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INVOLUNTARY TREATMENT FOR THE HOMELESS MENTALLY ILL

H. RICHARD LAMB, M.D.*

A 26-year-old man was first hospitalized at age 18 and many times since.

He had been asked to leave his parents' home at age 20 because they were afraid of him. They had taken him back twice, but at age 22 had decided not to take him back again, after he had broken his mother's arm. He has been homeless for the past four years, sometimes in shelters, but mostly on the streets and in parks.

He is extremely paranoid, guarded and irritable to the point where any contact with people quickly escalates to physical violence. Voices constantly tell him that various people want to hurt him.

He wanders from city to city and place to place, only occasionally receiving his Supplemental Security Income (SSI) check because of his constantly changing whereabouts.

He is totally resistant to antipsychotic medications when not in hospitals and is medicated only with great difficulty during his brief hospitalizations. He refuses all housing placements.

He has had several arrests for assaults on strangers whom he had instantly incorporated into his delusional system. His longest stay in jail has been a week, and each time he has been sent to a psychiatric hospital. He is, at this time, living on the streets.

A 32-year-old man was first hospitalized at age 20. He has had multiple hospitalizations since, because of delusions, hallucinations and severe depression. He lived at home until age 26 when his mother died.

He has been in a variety of placements since the death of his mother, including halfway houses and board and care homes, but has been asked to leave by all of them because of his constantly putting his hands on women and his masturbating in public. He refuses to take medications.

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For the past year he has been living on the streets. He has been beaten and robbed twice. He has even been thrown out of soup kitchen lines for open masturbation—the ultimate rejection.

He has been hospitalized with increasing frequency in the past year because of delusions, hallucinations and suicidal ideation. In the hospital his symptoms quickly disappear, and he no longer meets the criteria for ongoing involuntary treatment.

He refuses long-term hospitalization or any other locked facility, and discharge is usually to the streets.

Unfortunately, these are not unusual cases, but are simply two of the many thousands of homeless mentally ill persons in this country. To what extent has deinstitutionalization, and especially problems in its implementation, contributed to this homelessness? The purpose of this article is to examine the problems of deinstitutionalization not just with regard to the homeless mentally ill but for the long-term mentally ill generally, to draw upon our experience, especially our clinical experience, and to discuss one aspect of the problem in particular, involuntary treatment for the homeless mentally ill.

I. THE SEDUCTIVENESS OF “FREEDOM”

There is sometimes a tendency on the part of those who advocate institutionalizing the mentally ill to underestimate the humanizing effects of long-term mental patients' simply having free movement in the community.¹ Even patients who live in “mini-institutions” in the community—i.e., in community-based settings such as board and care homes that share some characteristics of state hospital social structure—often enjoy the benefits of residence in unlocked facilities, as well as free access to a range of community resources. Although some of these patients may require structured residential settings, and although most of them may be unable to withstand independent employment, they may still experience living in the community as a positive event.

At the same time, however, not all long-term mental patients benefit equally from even limited amounts of freedom. For a portion of the population, that which requires a highly structured and controlled environment, freedom may result in intense anxiety, depression and deprivation, and, increasingly often, in a chaotic life on the streets. These patients often require ongoing involuntary treatment, sometimes in 24-hour

1. H.R. LAMB, *TREATING THE LONG-TERM MENTALLY ILL* 29 (1982).

settings like California's locked skilled-nursing facilities with special programs for psychiatric patients² or, when more structure is indicated, in hospitals where security is greater.

A recent task force report of the American Psychiatric Association³ traces the evolution of this concern:

The purported effectiveness of deinstitutionalization was predicated both on the availability of effective treatment in the community, and on the willingness of patients to accept treatment voluntarily. Unfortunately, a majority of the proposed community treatment facilities were never created, and many of the discharged patients continued to be unwilling to accept treatment voluntarily, and discontinued treatment immediately after discharge. Further, a growing number of young adult chronic patients did not accept the need for treatment and could not be treated involuntarily because they failed to meet the criteria of reformed commitment laws designed to limit the use of involuntary hospitalization. Many of these patients responded well to treatment when hospitalized, but rapidly relapsed after discharge, leading to the "revolving door" syndrome of repeated brief hospitalizations followed by relapse after discharge.

It can be seen then that freedom for the chronically and severely mentally ill is a much more complex issue than it might appear at first glance. Each patient must be evaluated individually and society and the mental health system must provide a range of options allowing varying degrees of autonomy for these persons.

II. DEINSTITUTIONALIZATION

Probably nothing more graphically illustrates the problems of deinstitutionalization than the shameful and incredible phenomenon of the homeless mentally ill. The conditions under which they live are symptomatic of the lack of a comprehensive system of care for the long-term mentally ill generally. Though the homeless mentally ill have become an everyday part of today's society, they are nameless; the great majority are not on the caseload of any mental health professional or mental health

2. Lamb, *Structure: The Neglected Ingredient of Community Treatment*, 37 ARCHIVES GEN. PSYCHIATRY 1224-28 (1980).

3. AMERICAN PSYCHIATRIC ASS'N, TASK FORCE REPORT NO. 26, INVOLUNTARY COMMITMENT TO OUTPATIENT TREATMENT 1 (1987).

agency.⁴ Hardly anyone is out looking for them, for they are not officially missing. By and large the system does not know who they are or where they came from. We can see first hand society's reluctance to do anything definitive for them; for instance, stop-gap measures such as shelters may be provided, but the underlying problem of a lack of a comprehensive system of care is not addressed.⁵ We can see our own ambivalence about taking the difficult stands that need to be taken—for instance, advocating changes in the laws for involuntary treatment and the ways these laws are administered. When we get to know homeless mentally ill persons as individuals, we often find that they are not able to meet the criteria for the programs that most appeal to us as professionals: those that require a higher degree of patient functioning. For the citizenry generally, the homeless mentally ill represent everything that has gone wrong with deinstitutionalization and have persuaded many that deinstitutionalization was a mistake.

Yet, many things have gone right with deinstitutionalization. For instance: the chronically mentally ill have much more liberty, in the majority of cases appropriately so; we have learned what is necessary to meet their needs in the community; and we have begun to understand the plight of families and how to enlist their help in the treatment process. In this article, however, the focus is on what has gone wrong with deinstitutionalization, and in particular the ways that various forms of involuntary treatment could help resolve the problems of the homeless mentally ill.

III. HOSPITAL AND COMMUNITY

Has deinstitutionalization gone too far in terms of attempting to treat long-term mentally ill persons in the community? We now have over three decades of experience to guide us. Some long-term mentally ill persons require a highly structured, locked, 24-hour setting for adequate intermediate or long-term management.⁶ For those who need such care, do we not have a professional obligation to provide it,⁷ either in a hospital or a

4. Lamb, *Deinstitutionalization at the Crossroads*, 39 HOSP. & COMMUNITY PSYCHIATRY 941-45 (1988).

5. See AMERICAN PSYCHIATRIC ASS'N, *THE HOMELESS MENTALLY ILL* (H.R. Lamb ed. 1984).

6. Belcher, *Defining the Service Needs of Homeless Mentally Ill Persons*, 39 HOSP. & COMMUNITY PSYCHIATRY 1203-05 (1988); Dorwart, *A Ten-Year Follow-up Study of the Effects of Deinstitutionalization*, 39 HOSP. & COMMUNITY PSYCHIATRY 287-91 (1988).

7. GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, *THE POSITIVE*

hospital-like alternative such as California's Locked Skilled Nursing Facilities with Special Programs for Psychiatric Patients?⁸ Where to treat should not be an ideological issue; it is a decision best based on the clinical needs of each person. Unfortunately, deinstitutionalization efforts have, in practice, too often confused locus of care and quality of care. Where mentally ill persons are treated has been seen as more important than how they are treated. Care in the community has often been assumed almost by definition to be better than hospital care.⁹ In actuality, poor care can be found in both hospital and community settings. But the other issue that requires attention is appropriateness. The long-term mentally ill are not a homogeneous population; what is appropriate for some is not appropriate for others.

For instance, what of those persons who are characterized by such problems as assaultive behavior; severe, overt major psychopathology; lack of internal controls; reluctance to take psychotropic medications; inability to adjust to open settings; problems with drugs and alcohol; and self-destructive behavior. When attempts have been made to treat some of these persons in open community settings, they have required an inordinate amount of time and effort from mental health professionals, various social agencies, and the criminal justice system. Many have been lost to the mental health system and are on the streets and in the jails.

Moreover, the result has often been seen as a series of failures on the part of both mentally ill persons and mental health professionals; as a consequence, a number of long-term mentally ill persons have become alienated from the system that has not met their needs, and some mental health professionals have become disenchanted with their treatment. Unfortunately, the heat of the debate over this issue of whether or not to provide intermediate and long-term hospitalization for such patients has tended to obscure the benefits of community treatment for the great majority of the long-term mentally ill who do not require such highly structured, 24-hour care.

ASPECTS OF LONG TERM HOSPITALIZATION IN THE PUBLIC SECTOR FOR CHRONIC PSYCHIATRIC PATIENTS (1982).

8. See *supra* note 2.

9. Bachrach, *A Conceptual Approach to Deinstitutionalization*, 29 HOSP. & COMMUNITY PSYCHIATRY 573-78 (1978).

IV. FUNCTIONS OF THE STATE HOSPITALS

In the midst of very valid concerns about the shortcomings and antitherapeutic aspects of state hospitals, it was not appreciated that the state hospitals fulfilled some very crucial functions for the chronically and severely mentally ill. The term "asylum" was in many ways an appropriate one, for these imperfect institutions did provide asylum and sanctuary from the pressures of the world with which, in varying degrees, most of these patients were unable to cope.¹⁰ Further, these institutions provided such services as medical care, patient monitoring, respite for the patient's family, a social network for the patient as well as food and shelter and needed support and structure.¹¹

In the state hospitals what treatment and services that did exist were in one place and under one administration. In the community the situation is very different. Services and treatment are under various administrative jurisdictions and in various locations. Even the mentally healthy have difficulty dealing with a number of bureaucracies, both governmental and private, and getting their needs met.

Further, patients can easily get lost in the community as compared to a hospital where they may have been neglected, but at least their whereabouts were known. It is these problems that have led to the recognition of the importance of case management. It is probable that many of the homeless mentally ill would not be on the streets if they were on the caseload of a professional or paraprofessional trained to deal with the problems of the chronically mentally ill, monitor them, with considerable persistence when necessary, and facilitate their receiving services.

V. SOME BASIC QUESTIONS

It should be emphasized that the majority of long-term mentally ill persons are able to live in the community. With regard to this majority, we need to ask ourselves if we have truly established this population as the highest priority population in public mental health. If so, does this priority include our concern, our resources and our funding? We have learned a great deal about the needs of the long-term mentally ill in the community. Thus, we know that this population needs a com-

10. Lamb & Peele, *The Need for Continuing Asylum and Sanctuary*, 35 HOSP. & COMMUNITY PSYCHIATRY 798-802 (1984).

11. Bachrach, *Asylum and Chronically Ill Psychiatric Patients*, 141 AM. J. PSYCHIATRY 975-78 (1984).

prehensive and integrated system of care;¹² such a system would include an adequate number and range of supervised, supportive housing settings, adequate, comprehensive, and accessible crisis intervention, both in the community and in hospitals, easier access to involuntary treatment, and ongoing treatment and rehabilitative services, all provided assertively through outreach when necessary. We know the importance of a system of case management such that every long-term mentally ill person is on the case-load of some mental health agency which will take full responsibility for individualized treatment planning, linking these persons to the needed resources and monitoring these persons so that they not only receive the services they need, but are not lost to the system. Have we done enough to put our knowledge into practice? For most parts of this nation, the answer is clearly no.¹³ If this comprehensive system of care were in place, fewer patients would deteriorate to the point where they need involuntary treatment.

VI. CIVIL COMMITMENT

In 1969, California's then-novel civil commitment law, the Lanterman-Petris Short Act, went into effect.¹⁴ Within a decade every state (and Puerto Rico) modified its commitment code to make similar changes.¹⁵ Such a rapid and complete consensus among legislatures is virtually unprecedented; more important, it reflected a nearly universal view, which I share, that past inattention to the rights of the mentally ill needed to be corrected.

In effect, the new civil commitment laws accomplished three things. First, the laws changed the substantive criteria for commitment from more general criteria simply embodying concepts of mental illness and need for treatment to more specific criteria that embodied either dangerousness or the incapacity to care for self with the presence of mental illness as a requisite for commitment. Second, the laws changed the duration of commitment from indeterminate and extensive to determinate and brief. Third, the new laws explicitly provided that persons civilly committed have rapid access to the courts, to public defenders, and, in some cases, to jury trials; this access

12. Bachrach, *The Challenge of Service Planning for Chronic Mental Patients*, 22 *COMMUNITY MENTAL HEALTH J.* 170-74 (1986).

13. Talbott, *The Fate of the Public Psychiatric System*, 36 *HOSP. & COMMUNITY PSYCHIATRY* 46-50 (1985).

14. CAL. WELF. & INST. CODE §§ 5000-5599 (West 1984 & Supp. 1989).

15. Lamb & Mills, *Needed Changes in Law and Procedure for the Chronically Mentally Ill*, 37 *HOSP. & COMMUNITY PSYCHIATRY* 475-80 (1986).

secured for civilly committed persons the kinds of due process guarantees that criminals had obtained over the prior decade.

Numerous motivations may have accounted for these changes. The most straightforward should not be dismissed: legal reformers were concerned that mentally ill individuals, persons who often had difficulty defending their liberty interests, should not be civilly committed without a deliberate process, and then only when specific criteria were met. Still, such an explanation would not be considered complete. Throughout the works of Szasz,¹⁶ Goffman,¹⁷ and Laing,¹⁸ many attorneys had almost come to believe that mental illness indeed was a myth and that the so-called mentally ill were otherwise ordinary people who were "choosing an alternative life-style."

This last perspective, and it is difficult to ascertain how wide-spread it was, clearly helped to shape the new laws. Moreover, libertarian perspectives appear to have taken precedence over clinical ones; commitment periods in most states are not geared to the clinical needs of acutely psychotic and depressed patients. Thus the new laws frequently, though unwittingly, contributed to the toll of chronic mental illness by providing unrealistically short treatment durations for both psychotic and depressed patients.

Consideration of the duration of commitment, then, suggests that legislators were more preoccupied with the rights than the needs of involuntary patients.

If one accepts the findings of various studies that suggest that, irrespective of commitment criteria, about 85 percent of persons committed are not dangerous,¹⁹ then commitment laws that base civil commitment only on dangerousness reduce the potential number of patients who could be helped by commitment by that same amount, 85 percent. In fact, however, many, though not all, of the new laws allow involuntary hospitalization of mentally ill persons who are incapable of providing for their basic necessities, such as food, clothing, and shelter.²⁰

16. T.S. SZASZ, *THE MYTH OF MENTAL ILLNESS* (1961).

17. E. GOFFMAN, *ASYLUMS: ESSAYS ON THE SOCIAL SITUATION OF MENTAL PATIENTS AND OTHER INMATES* (1961).

18. R.D. LAING, *THE DIVIDED SELF* (1960).

19. Monahan, Ruggiero & Friedlander, *The Stone-Roth Model of Civil Commitment and the California Dangerousness Standard: An Operational Comparison*, 39 *ARCHIVES GEN. PSYCHIATRY* 1267-71 (1982).

20. AMERICAN BAR FOUNDATION, *Involuntary Hospitalization*, in *THE MENTALLY DISABLED AND THE LAW* 34-63 (S.J. Brakel & R.S. Rock eds. rev. ed. 1971).

Yet because of the way in which the new laws were drafted, the courts have often applied the new criteria literally. That is, a patient who obviously is seriously mentally ill, though less floridly psychotic than when first admitted, may not be retained in the hospital because he has avoided starvation (thus he must be providing himself with sufficient food), has obtained the rags he is wearing (has clothing), and claims to prefer living in a cardboard box (has shelter). Such interpretations should not be dismissed as the capricious acts of the judiciary, but should be viewed as the nearly inevitable result of narrowed commitment criteria.

Only the seriously mentally ill should be committed. However, the new commitment laws affected the chronically mentally ill by limiting commitment to those who are dangerous or are so deteriorated that they can generate only the most minimal efforts to sustain their own life. This restrictive scope, coupled with other changes that shorten commitments and provide more opportunities to challenge their legality, has made commitment a less effective vehicle for detecting, evaluating, and treating the seriously mentally ill.

What has been the result? Consider the homeless mentally ill as an example. Given that the estimates of the seriously mentally ill in the urban homeless population range from 25 to 50 percent,²¹ and that the true percentage is most likely in the upper end of that range, the changes in commitment laws have, in my opinion, contributed substantially to this grave nationwide problem. For instance, it has been shown that involuntary hospitalization has an important role to play in the treatment of the homeless mentally ill.²²

Often overshadowed by the concerns about the laws governing emergency involuntary commitment are the importance and the therapeutic potential of ongoing involuntary treatment. Such treatment, includes conservatorship or guardianship, outpatient commitment,²³ and treatment as a condition of probation. They will be discussed later.

21. Arce & Vergare, *Identifying and Characterizing the Mentally Ill Among the Homeless*, in AMERICAN PSYCHIATRIC ASS'N, *supra* note 5, at 75, 88.

22. Bennett, Gudeman, Jenkins, Brown & Bennett, *The Value of Hospital-Based Treatment for the Homeless Mentally Ill*, 145 AM. J. PSYCHIATRY 1273-76 (1988).

23. Miller, *Commitment to Outpatient Treatment: A National Survey*, 36 HOSP. & COMMUNITY PSYCHIATRY 265-67 (1985); Miller & Fiddleman, *Outpatient Commitment: Treatment in the Least Restrictive Environment?*, 35 HOSP. & COMMUNITY PSYCHIATRY 147-51 (1984).

VII. RECOMMENDATIONS

To begin with, the civil commitment laws need to be redrafted and the criteria for commitment should be altered in a substantive way. Proposed revisions should include many of those found in the American Psychiatric Association's Model State Law on Civil Commitment of the Mentally Ill.²⁴ The criteria for commitment should include the following. First, the person suffers from a severe mental illness. Second, the person is likely to cause harm to others (including substantial damage to property) or harm to self, or is gravely disabled (that is, he is unable to satisfy his basic needs for nourishment, medical care, shelter, or safety without prompt and adequate treatment, or, from repeated history, is likely to suffer substantial mental or physical deterioration). Third, hospitalization is necessary to prevent harm to the person or to others.

It is important to note that expansion of the criteria of grave disability to allow commitment of a person who is likely to suffer deterioration represents a reintroduction of a need-for-treatment standard, in addition to the now-usual dangerousness criteria. Legislation expanding the criteria of grave disability to include deterioration has already been enacted in such states as Alaska, Texas, and Washington.

Under the ideal law, in nonemergency situations or after three days of emergency commitment, a judicial hearing would be required as a prelude to commitment for 30 days, a length of time that makes sense clinically. Although the patient would have the right to be present, to be represented by counsel, and to have a record of the hearing kept, informal rules of evidence would be employed. For example, testimony could be heard from all parties with relevant information without rigorous adherence to such doctrines as the hearsay rule and without observance of conventional courtroom procedure, with its strict adherence to rules of direct examination and cross-examination. The use of informal rules of evidence would make the judicial hearing much less countertherapeutic than it has been, and that informal rules are more appropriate for a commitment hearing than the model based on courtroom procedures for criminals. Subsequent recommitment, following another court hearing, would be for up to 60 days; thereafter patients could be recommitted for 180-day periods.

Guardianship (conventionally granted by probate courts) and conservatorship are potentially important resources for

24. Stromberg & Stone, *A Model State Law on Civil Commitment of the Mentally Ill*, 20 HARV. J. ON LEGIS. 275 (1983).

that relatively small proportion of the long-term mentally ill who need ongoing legal controls in the community as an alternative to total control in a hospital. Unfortunately in many states these legal mechanisms have only theoretical value, since the authority available through the guardianship laws is often inadequate, and the procedures are discouraging.²⁵

In California, conservatorship provides continuous control and monitoring of patients who need social controls while also providing adequate legal safeguards. Conservatorship is granted by the court for one-year renewable periods for patients found gravely disabled (that is, as a result of mental disorder, they are unable to provide for their basic needs for food, clothing, and shelter). Patients under conservatorship may be hospitalized when necessary, and for an indefinite period; their money may be managed when they cannot manage it themselves; and they may be compelled to live in a suitable community residential facility that meets their needs for care and structure. Such a facility may be a board and care home or, if needed, a locked skilled nursing facility with special programs for psychiatric patients, as exists in California.²⁶

Why is greater use not made of conservatorship? Among the problems are bureaucratic obstacles, the opposition of some lawyers, and the lack of recognition by mental health professionals of the need for ongoing controls of patients who are in the community. A major problem here, as well as in emergency commitment, has been the narrowness of the definition of grave disability. This definition should be expanded to include those who are currently able to provide for their basic needs but have a history of repeatedly suffering substantial mental and physical deterioration whenever involuntary treatment is discontinued.

The system also needs a new treatment philosophy. Ideally, this new philosophy should recognize that external controls, such as conservatorship, are a positive, even crucial, therapeutic approach for those who lack the internal controls to deal with their impulses and to organize themselves to cope with life's demands.²⁷ Such external controls may interrupt a self-destructive, chaotic life on the streets and in and out of jails and hospitals.

25. Peele, Gross, Arons, & Jafri, *The Legal System and the Homeless*, in AMERICAN PSYCHIATRIC ASS'N, *supra* note 5, at 261.

26. *See supra* note 2.

27. Lamb & Grant, *The Mentally Ill in an Urban County Jail*, 39 ARCHIVES GEN. PSYCHIATRY 17-22 (1982).

In California, conservatorship has become an important therapeutic modality. This is particularly true when conservators are psychiatric social workers or persons with similar backgrounds and skills who may become a crucial source of stability and support for chronically mentally ill persons. Conservatorship thus enables patients who would otherwise be long-term residents of hospitals to live in the community and achieve a considerable measure of autonomy and satisfaction in their lives.

Other promising modalities are commitment to outpatient treatment²⁸ as an alternative to involuntary hospitalization (so long as the patient complies with treatment, he can remain in the community) and, when the criminal justice system is involved, treatment as a condition of probation.

CONCLUSION

Suppose I were acutely or chronically psychotic to the point of incompetency to make a decision about treatment and were living on the streets, vulnerable to every predator, eating out of garbage cans, and in and out of jail. I would fervently hope that the agent of society who saw my plight would not simply tell me that I have a right to live my life that way but instead would do something to rescue me—"against my will" if necessary. Society owes us that much.

Thus, the mentally ill have another crucial right. When, because of severe mental illness, they present a serious threat to their own welfare or that of others and at the same time are not able to ask for or even to accept treatment, they have a right to involuntary treatment. Not to grant them that right is inhumane.

28. See *supra* note 23.