**Commitment Laws and Homelessness Among Chronically Mentally Ill Persons: Is There a Need for a More Liberal Commitment Law?**

Unwarranted intrusion into people's lives before 1970 through the use of too loosely and vaguely defined civil commitment statutes has been recognized as a national tragedy (Treffert, 1985). Since that time, a majority of states have adopted more narrowly defined civil commitment statutes in an effort to curb abuses of peoples' right to liberty and prevent the unwarranted commitment of persons (Beiss, 1983). Unfortunately, the needs of some persons who are severely chronically mentally ill have been overlooked in this process of reform.

The author explores this phenomenon among mentally ill persons who have become homeless to better determine the interrelationship between restrictive commitment laws and their contribution to homelessness among mentally ill persons. A more broadly interpreted third criterion for commitment, grave disability, is suggested as one method of preventing homelessness among some chronically mentally ill persons.

**Problem Statement**

The narrowing of civil commitment statutes received strong support from the concept of treating persons in the least restrictive environment (Gutheil el al, 1983). In 1966, Judge David Bazelon heard Lake v. Cameron (Lake v. Cameron, 1966). Bazelon pointed out that "an earnest effort should be made to review and exhaust available resources of the community in order to provide care reasonably suited to her (petitioner) needs" (Lake v. Cameron, 1966). This statement alluded to the idea that commitment of persons should not be sweeping in nature and designed to further government interests; Instead it should be more narrowly interpreted to refer to what is in the best interest of the individual. In reference to mentally ill persons who are brought before the court for civil commitment, the best interest of the individual has been interpreted in a variety of ways.

The third criterion for commitment, grave disability, is included in most state statute books. It has generally been interpreted to mean that the degree of freedom taken away from a person by the restrictiveness of the intervention should be the main condition when considering commitment. However, Gutheil, Appelbaum and Weller (Gutheil et al, 1983) point out that "specific restrictiveness of an intervention in cases involving mental illness varies with the degree of freedom it is likely to restore to the person who receives it." Focusing on the restrictiveness of an intervention without also considering equally the degree of freedom that could be restored to a person through treatment has meant that a person's rights have been protected at the expense of their needs. Courts have overlooked the reality that the "quality of a person's right varies directly with ones ability to enjoy it" (Stone, 1985).

A chronically mentally ill person who is psychotic and is slowly freezing to death because of the inability to understand that he/she cannot stand outside with no coat on in below zero weather is free and has their rights, but the quality of that right can be questioned. The application of commitment statutes on a narrow basis has meant that persons who are not considered dangerous, but are in desperate need of hospitalization, "become increasingly sick, hopeless and deteriorated" (Gralnick, 1985). Deinstitutionalization has contributed to this process of deterioration by insisting that all mentally ill persons be treated in the community therefore creating an anti-hospital bias.

This viewpoint violated the intent of the 1978 President's Commission on Mental Health which defined the least restrictive environment as "the objective of maintaining the greatest degree of freedom, self determination, autonomy, dignity, and integrity of body, mind and spirit for the individual while he or she participates in treatment or receives services" (President's Commission, 1978). The "integrity of the body, mind and spirit" has been ignored in favor of granting the "greatest degree of freedom." This is particularly true for some mentally ill persons who do not respond well to a nonstructured environment because of the severity of their mental illness. These persons begin to decompensate because of poor pre-morbid functioning brought on by the chronic nature of their mental illness, a documented failure to take psychotropic medication, the tendency to self-medicate with alcohol and/or street drugs, and an inability to maintain social supports because of a lack of internal controls. (Chapman and Chapman, 1973; Harrow et al, 1983; Wing and Brown, 1970).

Persons among this group who have lost the ability to maintain a residence have a unique form of participation with the mental health system. Studies have shown that these persons have more frequent contact with the police and are more likely to be seen on an emergency basis by a psychiatrist instead of through a scheduled appointment time (Appleby and Desai, 1985). The different path taken into the community mental health system by homeless mentally ill persons suggests that they are more deteriorated, alienated and remain hidden in the community until they are discovered by the police and brought into a mental health center because of their bizarre behavior. Unlike the domociled mentally ill person who is brought into a mental health center by friends and/or neighbors because of bizarre behavior and is then released into their custody, homeless mentally ill persons disappear into the oblivion of street life when they leave the mental health center. Other alternatives can be attempted when intervening with a domociled mentally ill person such as giving their parents the medication and having them give it to their adult child. However, homeless mentally ill persons who have a documented history of wandering and are not rational because of their mental illness have few alternatives for effective intervention other than the state hospital.

The least restrictive alternative needs to be reexamined carefully when attempting to intervene with a population that has limited choices. Their choices are often the street, jail and hospital. Ohio has three criteria on its statute books concerning commitment to a psychiatric facility. These include dangerous to self, dangerous to others and grave disability. The interpretation of these three criteria varies according to the particular Ohio county (Belcher and Toomey, 1986). Franklin County is the focus of this study and it primarily utilizes the first two. It also utilizes grave disability but it is interpreted very narrowly. For example, if it is 22 degrees outside and a person is wearing a heavy shirt then it is assumed that he/she is not gravely disabled. He/she may be grossly psychotic, significantly decompensated, and believe that it is warm but the fact that he/she is wearing more than a tee shirt is interpreted to mean that they are not gravely disabled and can rationally make decisions.

**Methodology**

This study was conducted beginning in May 1985 and lasted through January 1986. It observed 132 former patients of an acute care treatment unit of a state hospital to determine who became homeless. The homeless respondents to be interviewed emerged from this larger sample of 132 respondents. Working hypotheses were developed as the project progressed. This research documented the patterns of homelessness discovered and developed categories to explain how and why these former patients became homeless. This study utilized qualitative research methods and was longitudinally focused.

After a respondent was discharged from the state hospital, his/her discharge information, including a home address, was verified by the author. This was accomplished by phone or in person if the respondent had no phone. This process took place with every respondent in the study. Those persons who could not be found received more intensive tracking, including talking with relatives and neighbors, and contacting various community agencies that might have had prior contact with the respondent. The author considered it important to account for all respondents in the study.

Contacts were developed among community informants who had knowledge about homeless persons. This included, but was not limited to, homeless shelter staff, soup kitchen staff, community mental health center staff and other persons that emerged as knowledgeable about homeless persons. These contacts provided useful information on the possible whereabouts of those persons in the study who could not be immediately located and might be homeless.

Interviews with those respondents found to be living in homes were brief and consisted of open-ended questions which sought to determine the respondent's medication compliance, plans for the future and any problems the respondent was having since being discharged from

the hospital. This information helped to establish a history of the respondent which proved useful if the person could not be found in subsequent months. This process was repeated at one, three and six months after discharge.

Those respondents who became homeless received intensive follow-up interviews; this included contacting the person on a weekly basis or more often if possible. The interviews began with the author attempting to establish some rapport with the homeless persons and then proceeding with open-ended questions such as, "How long have you been living in this alley?" The process continued and developed into a conversation, if possible.

In order to become familiar with the context of the conditions where homeless persons lived, the author spent considerable time in homeless shelters and on the street before and during the life of the project. This process developed into the activities of prolonged engagement and persistent observation, which ensured the trustworthiness of the findings. To further ensure the trustworthiness of the findings, the author developed as many resources as possible so information about a respondent could be verified by multiple sources. These resources included the Social Security Administration, the county welfare office and other community agencies.

Hospital case records on each homeless respondent were reviewed to document historical information, such as the onset of the psychiatric illness, age at onset, involvement of family members, employment information and other relevant historical data.

**Data Analysis**

Case files, which contained a chronological record of contacts with the respondent and information obtained from community contacts, were developed on each person in the study. Tape recorders were not used in the interview process because they were found to frighten many of the homeless persons in the sample. Field notes from each day's experiences with respondents were appropriately catalogued and recorded in the files.

Working hypotheses were developed during the life of the project by utilizing the constant comparative method as developed by Glaser and Strauss (Glaser and Strauss, 1967). This method entails the constant comparison of cases according to discovered emergent themes. Categories were formed as similarities began to appear in these themes. The development of these themes and subsequent categories rely upon intuitive knowledge. Together, themes and categories create working hypotheses. This process is aided by an ongoing literature review of material that is relevant to the population being studied.

**Context**

The context of any qualitative research is important because it is necessary in order for users of the research to be able to "transfer" the findings to their settings.

This study took place in a large Ohio city of approximately 1,500,000 people. A study conducted by the Metropolitan Human Services Commission in 1984 estimated the number of homeless persons in the county at 9,000 people including 7,400 single adults and 1,600 family members (Metropolitan Human Services Commission, 1984).

Many homeless persons congregate in the downtown section of the city among office workers and shoppers. They tend to become part of the landscape and go relatively unnoticed. The city is served by two large shelters; one accommodates only men and one accommodates men and women. There are also several traditional programs and missions which have various requirements such as attendance at a nightly religious service in order to be given shelter. The average city-wide shelter census is approximately 300 to 350 persons.

Franklin County has four major community mental health centers from which a commitment to the state hospital must originate. Indigent persons and persons with medicaid are not usually welcome by private hospitals and the state hospital provides the primary source of inpatient psychiatric care to these persons. Homeless persons are generally indigent or they have insurance through the medicaid system. Admission to the state hospital is through commitment and persons must be determined to be suicidal, homocidal or gravely disabled. Since the 1960s, Ohio has reduced its state hospital population and has restrictive admission policies to keep treatment community focused. A state hospital is located in the city and serves a multi-county area.

**Findings**

One of the working hypotheses developed during the life of the project was: there was a connection found between the restrictiveness of the commitment statutes as interpreted in Franklin County, Ohio and its contribution to homelessness among mentally ill persons. The findings will focus on the examination of this connection.

Forty-seven persons became homeless during the six months of the study. Thirty-three of these 47 homeless persons were identified as chronically mentally ill and homeless, and the interpretation of the commitment statutes both contributed and exacerbated their homeless condition. These 33 persons can be characterized as follows:

**Demographics**

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| Male | 25 | Black | 18 | Age $\bar{x}$=31.67 |
| Female | 8 | White | 25 | |

Diagnoses: Affective 9, Schizophrenia 15, Adjustment 3, Drug/Alcohol 4, Borderline Personality 2.

| | |
|---|---|
| Involuntarily committed to the state hospital | 33 |
| Homeless upon admission | 33 |

The 33 persons in this group were characterized by long histories of chronic mental illness and continuing problems with severe psychotic behavior. This led to a gradual inability to understand the world around them and an increasing distancing from normative reality. Twenty-six (79 percent) of these 33 individuals came in regular contact with the police, emergency mental health staff and shelter staff. However, these contacts, although regular, were brief. Request for assistance often indicated their level of decompensation. One respondent requested assistance in "getting to China" but he believed he was in California and he could use his coffee to buy a ticket on a plane. Mental health staff pointed out that his behavior indicated that he was in need of hospitalization but he did not meet the state criteria. The staff believed that if they committed too many people like the respondent the staff would "get in trouble."

Those respondents who were brought in for a mental health assessment were routinely turned down for commitment to the state hospital. One social worker in an emergency services unit pointed out "if they come in for help, even if the help requested is illogical, they are judged to be capable of taking care of themselves. What you have is a Catch-22. It's better to wait on the street until the police pick you up." Being brought in by the police made it more likely that the persons would be committed but as one social worker pointed out "if COPH is full then we reject them even if they need hospitalization." The police pointed out that they were protecting themselves in case the person froze to death, but they realized that the mental health center would reject the person for commitment.

Fifteen of the 26 homeless people were recommitted to the state hospital only after repeated contacts with community workers who were eventually placed in a position of having no other choice but to commit the respondent. One respondent tried seven times to gain admission to the hospital. Each time he was more deteriorated. Eventually he laid down in the middle of the street and the police placed him under arrest and transported him to a mental health center. Several staff at the center pointed out that the respondent was "faking" but the police prevailed and the respondent was committed.

Several staff at various community agencies commented to the author that they were frustrated in their inability to make the "system"

listen to them in regards to the daily deterioration of these fifteen persons. Homeless shelter staff observed that homeless persons faced a daily struggle to survive, which was exacerbated by the growing deterioration in their mental condition. This resulted in a greater inability to understand the rules of homeless shelters. The homeless shelters had lines which had to be formed at a certain time so a space for the night could be secured. This required a concept of time, but time had less and less meaning for these persons as they became more deteriorated.

Many of these 15 persons realized they needed some help. Some went into a shelter and asked a staff member to help them with their open sores or cut their hair so the lice would not bother them as much. A realization of their problems combined with the often transient nature of their psychotic behavior led many staff at shelters and mental health centers to interpret their behaviors as indicative of a higher level of functioning. This would frequently lead to disagreements between staff of various agencies over whether the respondent was "faking." One respondent at the Open Shelter was believed by staff to be in desperate need of mental health assistance, whereas the staff at Southwest Community Mental Health Center believed the respondent to be trying to get back in the hospital where he could get three meals a day and a bed. This friction between agencies over the actual health of the respondents created more confusion for the respondents.

The five remaining respondents in this group of 33 people were seen more infrequently by community workers. They were able to remain less visible because they functioned slightly higher than the other persons. They were not as psychotic, appeared to be able to control their behaviors by having more internal controls and their illness appeared to have fewer acute episodes. This improved level of functioning did not prevent them from avoiding homelessness and their histories indicated that they were always recommitted to the state hospital after decompensating to a dangerously low level of functioning. As they began to decompensate, they would come in more frequent contact with community workers and like the other 26 respondents would revolve in and out of psychiatric emergency rooms until a precipitating incident, such as making a police officer who had seen the respondent one too many times mad, would result in the person's commitment.

### Jake

Jake is a 64-year-old black man who has been diagnosed with schizophrenia and has been homeless for over ten years. Jake has been hospitalized at COPH 15 times and his process of commitment is similar each time. Jake is usually discharged to an address which is either made up by him or is assumed by the discharge social worker. After being in the community for a few days, Jake begins to abuse alcohol, fails to take his medication and starts to come in more contact with the police.

Often times, Jake will enter a bar or small grocery and begin to "talk crazy" and threaten the manager. The police will be called and they will transport Jake to a mental health center. The mental health center determines that Jake is not suicidal or homocidal. They then evaluate him to determine if he is gravely disabled. Jake may be wearing a shirt with holes, ill fitting shoes and a coat even though it is 80 degrees outside, but his dress is deemed to be appropriate simply because he is wearing them as opposed to going naked. He is asked questions by mental health staff concerning his behavior and his answers, although indicating significant mental decompensation, are construed as appropriate. Eventually Jake is released into the community and given an appointment date to see a psychiatrist. He fails to come back, which could have been predicted as evidenced by his repeated past inability to follow through with aftercare.

Jake is seen at numerous mental health centers and shelters, and by police officers and other community workers. Eventually Jake engages in the wrong behavior with the wrong person and he is committed. During the study period, Jake became "agressive" with a man who he said had taken his hat and the man insisted that "something be done." Pressure in the form of a police officer relating this information to a staff member at the mental health center and the staff person relating this information to a psychiatrist eventually succeeded in having Jake committed. Jake's life in the community is a series of wanderings for no apparent reason and frequent encounters like the incident involving the taking of the man's hat. The longer that Jake remains in the community, the more decompensated he becomes and the more frequent are his contacts with community workers who eventually press for his commitment.

**Sid**

Sid is a 20-year-old white male with a diagnosis of dysthymic disorder, although that diagnosis has been disputed by many community workers. Many feel that his diagnosis should more appropriately be unipolar depression with psychotic features. Sid did not fully recompensate while in COPH and his transfer to a long term ward was considered but rejected because it was felt that he was a manipulator. Sid was discharged and was homeless three days after his release. He went to the Open Shelter and began to rapidly decompensate. The shelter staff had him go to see a psychiatrist at the local mental health center and the psychiatrist suggested that Sid should get "married and settle down" and his problems would be greatly reduced.

Frustrated, Sid began to wander the streets and decompensated to a lower level of functioning. Sid was rehospitalized three times during the six months of the study and each time was discharged even though he was not yet recompensated. His having enough awareness to came into a center for help was used as evidence of his ability to take care of

himself. He often talked of suicide, but his behavior was dismissed as acting out in order to get back in COPH. He remained homeless the six months of the study except for when he was rehospitalized. Sid's mental decompensation was ignored, instead his ability to survive the struggles of homelessness were used as further evidence to support the contention that he was functioning adequately. He did appear as gravely disabled to many community workers in the homeless shelter because they used a less conservative definition of what constituted evidence that a person was or was not able to take care of themselves.

Sid would often sit under a railroad bridge and wait for the train to come, hoping it would collapse the bridge over top of him. One worker pointed out that Sid actually knew the bridge would not collapse and this represented insight. However, another worker pointed out that sitting under a railroad bridge day in and day out in the hopes that it would collapse represented significant impairment and a lack of insight. Sid was obviously ill and in need of treatment. He would not respond to a nonstructured environment. He had his freedom but the quality of that freedom can be questioned.

**Ted**

Ted is a 21-year old white male who the state hospital could not accurately diagnosis. Unable to determine his diagnosis and frustrated with his lack of progress he was discharged because there was a fear that he would become "institutionalized." Ted was rehospitalized three times at COPH during the six-month study period. He was "picked up" several times by the police for a variety of activities including pandering, jaywalking and disorderly conduct. When transported to a mental health center, the center staff would attempt to find an alternative to the state hospital because the hospital did not want him back. He was unable to function in the community as evidenced by his lack of ability to maintain himself physically. He would quit eating, sleep in the rain with his mouth open and wake up with a congested lung, would not wash himself and would become infested with lice and was generally unable to provide for himself.

These behaviors were interpreted differently by staff in the mental health center who pointed out that if he came into the Open Shelter after several days in the cold and wet that he exhibited insight and could take care of himself. Police became frustrated with him because they could not understand why COPH refused to "hold" him and once in the community Ted was at risk of being hit by a car. He would walk into oncoming traffic, yet usually managed to avoid being hit by a car. Ted became a revolving door patient in both the state hospital and the mental health center. For this he was blamed by the staff of both, yet he seemed to be unable to understand his own behaviors. Blaming him for behaviors he could not understand, he became more alienated and alone.

**Implications**

Social work is concerned with improving the social functioning of persons by helping to create an environment which reduces vulnerability to such conditions as homelessness. The three cases illustrate the precarious legal environment in which homeless mentally ill persons must now function. They are protected in their right to be free, yet their needs are ignored. Although not overtly suicidal or homocidal, they were in need of a stronger intervention than the community is currently able to provide. Their daily struggle to survive on the street was further complicated by their mental decompensation and inabilities to understand the world around them. They had long histories indicating an inability or unwillingness to comply with aftercare and take needed psychotropic medication.

Grave disability as a criterion for commitment was considered for the case example but its interpretation was so narrow that only a person whose functioning was at a very low level and death was eminent could be committed. Such an interpretation is not in the best interest of the client because it ignores their needs and contributes further to their decompensation. Any behavior that suggests that the person is capable of insight such as wearing a flannel shirt when it is cold is used as justification that the person is not gravely disabled. This justification ignores the complexity of clinical diagnosis and substitutes an interpretation that is furthering the interests of society by saving the cost of inpatient hospitalization.

Judge Bazelon pointed out that the interests of the person are to supersede furthering the interests of society when considering the least restrictive alternative. This interpretation of the law needs to be reexamined by both the courts and the mental health systems. Unlike lawyers who may be solely interested in protecting the rights of their clients, social workers must also be aware of the needs of the clients. The central issue should be the potential freedom restored by commitment to a hospital and subsequent treatment instead of focusing solely on the client's current right to freedom.

## References


Appleby, L. and Desai, P.N. (1985). Documenting the relationship between homelessness and psychiatric disability. Hospital and Community Psychiatry, 36, 732-737.

Beiss, E. (1983). State involuntary commitment statutes. Mental Disability Law Reporter, 7, 358-369.

Belcher, J.R. and Toomey, B.G. (1986). Preliminary findings -- the relationship between psychiatric disability and homelessness. Presentation to the Ohio Department of Mental Health.

Chapman, L.J. and Chapman, J.P. (1973). Disordered Thought in Schizophrenia. New York, New York: Appleton, Century Crofts.

Gralnick, A. (1983). Build a better state hospital: deinstitutionalization has failed. Hospital and Community Psychiatry, 36, 739.

Gutheil, T.G., Appelbaum, P.S. and Wexler, D.B. (1983). The inappropriateness of least restrictive alternative analysis for involuntary procedures with the institutionalized mentally ill. The Journal of Psychiatry and the Law, 7-21.

Harrow, M., Larin-Kettering, I., Prosen, M. and Miller, J.G. (1983). Disordered thinking in schizophrenia: intermingling and loss of set. Schizophrenia Bulletin, 9, 354-367.

Lake v. Cameron, (1966). D.C. C.R., 364, F2d 657.

Metropolitan Human Services Commission (1984). Health Care for the Homeless, Columbus, Ohio.

Report to the President from the President's Commission on Mental Illness (1978). Washington, D.C., 1, 44.

Stone, A.A. (1985). A response to comments on APA's model commitment law. Hospital and Community Psychiatry, 36, 985.

Treffert, D.A. (1985). The obviously ill patient in need of treatment: a fourth standard of civil commitment. Hospital and Community Psychiatry 36, 259-264.

Wing, J.K. and Brown, C.W. (1970). Institutionalism and Schizophrenia. New York: Cambridge University Press.