic psychotic condition. It appeared that the patient was somewhat motivated to treatment but probably still too disorganized to be able to pursue it on his own mandating some sort of hospital intervention. Additionally, it appeared that this patient might actually get better. He seemed polite and engageable and had a history apparently of some prior treatment compliance.

This talk begs a question. This man was simultaneously judged by Psychiatrist 2 as "polite and engageable" and "potentially dangerous to others." Could it be that the psychiatrist's beliefs about the hospital as a positive source of help for this man affected how he judged the man's

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to me. Therefore, most of the talk that occurred in my observation notes with these psychiatrists was unsolicited. Team members also participated in discussions initiated by these psychiatrists. Unless noted, this talk was not in response to questioning.

risk of danger, or at least how he talked about the man's risk in terms of the legal criteria for hospitalization? He stated, "It is clear that outside of a hospital setting his self-care would remain questionable." At one point he seemed to be considering a voluntary hospitalization because, "He said he would consider assistance with getting his benefits reinstated and some housing and he indicated that perhaps the government job he was doing may have ended" (help that, from my view, did not necessarily require hospitalization). But, he continued:

> Because of his unpredictability and some hesitancy and ambivalence I thought at that point that it would probably be more reasonable to designate him to benefit from the police presence in the van. And at a later point when he's more overtly compliant to treatment he could always be converted to voluntary status.

Was the level of risk that confirmed danger to self or others discretionary and based, at least in part, on the beliefs of the psychiatrist about the ability of the hospital to help and about the kind of person who can be helped? It appeared that, in addition to person-related categories and system-related categories, there were categories that constituted a "match between person and system."

"Ideological" differences between psychiatrists.

During these two cases, talk between team members revealed that decisions to designate are affected by psychiatrists' individual judgments. In the van, Social

Worker 2 provided an unsolicited comment about differences between psychiatrists in decisions to designate. He said that a person is asked certain basic things during an encounter (he did not elaborate on the content) and if the person doesn't know these things then he or she could be designated. He elaborated. "It's when a doctor thinks that person can't answer them but some people are more conservative."

Later, I asked Psychiatrist 2 to comment on this statement. He said that there were ideological differences in the psychiatrists. I asked what that meant. He said that it was the difference between taking someone to the hospital when they were "gravely disabled" vs. "at imminent risk." These two statements were the only references to this important concept. However, I proposed that beliefs about help and the person being helped constituted the core components of "ideologies."

The psychiatrist's role as primary decision-maker. The psychiatrist was the primary decision-maker in both cases. It appeared that Psychiatrist 1 was more open to the suggestions of other team members than Psychiatrist 2, however this may have been a function of her special relationship with Social Worker 1.

The community liaison worker stated, "I had completed a referral form but when the psychiatrist walked in I stepped back to let her handle it." Social Worker 1 stated:

> Basically the psychiatrist is the person who will make the decision but I am there to have input and this psychiatrist is one of the, I mean I work with a lot of psychiatrists on the Team and everyone comes from a different place in the moment and so I'm constantly really adapting to people's thoughts and beginning to understand over a period of time how people go, how the psychiatrists go about evaluating the client. I basically defer the decision to them because they are the ones that have legal responsibility for it. But she always ask me what do you think and then I'll tell her what I think and she'll tell me what she thinks and you know sometimes something comes out of that.

Social Worker 3 stated:

> I think what happens in the decision-making process is everybody tends to hang back and the psychiatrist basically takes over. This is what happened tonight.

Because of the psychiatrists' primary role as decision-makers, I decided to focus on their judgments and beliefs in further analysis. However, I remained attentive to how comments by other members elucidated the meanings of the psychiatrists' talk and actions, either by comparison or contrast, or influenced the psychiatrists' decisions.

Negotiation. This concept emerged during Case 2 when Psychiatrist 2 arranged for two officers who had somewhat of a rapport with the man to go out with the Team to meet him. In so doing, the psychiatrist was trying to avoid a situation in which the man would immediately become hostile or aggressive and, by virtue of the situation, could be immediately judged "a danger to others." I gathered that he wanted to regain some control of the situation and make his own decision about whether he felt the man was appropriate

for hospitalization. Thus, Psychiatrist 2 was not only a passive observer. Rather, he took action to, in this case, inhibit unwanted behavior. He also negotiated to maintain control when he chose involuntary over voluntary hospitalization "to benefit from police presence."

Another case seen by this Psychiatrist, and that will be discussed later (Case 6), was that of a young man taken into their loft by private citizens. Psychiatrist 2 felt this man would be appropriate for treatment in the hospital. While he judged that he was mentally ill, he did not think he was in danger either to self or others. He made a strong case to the "patient" for voluntary hospitalization, detailing the ways in which the hospital could help him and telling him (the social worker told me later that this was not necessarily true) that if he did not go now there would be no bed for him.

Moreover, Psychiatrist 2 not only set up a picture of potential threat to the people with whom the man was staying ("He will get more suspicious, more distrustful") but also told them that if they were to set him out on the street at an appropriate time so that it would put him in potential danger to self (the weather was bitterly cold) and at a time when a psychiatrist who was willing to designate was on duty, then he could be taken involuntarily to the hospital. Back in the van after this encounter, Psychiatrist 2 explained to me, "We are building a case."

CHAPTER V

ASSESSMENT OF NEED FOR HOSPITALIZATION

Development of a Conceptual Framework

Based on information gathered during the first two sets of observation and interview material, I developed a conceptual framework of decision-making, based on assessment of need for hospitalization, through which subsequent cases could be viewed and the framework refined. The framework included categories at several levels and delineated relations within and across levels.

Person-related categories. Mental illness and danger to self or others are important components in terms of criteria required by law for involuntary hospitalizations. However, it is judgment of danger more so than mental illness that determines whether or not a person will be designated. Mental illness and danger are related bi-directionally. Talk about and information used in support of a diagnosis of mental illness (e.g., the person's behavior showing impaired, compromised judgment) can be used to support a judgment of danger: Alternately, talk about and information used in support of a determination of danger can be used to support a diagnosis of mental illness (e.g., living in an isolated area subjecting the person to exposure as a sign of mental illness).

Judgments about danger are more or less discretionary and may be affected by several factors. The first set of factors occurs at the system-level. These include the "tools" of help, or resources, that the Team has available that consist of other people involved and other tangible resources, such as other service agencies. Available tools are limited by the kinds of help the team can provide directly as set forth in their mandate -- the hospital, and the kinds of help that the larger system of care for homeless mentally ill can provide.

The second set of factors occurs as a product of the intersection between various person and system levels. Beliefs of the decision-maker about systems of care as positive or negative determines their subjective availability as resources. Beliefs of the decision-maker about the kinds of people that can be helped, and by what kinds of resources, also limits subjective options. These intersecting beliefs constitute people's "ideologies" of help. The development of ideologies may begin with training (e.g., community vs. biological psychiatry) but evolve with knowledge of and experience with systems of care that have or haven't worked.[5] Related beliefs include ideas about the ability of the homeless person to help him or herself.

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[5] During a later observation period, I asked team members about "ideological differences." Nurse 1 said that Psychiatrist 1 didn't like to designate. Psychiatrist 3 asked, "Why not, she's worked in emergency rooms. Nurse 1 said, "Exactly because she's worked in emergency rooms.

Beliefs about help may focus attention on a particular sub-component of the person's needs.

The third set of factors is situational. There are factors present in the situation that impact the determination of danger directly (e.g., weather or aggressiveness exacerbated by the encounter itself).

The framework is not static in that it presents decision-making as a process that unfolds through time and interaction. (1) There is a goal-directed dimension to decision-making. The Team has three tasks, both system- and person-driven, in each encounter. The first is taking care of the situation for the referral source. The second is taking care of the person being assessed. The third is taking care of their own need to accomplish the first two tasks in the way that matches their own beliefs about helping. (2) The decision to designate is more or less the result of a group process. Psychiatrists differ in the input they allow from other members of the team and from other sources. Beliefs about the expertise of the referral source and attention to expectations of the referral source determine the weight given to provided information. If the referral source is seen as "good," pre-judgments might be made based on that information. Psychiatrists appear to be least affected by this initial information. (3) Team members are not passive decision-makers but use at least two

strategies, negotiation and building a case, to direct the course of decisions.

Testing and Refining the Model

Over the next several observation periods and during review of notes taken and protocols recorded, I tested concepts and relationships that had been developed in the previous two observations. The next case observed (Case 3; Psychiatrist 3, Nurse 1) occurred two days later. This encounter resulted in a decision to designate a homeless man who had been known to the Team for some time. The weather was bitterly cold and the man had been seen, standing on the library steps with his face "busted up and bleeding," by a staff member of the Team on her way home from work This was the only case that was encountered during the team's shift.

After responding to the call from the staff member, the van changed direction, headed downtown and parked on the street several feet away from the man. Psychiatrist 3 and Nurse 1 approached the man and began asking him questions about how he was feeling and how he had been hurt. He said he was fine. He appeared to know who the Team was. He spoke about a criminal organization perpetrating places like the Hospital. The Team offered him a ride to a service center for the homeless mentally ill that was nearby. He refused, stating, "There are some of those homicidal people there." As they spoke, the man was bouncing up and down and

admitted that he was cold. He had no gloves. His sneakers were worn through and there were holes in the toes. He had covered them with plastic.

Back in the van, Psychiatrist 3 called the police "task force" to come and pick the man up. He told me that he based his decision on three factors. First of all, the man was delusional. Second, he was poorly dressed. And third, he refused help. He explained that, while the man had seen before by the team, the situation was different now because these three factors occurred together. He said that the cuts on his face posed a risk because they could get infected and the fact that he did not want help showed a poor attitude. He stated, "the whole picture" puts him in the hospital.

In the verbal protocol, the desire of Psychiatrist 3 to help this man and the constraints on his ability to do that in any way other than through hospitalization are revealed:

> I was prepared to meet someone who had survived winters on the street and was not particularly interested in any help from us and was quite thought disordered and delusional....I was concerned that if his face were all busted up and he was bleeding and he was doing nothing about it that that marked a shift or a very unadaptive sign on his part....We were careful to make sure that he would accept no voluntary help, offers to a privately-run, church-affiliated drop-in center as well as offers of clothing and food. In talking with him I was struck, again, by the raggedness of his clothes although he had always in the past seemed adequately dressed for the weather tonight he did not. He had a thick coat on...but his shoes were simply unfit. On the left foot the top was completely gone and it was, I could just see the outlines of his toes, which meant they weren't very well protected from the weather. His hat didn't even reach his ears and his face was

> completely exposed and he had no gloves. The weather, of course, was sub-freezing and quite bitterly cold....So all these factors together...all these individually would not impair his ability to thrive, or uh survive, on the streets but that he seemed more impaired...and it seemed to me that he would benefit, he needed to be in the hospital to avoid more serious harm. When the police came we confronted him and took him very unwillingly to the Hospital.
>
> Looking back was there anything that he might have done that could have averted our taking him to the hospital? Sure. He could have agreed to go to a drop-in center. The cuts on his face bothered me, but if he had agreed to go do a drop-in center, church-run, where they would have given him food, clean clothing, a shower and in the process they would have cleaned his face then I would have said that would be fine. They wouldn't offer him medication but they would work to build a relationship with him, giving him all kinds of services that he needs. But he refused. I felt the alternative to leave him shivering -- I should point out that he was shivering -- which is not a good sign in this weather because the next stage, step after shivering is to go into hypothermia so I couldn't just leave him there after he refused all offers of voluntary help.
>
> The weather in this case was a real factor. If it had not been cold I probably would not have brought him simply because of the superficial cuts on his face. Because he's a creature of habit and he has reputation of always being in the same place at the same time each day the team each day could do follow up and simply look at him and if his face looked like it was getting infected, medically not the best way to examine him, but if his face looked like it was getting worse then we would take him in on that basis even in warm weather.

By the way Psychiatrist 3 talked about this man, it seemed clear to me that this was someone with whom the team had a long, albeit unsuccessful, relationship. Even so, they felt very sympathetic toward him and had been concerned with how he was handling the extreme cold (I verified this assumption by looking over the contact sheets for the past

several days). When the situation (the weather and his cuts) became more serious they "couldn't just leave him there."

It's unclear just how dangerous Psychiatrist 3 felt the situation was. When asked specifically about danger after the case had been settled, he reported that the level of danger was severe and that this was related mainly to the weather and his refusal of offers of help, but also to his paranoid delusions. But, in the protocol he said that his decision was related to the man's "inability to thrive," but quickly changed that assessment to "inability to survive." The distinction, under the present circumstances, may have been meaningless except for its relation to legal language required for designations.

In contrast to the first case, beliefs about the alternate sources of help available did not appear to affect the determination of level of danger required for hospitalization. The drop-in center seemed to be an adequate solution for Psychiatrist 2. Unfortunately, the man did not think so which, in effect, cancelled out all alternatives. There was some evidence in his delusional material that he may have had negative experiences both with the hospital and this specific drop-in center (his statements that there were "homicidal" people there and a comment made after he struggled madly with the police and was finally subdued in the van, "Thanks loads for another

kidnapping.").[6] However, Psychiatrist 3 was not interested in the man's reasons for refusing this alternative (whether this lack of interest was specific to this particular situation or not is unknown) because he was clear that the man needed help now and blamed his refusal on "a poor attitude."

In contrast to the first and second cases, neither beliefs about the hospital nor the man as appropriate for the hospital figured into the decision to designate. In the van, both Psychiatrist 3 and Nurse 1 told me (unsolicited) that they didn't believe the man could be helped. Nurse 1 stated, "His delusions have gone too far." Psychiatrist 3 stated, "He's not going to give up his long-term delusions."

But, he qualified this position when he stated, "Over the long run he'll be better off." Nurse 1 stated, "Maybe (the Hospital) will help him become more acceptable to accepting some help." It appeared to me that they were justifying their decision because there was really nothing else they could do and neither seemed to put much faith in what the hospital could do for this man. In this way, the hospital, as help, was rationalized as satisying the man's need when, in effect, it was implied that the hospital could probably only keep him warm and protected.

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[6] During this struggle, several people gathered on the sidewalk outside the van. The man yelled at them to "call the real cops. These are the fake cops and they're kidnapping me." People watching shouted at the task force police, "Let him go."

In the verbal protocol Nurse 1 reported:

> It seemed to me that at least he would be warm in the hospital, maybe with medications he could be helped some. Hopefully could be gotten a place to live, housed in some kind of program that would be better than standing out in the street year after year. I always am sort of optimistic for what the system can do to help people and sometimes they can and usually it ends up not helping them, but I always, 'Hope springs eternal.'

From talk in her verbal protocol, it appeared that Nurse 1 believed everybody should be taken to the hospital. She reported:

> People are taken involuntarily to the hospital if they're a danger to themselves or others but I usually consider anyone homeless and mentally ill a danger to themselves...It's really not safe being out on the streets but to me its really the degree of danger ...also I prefer personally to take people to the hospital who have a chance of being helped....

I was unable, in this period, to uncover what kinds of people she thought could be helped. In this case, it appeared that her decision was based more on a sympathetic response toward this man than the kind of matching process that occurred with Psychiatrist 2.

Nurse 1 acknowledged that hers was not the legal reason for taking people to the hospital but that "its just my personal goals here." She made clear to me that she was not the person on the team who made decisions but "I can try to influence the person who does make a decision. In this case the psychiatrist wanted to know my opinion."

Nurse 1 expressed particular dismay with one aspect of the mental health service system that impacted on this case. Because of legal requirements no team may coerce a person to attend another environment less restrictive than a hospital, like a drop-in or residence center. Mental health law provides that treatment can be required only in a hospital. She stated, "People can only be brought in at the end of a crisis when there is no way to help them."

Relating this Case to the Framework

Situational demands. This case lends support to the initial proposition that some situations are so inherently dangerous (weather leading to hypothermia) that beliefs/ideologies do not figure into the decision to designate. Determinations of dangerous in cases like these may not be "discretionary" and all Team members would probably make the same decision to designate.

Help. In this case, the team believed an intervention was required. The talk and action of these two team members, when compared to the that of Psychiatrist 2, revealed two distinct interpretations (meanings) of the hospital as "help" and the need of the person that matched him to the hospital. In Case 2, taking the man to the hospital meant that he would receive "treatment." Therefore, the need of the person that could be helped was a treatable mental illness, such as a psychotic disorder that

could be treated with medication. In Case 3, taking the man to the hospital meant that he would receive "care." The team seemed to be saying, "There's no alternative here. We give him what we can. We'll protect him from himself."

Because Psychiatrist 2 and Psychiatrist 3 were not observed again in other situations, it is impossible to test what would have happened if each psychiatrist encountered a case similar to that seen by the other. For example, if Psychiatrist 2 encountered the man with the bleeding face who was freezing but did not think he could be successfully treated, would he have recommended monitoring and foregone designation? Or, would he have been satisfied with the ability of the hospital to provide care for someone who was cold and hurt. Would his talk in this hypothetical situation have revealed an "ideology" similar to that of Psychiatrist 3? It would be an interesting experiment.

One clue to the cross-situational persistence of ideologies was provided in a later observation period. In a transportation terminal, we saw a woman asleep in a pool of spilled coffee under one of the benches. Evidently she has been taken to the Hospital many, many times. Social Worker 2 pointed her out to me and said, "She is always organizing advocacy and civil liberties groups on the Ward, stirring the patients up. That woman makes [Psychiatrist 2's] blood boil." [Recall that the beliefs of Psychiatrist 2 about the kinds of people that can be helped included those with a

history of prior treatment compliance.] A comment was made that she would have to be really bad off for him to take her again.

Of course, the point is what would have to be going on for Psychiatrist 2 to think that the woman was "really bad off?" It may be that the ideologies of some pychiatrists are more persistent than others and that others are more responsive to the situation. At some point though, all psychiatrists would take the person to the hospital or suffer personal or legal ramifications based on either their identify as healers or on the medical mandate under which they operate.

Relation between person and help. Another kind of person who can be helped is the kind you want to help. Another kind of person who can't be helped is one that you've tried to help before but it hasn't worked.

Relation between system and help. The legal system sets limits on the kind of help that can be ordered involuntarily. This is another constraint under which the team operates.

Relation between person and system. Another reason for lack of available options is the person's refusal to accept services offered. A cyclical relationship probably exists between the person who refuses help and the system of care, with the Team as interface between the two. The person refuses because of mistrust of the system and leaves the

Team no alternative but to force them into the system which perpetuates the person's distrust of the system, etc.

Strategies. Rationalizing/justifying are strategies that appear to result from beliefs that you are operating under a negative-negative choice: "I can't just leave him there," and "The hospital can't really help." These strategies are consequences of decisions whereas negotiation and case-building are strategies that direct the course of decisions.

Mode of entry. The way in which the person became an object of Team's attention differed between Case 3 and Cases 1 and 2; regular outreach vs. referral. Of course, in Case 3 the person was a well-known client so this case may be different than those encountered during regular outreach when the person has never been seen before. Nonetheless, because in Case 3 the team did not have the additional task of handling the situation for the referral, more attention was focused on the person being assessed and on the team's objectives in relation to that assessment. Because the man was known, the team was able to compare his present with past condition. Furthermore, there may have been affective components in the decision made.

Comparing this case with past cases on how the person was first noticed by the Team, two typologies of attention are proposed that should be added as an antecedent, or condition, in the framework.

Attention

An essential preliminary condition for entry into the "field" was that the homeless individual was noticed, causing attention to be focused on the person and the team to make a determination of need. Two typologies of attention emerged from review of the data -- physical and sympathetic (psychological) -- by which a person became the focus of attention. The first, termed physical, occurred when the person became visible and disrupted the local social system, creating what Goffman (1971) termed "organizational havoc." This occurred when the person was behaving in a bizarre or threatening manner. It might also occurred when the person had withdrawn and was seen "starving in a corner."

The second occurred when the person attracted attention eliciting a psychological or sympathetic response of empathy or pity from the team member creating a need in the worker to help that person either within or beyond the legal mandate -- a function of the person's personal project.[7]

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[7] According to Schutz (1970), people have personal "projects" that are a product of training and experience that set forth what people conceive themselves as wanting to do, or equivalently, their definition of the situation. In the proposed framework, ideologies of help, in all their complexity, are included as an integral part of that project.

Five Cases Not Designated

During the next observation period, the van set out early Sunday afternoon. Later in the day, Psychiatrist 4 and Social Worker 2 were going to meet a worker from a social service agency to evaluate one of his clients whom he believed, according to Social Worker 2, "should be taken to the hospital." In the meantime they were going to "check up on" the person from the loft and "cruise" downtown. Over the course of two hours, they encountered five people:

Case 4. A young, black, male on the steps of a building downtown smiled when he saw the van approach and went down the steps to meet Social Worker 2 who gave him a bag lunch. In the verbal protocol, Social Worker 2 reported:

> We've known him a long time and he has a big delusional system. That doesn't mean he's not organized. He chooses boxes that will support him. He insulates them well. He takes very good care of himself.

Case 5. The team spotted a black male in his 40's and stopped the van. Psychiatrist 4 and Social Worker 2 approached him, gave him two bag lunches, and asked him questions about where he had been sleeping and eating, and if he had any medical problems. Psychiatrist 4 told him, "If you have to go to the hospital for any reason we can take you."

Social Worker 2 knew the man and his verbal protocol referred to a change in his condition:

> I used to see [him] sitting up more. He was always a passive panhandler but now he seemed real lethargic. I guess that was the change in him....He looked more tired than usual indicating maybe a medical problem....But being out in the cold maybe drinking he could be hung over. He was responsive enough that he denied medical problems.

Social Worker 2 believed that his condition required monitoring. Psychiatrist 4 decided that "he's not somebody that we needed to evaluate at any greater length today in the sense of him being an immediate danger to self or others." She reported, "When we wrote down information about him, my sense is he certainly has mainly an alcohol problem."

I asked her what information she used to make this determination. She stated:

> He did not seem overtly psychotic even though we did a very brief interview. He also offered a circumstance, he offered alcohol and probably alcoholism, which could certainly explain in large part. I mean we see many people who are out on the street and homeless for years who are primarily alcoholics and who do not have any other major Axis I diagnosis, so he fit into some kind of category. But I don't think that by any means I have an incredibly clear view of him.

This was the first time that Psychiatrist 4 had seen this client.

Case 6. The man who had been seen in the couple's loft by Psychiatrist 2 and Social Worker 2 several days earlier, was sitting in front of the same building in a spread of clean blankets and covers, dry cardboard, and a new down coat. As the team sat in the van observing him, someone

came outside of the building and stopped to speak to him. Someone in the van (I didn't identify this statement in my notes) said, "Everyone in the building is taking care of him." The team got out and went over to talk to him. He looked up, smiling, made a bit of small talk, got up, stretched, and said that he had "just been getting ready to take a walk." Social Worker 2 asked, "Are you just going to leave your stuff?" He replied, "It'll be okay" and left quickly.

The team got back in the van and a conversation ensued. In this discourse notice how the social worker's questioning of the person's behavior influenced the psychiatrist who subtlely changed her opinion of the person from one of "more organized" to one who might "turn against those people," a sign, it appeared to me, of potential danger:

P: He's more organized than he was on Wednesday night. When we went up then he was very delusional. He said one thing after another in a lose way: There was HIV in the air -- somatic and paranoid -- something about the government and the CIA.

SW: We're seeing different sides of him. He's a raving paranoid. How many corrections did he make of what we said?

P: But he does it in a socially organized way.

SW: He always corrects the interviewer.

P: His hair was clean the other day. He referred to drug stuff, mescaline. I hope he doesn't turn against those people. Not that there's any evidence. But it's a possibility.

This case would have to be settled at some time in the future but it appeared that the team, led by Social Worker 2, had continued to "build a case" that would match the person to the legal criteria for hospitalization, a process that had begun several days earlier by himself and Psychiatrist 2.

Case 7. Travelling down a major thoroughfare, the team spotted a man who appeared to be "talking to himself." The van parked about a block away from him. The team members got out and began cautiously approaching him. Social Worker 2 told me, "Watch him, he may be psychotic." They asked questions about how long he'd been in town, what he had been doing, and whether or not he was sick. Then they walked back to the van. Nobody said anything (the first time this had happened).

I asked, "What do you think?" Psychiatrist 4 replied, "He's young and displaced, probably alcohol related, maybe MICA (Mentally Ill Chemical Abuser). Maybe schizophrenic, not psychotic. Nothing imminent." In the verbal protocol, Social Worker 2 also reported that he did not really know what was going on with this man. He stated, "Just from that interview, I would say he wasn't psychotic. Of course, schizophrenia is harder to know, certainly substance abuse. He admitted drinking pretty frequently."

In the verbal protocol, Psychiatrist 4 reported:

> I expected someone who would be more frightening to interview, more unpredictable feeling, more agitated

> during the interview. I really feel that with these situations where we don't know the person previously and we're doing some kind of intake, the main decision that I'm interested in is is the person in the moment an immediate risk of danger to self or others.

She continued,

> It doesn't mean that, I mean there's a million things that all these people could use, different kinds of help, some of which [the team] might be able to assist with or provide, some of which we can't, most of which we can't, but for me as a doctor on the team the main concern is deciding if somebody fits into that criteria and our main task of designation should proceed deciding if there's ambiguity and further evaluation in that moment or deciding if no they don't.

There are two important aspects of this report, coming as it did at the end of questions about five cases in which no action was taken, that relate to the framework -- "on-the-spot" assessments and help -- that will be discussed at the end of this section.

Case 8. The last case encountered before heading uptown to do the referred evaluation occurred in a transportation terminal when the team was rushed for time. Social Worker 2 took a bag lunch to a very dirty, skinny, man who was going through the garbage but did not talk to him. In the van, I asked why not? He replied, "He was an alcoholic, he didn't have that "schizo quality." In the verbal protocol, Social Worker 2 reported:

> To be honest, we were running on a shortened time frame and we were needed uptown. For me to invest a lot of time in that particular moment, no. Basically, if the schizophrenic process doesn't jump out at me in the opening relationship with the client, then I can rule out or temporarily rule out something. And there are looks of alcohol and drug people who might be ill

> secondary to their drinking and drugging so he removed himself from the mentally ill. I didn't get a feeling, as they say, of schizophrenia.

Whether or not the shortened time frame led to the almost immediate determination of alcohol rather than mental illness, based on lack of "a feeling" of schizophrenia, is unclear. Social Worker 2 continued to explain to me differences between those with alcohol or drug problems and those with mental illness based on his own personal "diagnostic indicators" that were "not in the textbooks" but rather "a proven thing I've learned to see that's consistent." It does seem that this team member has developed, over his long experience with the team, a set of information that allows him to immediately "type" people when that response is necessary.

Social Worker 2 may have been the only team member that I observed or interviewed that held and used such stereotypes. On the other hand, he may simply have been the most honest. Later, others did talk about judgments of mental illness that were made on "first impression" and determinations of danger as "intuitive."

In addition, Social Worker 2 told me in the van that "other teams will see him." He was referring to teams that are responsible for people with alcohol problems. I implied that alcohol problems were not the responsibility of the team. I will discuss responsibility as it relates to help in a later section.

Relating these Cases to the Framework

Attention. When a person enters the field of "attention" of the team through regular outreach and that person is being seen for the first time, an "on-the-spot" assessment occurs. Psychiatrist 4 described a more "conservative" approach to legal criteria of danger when people are seen for the first time. As in those cases that are immediately judged to be at a high level of risk, "on-the-spot" assessments may be similar across psychiatrists.

Situational factors. Time is included in this category. The amount of time you have available to spend with the person is related to the amount of attention that person receives. Of course, it may also be that time can be negotiated by team members when they want to pay attention to someone.

Typing. Both Psychiatrist 4 (Case 5) and Social Worker 2 (Case 8) talked about people fitting into some kind of category. Both judgments were made with little information other than the client's "way of talking and relating" and both had problems that were considered alcohol-related. This is a concept that requires further exploration.

Help. The focus of the verbal protocol (Case 7, Psychiatrist 4) is not on the person and the person's needs but rather on the system and the ability of the system to deliver. She talks about the system and what the system can

do for people and then jumps directly to whether the person can be protected from him or herself -- the category of danger to self or others. This is the key determination. Need, originally thought to be the core component of decisions to designate, appears to be a category about which its almost assumed that nothing can be done.[8]

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[8] All references to "need" or "take care of or help" were pulled from data from the first four observation periods and a rough count was done. There were approximately 81 references to "take care of or help"; 9 to "need". Of those 9, three were embedded in the phrase, "needs to go to the hospital." The rest referred to needs of the decision-maker or the team.

CHAPTER V

DECISION-MAKING UNDER CONSTRAINT

Constructing a Case for Designation in Legal Terms

The evaluation prompted by the referral (Case 9; Psychiatrist 4, Social Worker 2) resulted in designation. It appeared that the team had already made the decision to designate this man even before he was seen. The deciding factor in this case was the relationship to the referral source. Because of the relationship and the concern that the worker expressed for his client, provided information was weighted heavily. Psychiatrist 4 reported:

> I would say that this case is a little more unusual in that we had a significant amount of referral information available to us which I'm not going to go through right now which was both historical in terms of documenting mental illness and historical in terms of discussing risk to self. I guess I would say that my relationship and awareness of the [referral] team and particularly having worked with [worker] in the past...facilitated this rapport and conveying of information.

At this point in the protocol, the psychiatrist appeared to be finished. I urged her to continue, once again giving the probe, "Explain to me how you decided what was going on." She continued:

> Well, I have to admit that in this case, given all the information in the past and the referral source, I was probably thinking that this might well be a designation based on the description of where the patient lived and his history and his recent circumstances meaning his squandering of the money and being back on the street and being more hopeless and agitated and talking about the hemlock book and so forth. I felt that he,

> certainly, had evidence of mental illness and that he should be brought because of risk to self.
>
> I was struck by the concern of the Lenox Hill people not only in terms of referring him to us but also one of the workers coming in to show him to us and to introduce him to us and to show us where he lived although that was also certainly practically necessarily given the complicated way to get into his location.

Inspection of the discourse between Psychiatrist 4 and the referring worker in the van on the way to see the person, reveals that they matched him to hospitalization by selecting and elaborating on relevant factors and denying inconsistencies that might have kept the man out of the hospital according to the legal language of the mandate.[9]

[Referral agency worker describes the individual]

> This is a 62-year-old white male, born in New York City. He spent four years in the U.S. Army, honorable discharge, wandered the country, was nomadic. He has no significant relationship other than family. He is most likely schizophrenic and had all symptoms at one time or another -- not necessarily hallucinations. He complains of things being too loud and about things rushing at him on the street. He has no delusions. No hallucinations. He's had prior hospitalizations.

[The psychiatrist interrupts and asks if these were psychiatric hospitalizations.]

> We're very unclear about that. He has a major depressive component. He has hostility. He's had suicidal talk. Talks about getting the Hemlock Society book.

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[9] In an analysis of decisions made in psychiatric emergency rooms, Emerson (1989) suggested that such matches are an analytical construction that occurs when workers are committed to a plan of action early on and that the tenability of the person's present living situation is the focus of that construction.

[The psychiatrist asks if he has made any suicide attempts.]

He's made no attempts. He's often dysphoric. Eight years ago he lost his pension for failing to fill out papers. He had been known to us for two years before we began to "know" him. He's very pleasant, very bright.

[The psychiatrist asked how long he had been talking to the agency.]

Four years. He attaches himself to different members of the team. Five months ago he got his benefits back and got a huge retroactive check. He went inside to hotels that were 65 or 70 dollars a night. He cleaned up. There was a change in his mental status. He is a good argument for housing even without rehabilitation. He went through his entire money and went back to living in the same place which is why we're here today.

[We will have to walk along FDR Drive to get to his vault under the apartment building. The worker said it was filthy, smelly, and rat infested.]

After he spent his money he said, "This is awful...I got the money but it doesn't make any difference." He left the hotels three weeks ago. We could get him into low-demand housing because he gets a pension but he's unwilling to bring himself to go into housing. He won't adhere to a schedule. He started talking about the Hemlock Society book again. He's in the gray area of what the Team would take if they saw him on the street corner.

[The psychiatrist asked how depressed he was when he was seen this week.]

The worker saw him. He was very agitated, more than in the past year. He's able to compensate when necessary.

[The psychiatrist asked if he had been seen responding to internal stimuli.]

Not to internal stimuli.

[The psychiatrist asked about his weight and medical condition.]

That's okay, but...he may be obsessive-compulsive. Medically, I know of no real problems.

[The psychiatrist asked about substances and whether he had made any suicide threats.]

> No, he's an argument for extending designation to the chronically ill.

Throughout this conversation, there was no "hard" evidence that the man had any prior psychiatric hospitalizations, psychotic symptoms, current depressive symptoms, medical problems, or had made any suicide attempts or even threats. He had broken off his relationship with the referring team and refused to accept their help. Members of the referring team were frustrated and felt that they had no other recourse in helping this person than hospitalizing him. What did they hope the hospital would accomplish? Psychiatrist 4 reported:

> If he takes medication and gets better and his depression and psychosis improve then he may in fact be more clear in his thinking, less depressed in his outlook, and make choices that would be presented to him by a treating team.

In this explanation, she used the term psychosis, even though there was no evidence that the man was psychotic. Psychosis implies impaired judgment and may have been used to put forth the dangerousness of his situation. Her final determination was that the man had "suicidal ideation and that his paranoia, depression, and underlying psychosis had inhibited him from seeking assistance or accepting help." In the verbal protocol, however, she did not refer to

psychosis but rather to his dangerous living situation, hopelessness, and the risk involved demographically:

> I was very struck by the dangerousness of his situation in terms of where he stayed but I was most concerned about him having spent all the money recently having actually responded positively to that in some regard with his grooming and hygiene and so forth improving and yet not feeling any better and even a certain hopeless quality that even this money or staying in an indoor location was not going to help his overall situation or his overall mood or outlook on life and that then when he in fact was out on the street that he was more hopeless and depressed. I think that, you know, even though he didn't have any prior suicide attempts that we are aware of today I think he does, you know, there's certainly a definite suicide risk even demographically male, later in life, you know, with certainly a strong depressive component to his illness noted historically.

Social Worker 2 reported that this man was "someone with somewhat impaired judgment in a dangerous condition who might not do well if continued to be left there in the future." In the verbal protocol of Social Worker 2, he first made reference to the "very full referral from people who were credible sources." After describing in detail how dangerous he thought the man's living situation was he said, "I was glad to find him alive and in good shape." He quickly countered, "I mean relatively speaking." After the man had been taken into the van, and while Psychiatrist 4 was talking to him, Social Worker 2 kept telling her how dangerous it was for him to be living on the highway.[10]

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[10] The relationship between these two team members was more interactive than between the members of the other three teams. Social Worker 2 was an active decision-maker, exerting influence in both this case and in Case 6.

There are inconsistencies in the accounts of all people involved in this case. He was seen as both "an argument for housing without rehabilitation" and as "an argument for extending designation to the chronically ill" by the referring worker. There was a shared knowledge that "he is in the gray area of what the team would take to the hospital on the street." But, all factors present pushed the case toward designation. Psychistrist 4 stated:

> In this particular case I felt even more rushed than usual because the police were waiting. I would much rather have done a more leisurely, rapport-building interview with him but...there were just so many factors contributing to moving it ahead. The police do not like to come out if they are not going to take someone to the hospital. I really did feel pretty clear I wanted to take him to the hospital for further evaluation early on.

The last sentence by Psychiatrist 4 appears to be a justification for the action she took, even though (or because) there were so many factors that pushed her in that direction that, in a sense, she had no choice. She said that she felt badly that there wasn't enough time to create more rapport with the man. She said, "I don't enjoy patients being angry at me." Yet, she needed to maintain a sense of helpfulness.

Others involved in the encounter also wanted to feel that what happened was the right thing to do. The man taken to the hospital was very upset and, in the van, asked to call a lawyer. He expressed a sense of betrayal to the referral worker when he said, "Did you ask them to do this?"

The worker replied, "It was a group decision. We were worried about you." When told by the team the next day that the man was going to be hospitalized, the worker said, "I'm really pleased. He was very angry with me. I think he went voluntarily." The Team member stated, "No, it was an involuntary hospitalization." He replied, "Really."

Social Worker 2 told me that he had a "theory of relief," that accompanied his beliefs about taking people to the hospital. According to this theory, "No matter how much resistance a person puts up to being designated they are always relieved to be taken to the hospital because no one could really want to live that way." When asked to comment on this theory, the director said that he believed the homeless individual's reaction was more one of "resignation" because he or she was helpless to do anything about what was happening to him or her.

Trajectory

In Time for Dying, Glaser and Strauss (cited in Strauss, 1987) used the concept trajectory as the core category to portray the movement, through phases, of hospitalized sick persons toward their deaths. In this framework, trajectory is used to denote the directed path of the homeless person toward, or alternately, away from the hospital.

Because of the configuration of person (both target and observer), situational, and group and system factors that were present at the initiation and subsequent unfolding of each encounter (e.g., present in the "field at a given time," Lewin, 1951), it appeared that conditions either pushed the person toward or pulled them away from the hospital. It was along the trajectory that information was gathered and interpreted through a series of interactions.

The way in which people were brought to the attention of the team (e.g., through referral or outreach, whether known or unknown, whether physical or affective, whether affect was positive or negative) initiated the person's path. System categories and "ideologies" (e.g., "available" resources, beliefs about help, beliefs about people) were of course brought into the field with team members.

As the encounter unfolded, purposeful strategies were enacted. The purpose of <u>case-building</u> was to drive the trajectory toward designation. <u>Case-discounting</u> served the opposite function and results in driving the trajectory away from designation. When information was interpreted, there was both a search for positive information and discounting of negative information that allowed flow toward designation. This pattern was reversed when the team believed that designation was not needed.

Two processes were occurring almost simultaneously. First, case-building drove the trajectory in the direction

thought appropriate by the team. Second, matches were constructed in such a way that would satisfy legal criteria.

Mental illness was used as a tool that carried with it a set of assumptions about potential for danger due to the person's inability to take care of him or herself. According to Schutz (1962), mental illness serves as a scheme of interpretation that imposes a particular context upon all other information about and the behavior of the person. Judgments are then matched to commonsense knowledge about mentally ill persons in general.

When mental illness was assumed, garbage-hunting, bizarre behavior, and talking to oneself were judged as symptoms of mental illness (See Case 14, following). After the trajectory directed the person away from the path, equivalent behavior -- talking to oneself, hunting in the garbage, and "acting bizarre," were taken to indicate alcohol-related problems.

Self-reported symptoms were viewed alternately as legitimate or as a result of lack of judgment due to illness, a symptom, or as a lie or cover story, depending on how they matched the team's determinations of need for hospitalization. Within a mental illness schema behavior was described as inappropriate and a clear sign of mental illness. This was similar to interpretations that were found to be made in commitment hearings (Holstein, 1993).

Following the decision, people used strategies such as rationalization to justify choices. Justifications may develop into theories. Both help members maintain a sense of helpfulness.

Contrasting Designation

The last case observed will be presented next because of its contrast to the preceding case. In both, hospitalization was "prescribed" early in the encounter. However, this encounter (Case 14; Psychiatrist 7, Nurse 1) was not the result of a referral but was an "on-the-spot" assessment. The person's risk appeared to me clearly less ambiguous. Whereas in Case 9, there was an active construction of need for hospitalization, in this case the person was immediately diagnosed as mentally ill and determined to be at a high level of risk. Other information was interpreted through the framework of mental illness, similar to stereotypes based on initial impressions that occurred in other "on-the-spot" assessments.

Psychiatrist 7 reported:

> First, when we rode by I saw someone standing in traffic who caught my eye. I looked at him and obviously he was severely disheveled. So, the first question in my mind is, "Is he psychotic or is he just a drunk?" I think that's where the intuition comes in because giving him a quick look up and down sort of looking at just how disheveled his clothing was, looking at sort of the glazed look on his face and the stance, I decided that he was likely psychotic and that we should stop and try to observe him further.

> So, again I wanted to watch him from a distance at first and it sort of confirmed my sense that he was bizarre: He was just sort of standing there posturing and not really responding and stayed inappropriately in the street and was even in in front of a car at one point and so when we approached him that more or less clinched it because I spoke with him, offered him a lunch...it wasn't that he refused me but it was like he was completely in his world and he was smiling to himself and I could just see how profoundly disconnected he was.

He decided, almost immediately, to designate. Subsequent information, based on observation while waiting for the police task force to arrive, was used to support that decision.

The sequence of observations, reported by the psychiatrist (P) and nurse (N) in the van, are reported verbatim [the researcher's observations are bracketed]:

P: He's right in the traffic.

[He's walking a couple of feet from the sidewalk back and forth -- he goes maybe ten feet in either direction.]

N: He's urinating in the street.

P: Well, that's the kind of thing I need to know...to show me how socially inappropriate he is.

[A bus went by].

P: He doesn't even flinch.

N: He's kind of well-dressed.

P: He's absolutely filthy. His neck is grimy. He's walking backward. That weird posturing...smiling to himself...I need to wait till I can get a chance to interview him but I don't think I'm going to get very much. See, he's walking farther now.

[He steps further out into traffic.]

P: He's too far. He's doing that thing with his feet. He's definitely making me nervous. He's walking forward and backward.

[The psychiatrist says to the researcher, "This is like anthropology -- me watching his behavior. I don't get to interview them."]

P: He has catatonic posturing almost. He won't get on the curb though. Instead of turning and walking like a normal person would he walks sideways, like scissors, and he won't get on the curb. He has a thing about the curb.

[Shortly after this he stepped up on the curb.]

P: He crossed the imaginary line.

[The man walked down to the corner of the avenue and a crosstown street and went into the crosswalk -- into the street -- then he came back up on the sidewalk and started looking in the garbage.]

P: He's eating out of the garbage. The really dysfunctional ones live on garbage. They don't panhandle. They don't go to drop-in centers. Yeah, he's definitely a very sick one.

Psychiatrist 7 works in the Hospital. When asked about what the hospital could do for him he stated, "My hunch is neuroleptic medication. He might even be a candidate for [an experimental drug]"

The Last Set of Observations

Over the last two observation periods, four cases were encountered. The first (Case 10; Nurse 2) resulted in a voluntary hospitalization and was the result of a referral from transit police. In the second (Case 11; Psychiatrist 5, Nurse 1), the team spotted the man as they were driving down the street. He was not known to the Team. The man was

judged as having an alcohol-related problem and no action was taken.

The third encounter (Case 12; Psychiatrist 5, Nurse 1) occurred after the team went to check up on someone who had been hospitalized before. Psychiatrist 5 made the decision to go see this man because, "We're going to have to make a decision about him soon." No action was taken although further monitoring was suggested. The woman in Case 13 (Psychiatrist 6, Social Worker 2) was also spotted as the team drove along a major avenue and was judged to have a characterological problem. These cases will only be discussed as they relate to the conceptual framework.

In Case 10, Nurse 1 had a very good opinion of the referral source and an understanding that the transit police wanted the man out of the terminal. There was no doctor on duty to evaluate the man and, if he were to be taken to the hospital, then a voluntary hospitalization would have to be arranged. Voluntary hospitalization required that the person being taken express a willingness to go as well as an understanding of what was happening.

Nurse 2 reported:

> It was hard to know what was going on with him. He wasn't able to answer any of our questions. It just seemed very clear to me that he needed to be evaluated further really to try to figure out what was going on with him. He didn't seem to be really capable of making a decision on his own. He didn't seem like he could make any kind of decisions about anything in anyway being able to take care of himself. I think it was alcohol dementia. I don't know for sure. He needed to be evaluated and needs a pretty high level of

> care and there's no where else where he'd be able to get that.

Nurse 2 did not believe that the man was really dangerous. But, she needed to get him out of the terminal. She negotiated a voluntary hospitalization, even though she didn't think he understood that he was being asked if he wanted to go to the hospital, because "there was nowhere else he could get the care he needed" and there was no doctor available that would satisfy the legal requirements for involuntary status.

When Psychiatrist 5 and Nurse 1 first spotted the man in Case 11, they were very concerned about his welfare. He was sitting on a crate in a torn, dirty coat with a hood covering his head and part of his face. His feet were covered with paper bags. They approached him because they "wanted to see what was under those bags." They asked him if he were sick and if his feet hurt. He was Spanish-speaking and communication was difficult. The doctor carefully took off the bags, the layer of plastic underneath, his shoes, then his socks. His feet were fine. The team went back to the van. Almost simultaneously, everyone stated, "Well, he's an alcohol problem." [This judgment was based on an empty liquor bottle lying next to the man.] Psychiatrist 5 stated, "We'd better write him up. We'll see him again."

In the verbal protocol, Psychiatrist 6 reported:

> There's a kind of a gestalt about someone that you sort of know that there's something wrong and that they are probably homeless and probably have a psychiatric illness because there are many, many homeless people that we pass by without really looking at them.
>
> When we saw him I was very concerned. Then I saw his feet were fine and saw the liquor bottle. And though I'm not disinterested in someone like that [alcohol] because they may be behaving in a way that puts them in danger I'm actually less interested in someone like that then I might in someone who has a more clearly psychiatric kind of problem.
>
> After I saw his socks I even doubted he was homeless because his feet were so clean. And he was panhandling so I wasn't worried about him taking care of himself.

Psychiatrist 5 was most concerned with people who were sick and who needed to be taken care of in the hospital. This man was presenting himself in a way that elicited sympathy and suggested that he needed care. However, careful examination by the team revealed that this was not the case. I assume that the suggestion to "write him up" was designed to alert other team members that this man was probably not someone who needed to be attended to.

When Psychiatrist 6 spoke to the man in Case 12, she asked him, "How are you feeling?" He said "very well." She said, "Did you say not very well?" He replied, "Very well." She then asked, "Are you cold?" He did not answer. She said, "You know we would stop coming around to see you so much if we knew you were taking care of yourself."

In the van, she told me that people were concerned about him. I asked why. She replied, "I think its the fact

that he's kind of a fixture in the neighborhood." In the verbal protocol she reported:

> Each time he's gone in [into the Hospital] it has been in the winter. But the thing is that we do know that he does survive out there in really bad weather and he seems to manage alright so as time goes on it actually becomes harder to justify forcing him to go to a hospital when he doesn't want to go.

Moreover, she stated, "It's hard to know if he's psychotic. He won't speak to you and when he does most of what he says makes sense." "His dress and behavior are just so bizarre."

Although no more was said about this case, I inferred that the fact that this man was in "public" space brought him to the "physical" and "sympathetic" attention of the neighborhood and the Team. It may be that he is a concern in the neighborhood. He is taken to the Hospital when the weather heightens that concern. However, in order to continue to take him, the Team must justify why he is taken.

The conversation that occurred in the van between Psychiatrist 6 and Social Worker 2 revealed the "ideology" of Psychiatrist 6. She is "conservative" in her beliefs about who should be taken to the hospital, although it appears that this is for a different reason than Psychiatrist 2 and may be more similar to the beliefs of Psychiatrist 1. Like Psychiatrist 1, she works at a reception center for the homeless mentally ill.

When I asked her about people I knew at that center, her explanations led me to believe that she believes that certain kinds of help for certain kinds of problems (e.g., depression) foster dependency. When asked about depression, she stated, "You have to pay attention to what a person wants as they're telling you they are depressed. Do they want money? Medication? Services?" She also explained that those who are depressed usually have a better support network than those who are psychotic and so they are less likely to become homeless." She stated, "Clinical depression is very rare in the street business."

Social Worker 2 added, "Those who talk too much about being depressed aren't. If they can tell you they're depressed they're not. That's dependency and not depression." He continued, "The homeless are not depressed. Our people are usually in the other zone -- schizophrenic, schizoaffective, drug abuse."

He admitted that bias may exist by steering away from certain questions related to depression. He said that he would not ask someone about depression. "I am not going to spend a lot of time with any one person and I don't want to hear someone go on and on in the rain." He would rather "spend more time with those people who really need the Team."

After this conversation, he explained that there were people who presented as "cariactures of need."

> See him, he's got his box, got his spot, got his 'have a bad day' face. These people have constricted, frozen affect. If you talk to them they get mad because you're bothering their panhandling.

The team stopped in front of someone to show me what this was like and to show me what would happen when this person was approached. The team asked questions similar to those in every other encounter: "Have you been eating," "Where have you been sleeping?", "Are you okay?" The woman answered no to most things and appeared annoyed. As we went back to the van, Social Worker 2 told me that she was "probably borderline."

Psychiatrist 6 reported:

> We were having this conversation about helping people in general that are homeless. We were talking about, 'Is this woman a disturbed woman?' You made the point that, look, this isn't the best way to be making a living even if she doesn't have any psychotic thinking and she presents herself fairly well in terms of her hygiene.
>
> Isn't this a woman that is still impaired and yes, you're right and then the point that I was making earlier was that due to the resources we have available we have to make decisions about who we help and how far we go. Someone with a diagnosis of schizophrenia or bipolar illness or major depression, it's very easy to help them. We can get them SSI funds, we can take them to the hospital, maybe they'll be appropriate for medications, there's all kinds of ways to help them.
>
> Someone like her who probably had some kind of impaired childhood, has low self-esteem, we don't know as well how to help someone like her who probably has more of a personality disorder you know interfering with her functioning. So that would cause us to maybe spend more time with someone who has these things that we know how to help rather than someone like her who we don't know how to help.

Even though she had explained in detail her role in a system that is limited in available resources that are specific to certain kinds of problems, she went on to blame the woman.

> And another factor is that she doesn't want our help. If she was someone who had the personality problems who really wanted our help I could try to help her in some way. She has no motivation.

Given the limited nature of the interaction with the woman, it is impossible to know if this final determination is the Psychiatrist's rationalization for not helping this woman because she is constrained by the system's inability to help her or whether it is true. But, the people that other teams helped didn't seem to want their help either. How did these cases differ?

Attributions of Responsibility

I proposed that one reason it may be acceptable to take some people that don't want your help and not to take others is the attribution that people believed to be in need of hospitalization are impaired in judgment and can't take care of themselves. Those not believed to be in need of hospitalization either can take care of themselves or have someone else who can take care of them. Moreover, there may be some relationship not only to how responsibility is attributed to the solution of problems but also to attributions of responsibility for the cause of problems. Responsibility for cause would suggest that the "fault" lies

with the person and, therefore, the person may not "deserve" to be taken care of. If these attributions were part of a helper's "ideology" then tension created when someone who doesn't want to go is taken, as well as when someone who needs some kind of help but not anything you can provide is not taken, may be resolved. In other words, attributions might serve as justification strategies.

Following the verbal protocols in eight cases (Cases 1, 2, 3, 9, 10, 11, 12, and 14; five designations and three non-designations), circumstances allowed me to ask certain team members (six psychiatrists, four social workers, one nurse, and the community liaison worker) to respond to two questions: (1) To what extent do you think this person is responsible for the cause of his/her problem? and, (2) To what extent do you think this person is responsible for the solution to his/her problem? Responses could be either numerical (on a scale from one to six, with one being not at all responsible) or verbal (none, some, very, with an explanation). Verbal responses were coded 1, for none; 2, for some; or 3, for very. Numerical responses of either 1 or 2 were recoded 1; either 3 or 4 were recoded 2; and either 5 or 6 were recoded 3.

Although there was no attempt to perform tests of statistical significance because of the small number of cases, there appeared to be a relationship between whether the person was designated and team members' beliefs about

the person's responsibility for helping him or herself. In cases where the person was assessed as needing hospitalization and designation occurred (Cases 2, 4, 9, 10, and 14) the average response was 1.4 for responsibility for a solution to the problem. In cases where no action was taken (Cases 11 and 12), 3 was the average response. The average response in the remaining case (Case 1) was 2. In this case, there was a tangible, alternate solution to hospitalization.

A review of verbal responses to all designated cases revealed that "inability to take care of self due to mental impairment" was the reasoning that accompanied designations. People were only seen as part of a solution to the extent that they would comply with treatment and medication. When people were not designated, they were believed either to be able to "take care of themselves" or had someone else who could "take care of" them. People were also judged to be more responsible for the cause of their problems when the team believed that hospitalization was not needed: 2.5 vs. 1.5.

Responses to questions about responsibility were taken after decisions to designate or not had been made and the direction of the effect is difficult to ascertain. Were attributions of responsibility an integral component of how appraisals of need for hospitalization were made? Or, Did appraisals of need affect attributions of responsibility?

It may be that both were the case and that the direction of effect was related to forces impinging on the decisions to designate.

Typing individuals according to two basic types -- the "truly needy" and the "not really needy" -- may also be a useful tool for members who are overloaded with conflicting goals and limited means of helping the people seen every day who are in need. The truly needy are the people who need the team's help: The not really needy are the people who don't. Assumptions about responsibility related to each type may make it easier for team members to do their job of helping in a constrained environment but may also lead them to focus on some kinds of people and steer clear of others.

Conclusion

I entered the study thinking that need would be the central concept. I found, however, that the central concept was help. Moreover, the framework of need suggests that decisions are based on person-level categories. I found, however, that decisions made by outreach workers on the street are based on intersecting person, group, system, and situational realities and are framed in help-based language.

The literature proposes essentially that the whole basis of helping the homeless is about people's needs. In this study, the team was mandated to help those who, because of mental illness, were a danger to themselves or others.

This mandate reflected the system's interests as well as ideology (Kelley, 1984), one of professional service similar to those models that have come to dominate help for the homeless that view people through medical terms (Murray, 1990). The whole framework of that system is a framework of need where need is the top determinant with help being assumed to be available for that need. Accordingly, once the need (mental illness) has been recognized, the treatment (the hospital) can be provided.

When team members entered the field, they tried to work as much as possible from a need-help relationship. This was easier for some than for others because of the individual's evaluation of that system. Ideologies of help determined whether team members believed they had the tools available to meet the needs of those encountered. There were other situations in which team members did not even think about need because the person was believed to be in danger. In those cases, the need became one thing, to prevent the person from harming him or herself.

The team focused on the concept of risk of danger, not need. The primary question was, "Can this person be protected from him or herself?" Mental illness was used because of the implication that the person is not responsible (capable) for helping him or herself. In a sense, the act of attributing responsibility served the perceiver's purposes when hospitalization was deemed

necessary (Shaver, 1985): Those who were at risk because of mental illness needed someone to accept responsibility for decisions made about their care.

Judgments of risk of danger were discretionary and were affected not only by person-level categories but also by system-level categories, situational demands, and interaction between levels. In making a decision to designate, team members were evaluating both the person and the system. Thus, for many team members, there appeared to be tension involved in applying the framework of need to cases encountered on the street. The tension occurred because they did not believe the system was working, they knew the people were in need, and they had to balance those two views against one another.

Ultimately, the Team had to satisfy bureaucratic requirements. Legal requirements established criteria for hospitalization that acted as a "quasi-boundaried" framework of accounting practices (Heritage, 1983) and assessments tended to be designed and shaped in response to constraints imposed by that framework. Team members had to both adjust reality within that framework and adjust the framework to suit their own personal needs.

For those who did not believe that the system was working and that it could not meet people's needs in a positive way, the reason to use the system was because of risk. For those who did believe the system was working and

who believed that the person needed something that the system could provide (i.e., treatment for mental illness), the reason to use the system was also because of risk. In the first case, risk will overcome any restraints about using the system because there is such a risk of physical danger. In the second case, the risk occurs because the need has been recognized. Regardless of the underlying structure, the documentation in both cases reads that the person is in danger due to mental illness.

Research and Policy Implications

Findings from this study suggest several important considerations for research on decision-making and for policy directed at care for people who are homeless and may have concurrent mental health issues. First, to understand the processes involved in decision-making, it is crucial to understand how those processes operate in and are, in part, a function of the social and community contexts in which those decisions are made (Bittner, 1967; Emerson, 1989; Holstein, 1984). Decisions to designate were as much a function of the contextual contingencies in which encounters occurred as they were of individual or even system ideologies and goals.

Moreover, even though similarities could be discerned across cases, it was the different configuration of contextual variables filtered through different sets of

interacting individual ideologies that actually determined the decision made in each case. Complicating the process, decisions moved across and through dimensions of time and space. A real regression equation to account for the kind of decision-making encountered here would not be fully expressed in variables but with intersecting and changing orders of reality.

Second, the traditional view of decision-making as a bottom-up process, progressing from recognition of a set of symptoms through processing of information toward the proposal of a solution does not always hold true, especially in ambiguous and constrained contexts. Rather, decision-making may as often be driven through a top-down process. That is, decisions may be goal-directed and information may be used to serve the purpose of that goal.

At a micro-level this was present in individual member's assessments about need for hospitalization. These assessments were guided by perceptions of help available and the need to do something about those whose conditions had deteriorated to a desperate state.

Team members also had to transform peoples' need into criteria mandated by the system if they felt or thought they should be hospitalized. The system provided the goal, to transport to the hospital those for whom "inability to meet basic needs for food, shelter, medical care, or safety such that without prompt and adequate treatment death, serious

disability, physical injury, or serious physical disease will imminently ensue." The system also specified the conditions ("risk of danger due to mental illness") under which that goal could be accomplished. The assessment of need by the workers was, thus, goal-directed in another sense: They used information to serve the purpose of the system's goal.

When information was shaped to satisfy system requirements by these "street-level bureaucrats," those people who interface between the client and the system (Lipsky, 1980; Prottas, 1979), the complexity of factors on which a determination of need was based became obscured. The perception of need was skewed by focusing the problem on the individual's dangerousness and mental illness.

At a macro-level, decisions about need are also traditionally viewed as being driven by a bottom-up process; that is, that service systems are shaped by the recognition of a set of needs. However, the desire to help may obscure policy makers' ability to discover the complex components of need of the homeless mentally ill by focusing on problems for which help is believed to be available.

Information is provided to policy makers after assessments and justifications to designate have been made. This may lead to a self-fulfilling prophecy in which systems of care perpetuate that focus on specific needs, find that people indeed meet those definitions, and allow those people

with needs outside the systems ability to help to fall through the cracks, either inside the hospital or out. Moreover, this information, often a construction of reality, tends to set limits on the way we conceive those we want to help.

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