CLIENTS OR PATIENTS?: A STUDY OF BOUNDARY CROSSING IN A STATE PSYCHIATRIC CENTER

Hussein M. Ibrahim

Submitted in partial fulfillment of the requirements for the degree of Doctor of Social Welfare in the School of Social Work

COLUMBIA UNIVERSITY
1983

D. S. W. converted to Ph. D. in 2011
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ABSTRACT

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An increasing number of clients are seeking admission to state mental hospitals to satisfy non-psychiatric needs. The study described this phenomenon, its possible causes and its consequences. The study draws profiles of these clients' characteristics, problems, needs, and level of functioning. Clients' expectations from the state hospital and differences between them and the hospital inpatient population are explored.

The study was conducted on a time sample of 100 clients who sought admission to a New York State psychiatric center. The client sample were found not in need of inpatient treatment and were referred to an emergency housing program. Data were gathered through structured and unstructured questionnaires, interviews with clients, staff, center officials, and the center's statistical and patients' records. Chi-Square Test and Spearman Correlation were used to test relationships between variables.

Study data indicated that:

- The majority of clients were young, white, single, males, unemployed, educated below high school level, and were living with a relative or a friend at the time they appeared for admission.
Client's self assessment and staff assessment of clients' needs suggested that housing and financial aid were significant to more clients than psychiatric treatment.

- Clients's self assessment and staff assessments of individual client's level of functioning indicated that the majority of clients were able and willing to live independently in community settings.

- The majority of clients sought admission to the psychiatric center expecting help with housing, financial and emotional problems in that order.

- Client sample and patients admitted to the center during the same period did not differ significantly with regard to age, sex, race, religion and marital status. The two populations differed in admission status, educational level, employment status, and sources of referral to the Center.

The study recommended a clear boundary distinction of psychiatric and non-psychiatric services and that psychiatric admission be based on psychiatric rather than social factors. The study also recommended several policy and planning options in dealing with the problem. A major option was the initiation of local personal social service centers to service clients with non-psychiatric problems.
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CHAPTER I

INTRODUCTION: PSYCHIATRIC SERVICES AND SOCIAL SERVICES
THE BOUNDARIES QUESTION

For the past two decades scholars and practitioners have been debating the boundaries of psychiatry as a medical specialty and the scope of community mental health services in general.¹ In the United States this debate has dominated professional forums and journal articles since the enactment of the Community Mental Health Centers (C.M.H.C.) Act in 1963.

At the time the C.M.H.C. Bill was enacted, disease was perceived by many mental health professionals as a socially defined condition and mental health was conceived as a social problem.² The established Community Mental Health Centers, as Duhl and Leopold indicate, reflected "the expansion of the mental health world's system conception to include non-mental illness concerns but continued to rely upon psychiatry as the ruling discipline for the


²Duhl and Leopold, "Mental Health and Political Science," Ibid., p. 3.
Centers. Duhl and Leopold, two prominent psychiatrists, held that social problems cannot be solved by any one organization, whether headed by psychiatrists, social workers, or educators. They advocated a system's approach for service delivery in which "not any one program has a larger impact, but rather that all programs together have a greater impact." Duhl and Leopold also recommended in the 1960's that the NIMH take the final step away from psychiatric concerns into a broad strategy for mental health which "acknowledges that a dollar's worth of effort in low-income housing may pay off more than a dollar invested in psychiatric treatment."

Opponents of this view, argue that the remedy to social problems does not lie in psychiatrists abandoning their medical model and adopting an ecological one. Such a view suggests that psychiatrists should concentrate their efforts and expertise in treating mentally ill individuals and leave non-psychiatric problems for other intervention systems.

Another basic assumption of the C.M.H.C. Act, namely, the comprehensive service concept, was recently challenged. This assumption suggests that by integrating all community services under one C.M.H.C., "the high risk members of the community, whether patients or potential

1 Ibid., p. 11.
Patients, would not get lost somewhere along the line to the same isolation and helplessness that had originally helped to produce the illness or the probability of illness.\(^1\) Opponents refute this assumption on three grounds. The first is the lack of scientific evidence to indicate that ecological factors cause mental illness. Wing elaborates on this point and suggests, "...to think that schizophrenia will be prevented in a society where everyone is well-housed is to indulge in fantasy."\(^2\) Second, the findings of the labeling theory\(^3\) imply that by placing community services under psychiatric and mental health banners, clients of non-psychiatric services will be considered as patients. The end result is a mental illness public stigma that will haunt these clients for a prolonged period of time. Finally, opponents suggest that there is no need to argue that poverty, unemployment or bad housing cause psychiatric disorders in order to initiate social action to deal with these problems.\(^4\)

Proponents of Community Mental Health (C.M.H.) meanwhile, advocate a boundary definition that identifies a given community with its needs for treatment as well as preventive programs. A basic characteristic

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\(^1\)Duhl and Leopold, op. cit., p. 16.


\(^3\)See, T. Schiff, _Being Mentally Ill_, (Chicago: Aldine, 1966) for explanations and the rationale of the labeling theory.

\(^4\)J.K. Wing. op. cit., p. 228.
of the C.M.H. orientation is an emphasis on a total community or population rather than individual patients.\(^1\) According to this view psychopathology does not always arise from within the individual patient. Consequently, Community Mental Health Centers should identify sources of stress within the community and provide indirect services such as consultation, education and preventive programs to deal with such stress.\(^2\)

There are also differences in perceptions of the causes of individual problems. Bloom refers to these differences and suggests that "while the clinician has hardly any alternative to assuming that the locus of a problem lies within the individual, the community mental health professional has the option of assuming that the locus of human misery is within the social system itself - that human misery is created by the community."\(^3\)

Community mental health as a categorical option is credited as being sensitive and responsive to the special needs of ethnic minorities. In that regard, Miller agrees with Bloom that by its emphasis on prevention, community mental health "decreases the stigma frequently associated with the view of ethnic minority groups as 'high risk populations' and encourages the attention given to 'high risk situations'".\(^4\)


\(^2\) Ibid., p. 2.

\(^3\) Ibid., p. 234.

The question of the scope of mental health services leads directly to the boundaries question. The boundaries question is highly dependent on the practitioner's level of intervention. At the micro level, clinicians and case workers are more concerned about individual clients or patients who are brought to their attention. At this level, mechanisms which allow patients or clients to manipulate the system to satisfy their needs are considered more acceptable than efforts to identify service boundaries which may not permit such manipulation to occur.1

Meanwhile, many practitioners are likely to encounter the boundaries question as they move from the micro to the macro level of intervention. Policy analysts, social planners and administrators have to deal with the boundaries issue as part of the process of identifying the problem and the target group of any given program. Some practitioners, though, may still prefer not to deal with the boundaries question at any level of intervention. The avoidance of dealing with the boundaries issue leads to what Dunham identifies as "... ideas following money rather than ... money following ideas."2

Participants in and witnesses of the continual mental health debate would agree that the question of boundaries between psychiatric and non-psychiatric services remains a dominant issue. This study is


an attempt to explore some aspects of such boundaries as perceived by clients as well as providers of public psychiatric services. In more explicit terms, the study explores the problems, needs and expectations of individuals who attempted to cross boundaries of the public psychiatric treatment system in order to satisfy their needs for such non-psychiatric services as housing. The study also examines the policy and professional decisions which facilitate boundary crossing from psychiatric services for non-psychiatric needs.

The boundary crossing phenomenon is explored through the use of a state mental hospital (currently called a psychiatric center) as a point of entry to the state psychiatric inpatient treatment system.

Presently, providers of mental health services at the three levels of government are under economic and political pressure to re-examine their service priorities and define their "population at risk." This fact was clear in a recent New York State Office of Mental Health Plan. The plan states that "with economic resources being so scarce, it is critical that the office clearly identify and functionally classify those populations appropriately served by the public mental health system."¹

In general, the boundaries issue is of immense importance to those who are concerned about a service delivery system which recognizes the different needs of its users. The boundaries question also, as Kahn suggested, "...both reflects and creates

¹Five Year Comprehensive Plan for Mental Health Services, New York State Office of Mental Health, 1983, p. 66.
problems, and the way in which it is handled makes a substantial difference to those whom the practitioner would help."\(^1\) As will be illustrated in a later chapter, there are indications that the boundaries of state inpatient psychiatric treatment are frequently crossed by clients whose primary needs are social services such as housing, income maintenance, non-psychiatric medical care and personal social services in general. The purpose of this study is to explore this phenomenon and recommend some alternatives for dealing with it.

The current investigation as seen from a planning perspective is a 'case' study in boundary crossing by clients whose primary needs are not inpatient psychiatric treatment. The subjects of this investigation are clients who sought or were brought to be admitted to a state psychiatric center and were found not in need of such admission. Further, these clients were found to be in need of temporary or permanent housing at the time they appeared for admission.

During the past five years, starting with President Carter's Commission on Mental Health Report in 1978, new federal, state and local mental health plans were initiated. A review of these initiatives as they relate to the boundaries of public mental health services is in order.

1. The Federal Initiatives:

A preliminary report of President Carter's Commission on Mental Health indicated that:

America's mental health problem is not limited to those individuals with disabling mental illness and identified psychiatric disorders. It also includes those people who suffer the effects of a variety of societal ills which directly affect their everyday lives. Vast numbers of Americans experience the alienation and fear, the depression and anger associated with unrelenting poverty and the institutionalized discrimination that occurs on the basis of race, sex, class, age, and mental and physical handicaps. The Nation must realize the terrible emotional and mental damage that poverty and discrimination cause.¹

The Commission's final report did not define mental illness. The report stated that "opinions vary on how mental health and mental illness should be defined."² The Commission's task panel on deinstitutionalization, rehabilitation and long term care classified mental disability according to duration of disability and severity of disability. Using these combined continua, the panel defined the chronically mentally disabled as those people who are severely and persistently ill. They constitute "the people who are, have been, or might have been in earlier times, residents of large mental institutions."³

¹A White House memorandum dated Sept. 1, 1977 from Thomas E. Bryant Chairman of the President's Commission on Mental Health to the President titled "Preliminary Report to the President from the President's Commission on Mental Health," p.2.


Meanwhile, the Commission's panel on planning and review suggested that among the basic problems in mental health planning is the health planner's tendency to view mental health as a categorical special interest group rather than a major sector of the health delivery system. The panel recommended that government guidelines for the preparation of the State Comprehensive Mental Health Services Plan should be amended to permit the development of a consolidated four components plan that includes health, social services, rehabilitation and education.

A Mental Health Systems Act (MHSA) was also enacted into law in October 1980 (Public Law 96 - 398). The MHSA requires that Community Mental Health Centers focus their attention on the needs of chronically mentally ill individuals (Section 101). MHSA also requires that states which receive federal funds through Title II administer a program of services for chronically mentally ill individuals who have been discharged or diverted from inpatient facilities (Section 305).

In December 1980 the U. S. Surgeon General's Office released a 457 page report entitled Toward a National Plan for the Chronically Mentally Ill. The report, which was requested by President Carter's

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1Ibid., p. 247.

2Ibid., p. 254.


4Ibid.
Commission on Mental Health, made a concrete effort to "establish the objective boundaries of the chronically mentally ill population" by means of illustrative cases.¹ The report further referred to the clinical and social factors that contribute to what we call the boundary crossing phenomenon involving the turning to psychiatric services for non-psychiatric needs. In an attempt to delimit the target population, the report suggests that

Broadly speaking, a chronic condition is characterized by a long duration of illness, which may include periods of apparent well-being interrupted by flare-ups of acute symptoms, and secondary disabilities. This simple characterization is applicable to chronic mental illness, but the task of identifying persons who are chronically mentally ill is not at all straightforward. Although it is true that most such persons are, have been, or might have been...on the rolls of long-term mental institutions, especially State hospitals', any attempt to specify the attributes of State hospital patients must take into account the complex nature of clinical judgments about these patients. Moreover, it has been historically true at times that many members of racial and/or ethnic minority groups have been hospitalized for nonclinical reasons, such as lack of community resources or social controls, or have been misdiagnosed because of racial and/or ethnic biases on the part of service providers.²

The report adopts Minkoff's³ distinctions between persons who are severely mentally ill as defined by diagnosis, those who are mentally disabled as defined by level of disability and those who are

¹Ibid., Section 2, pp. 1-4.

²Ibid., p. 5.

chronic mental patients as defined by duration of hospitalization. Accordingly, the report estimated the number of the chronically mentally ill in the United States between 1975 - 1977 to be 1.7 million patients. This number represents 24 percent of the population who are identified in all the three dimensions of chronic mental illness during the same period. The following figure\(^1\) which was included in the report illustrates this point:

\[\text{THE DIMENSIONS OF CHRONIC MENTAL ILLNESS: DIAGNOSIS, DISABILITY, DURATION: WITH POPULATION ESTIMATES}\]

\[\text{CHRONICALLY MENTALLY ILL}\]

\[\text{THE TARGET POPULATION}\]

\(^1\text{Toward a National Plan, op. cit., Section 2, p. 6.}\]
Immediately after it was published in 1981, this federal report was criticized by Talbott in a leading psychiatric journal. Talbott suggested that the report should not have excluded the moderately mentally disabled group from the plan's target population.¹

In summary, our brief review of the recent federal planning initiatives indicates an awareness of the need to define the target population of psychiatric and mental health services. Such initiatives, however, do not include explicit mandates or recommendations that delimit the boundaries of psychiatric services and their population.

2. The State Initiatives:

New York is the site of our review of the current mental health planning scene as it relates to the boundaries issue.

Historically, the State of New York assumed full responsibility for its mentally ill citizens by the end of the nineteenth century. This action was taken after local communities failed to provide humane treatment and shelter for those citizens. The state system was based on asylums and later mental hospitals. In time the system developed into an autocratic style of operation.² The Department of Mental Hygiene came into existence in 1920 and inherited the system.

In 1927, the first state mental health law went into effect.


and in 1954, after the passage of the Mental Health Act, the Department of Mental Hygiene scrutinized local programs and activities, but no major changes were made. Politically, the department policy favored a "senior-junior partnership with the communities rather than total integration of state and community mental health services under a single local government unit."¹

The recodified Mental Hygiene Law in 1972 dealt with the issue of sharing the responsibility between the state and local government. This law became effective on January 1, 1973. It repealed the Mental Hygiene law which had been in effect since 1927. Article I of the law stated the policy directions as follows:

The state and local government shall share responsibility in accordance with the provisions of this chapter, for developing plans, programs, and services for the care, treatment, and rehabilitation of the mentally retarded, the mentally ill. . . ²

Also enacted in 1973 was the Unified Services Law. This law provided the mechanism for carrying out the principles expressed in the Mental Hygiene Law and made it possible to complete the development of a single system of state and local services in the field of mental health. Under Unified Services, the state and local communities share the cost of providing mental health services according to a specific formula, regardless of who is providing the services. In addition, Unified Services contains provisions for joint state and

¹Ibid.

²New York State Mental Hygiene Law, a reproduced copy issued by the New York State Department of Mental Hygiene, 1974, p. 2.
local planning of a single system of service designed to eliminate duplication and to expand the variety and the number of needed services. The intent was to facilitate the client's movement between appropriate programs regardless of the funding source or jurisdiction.

During the same year (1973) another law (Senate bill 10538) mandated that the state reimburse localities for 100 percent of the cost of mental hygiene services rendered in accordance with the approved local services or Unified Services Plan (USP) for persons who were patients or residents of Department of Mental Hygiene facilities during the period from January 1, 1969 through December 31, 1973. The purpose in a more basic sense was to avoid local resistance to deinstitutionalization through guarantees that cost would not be transferred by the state to localities. This legislation was to provide full support for lifetime care if necessary to discharged long term residents or patients. Under a companion bill (Senate bill 10537) the state assumed for a five year period the cost of public assistance and social services for persons who return to the community after five years of institutionalization.1

At the time President Carter's Commission on Mental Health Report was published in 1978, a new amendment to the Mental Hygiene Law in New York State went into effect.2 The new amendment reorganized the Department of Mental Hygiene into three offices: Mental

1 New York State Department of Mental Hygiene, 1974 Annual Report, June 1975, p. 3.

Health (OMH), Mental Retardation (OMR) and Alcoholism and Substance Abuse (OASA). According to the amendment, the Division of Mental Health became responsible for "comprehensively planned care, treatment and rehabilitation of the mentally ill citizens of the state."¹

The 1978 Amendment identified the state policy with reference to mental health and states:

The State of New York and its local governments have the responsibility for the prevention and early detection of mental illness and for the comprehensively planned care, treatment and rehabilitation of their mentally ill citizens. Therefore, it shall be the policy of the state to conduct research and develop programs which further prevention and early detection of mental illness; to develop a comprehensive, integrated system of treatment and rehabilitative services for the mentally ill. Such a system should include, whenever possible, the provision of necessary treatment services to people in their home communities; it should assure the adequacy and appropriateness of residential arrangements for people in need of services; and it should rely upon improved programs of institutional care only when necessary and appropriate.²

Accordingly, a 1978 plan was initiated by the Division of Mental Health to meet the "needs of the chronically mentally ill who can live in the community instead of institutions, if they are provided with community support services."³ The plan is said to be necessary for legal, economic, and moral reasons. Legally, the federal courts have ruled in class actions that people in mental hospitals are entitled to be treated in the least restrictive environment appropriate to

¹Ibid.
²Ibid.
³Appropriate Community Placement and Support, Phase One: Five Year Mental Health Plan, New York State Department of Mental Hygiene, Division of Mental Health, 1978, p. 11.
their needs and that those who require institutions must be provided with appropriate and effective programs. Economically, Medicare and Medicaid funds are conditional upon meeting federal regulations which require periodic determination of medical necessity and which also impose construction and staffing requirements for intensive treatment but not for custodial care. Morally, it was mentioned that since the needs of the chronically mentally ill are known and community support alternatives to institution living are identified, efforts should be made to meet these needs.

There are indications that the OMH exercised a great deal of caution and restraint in drafting its first plan. To illustrate this point, the plan's goals were to fulfill the federal legal requirement that the patient should be treated in the least restrictive environment (deinstitutionalized) and also to meet the federal Medicaid and Medicare requirements even though these requirements favor institutionalized care. Although the two goals are conflicting, the state plan did not take a stand on the issue. The premise was to comply with both demands.

Policy analysts such as Benveniste would argue that the state plan could be viewed as an imperative exercise which is adopted to the federal government/political or administrative mandates. The risk involved in the state plan is that it contributes to the legitimatization of federally mandated conflicting goals (institutionalization and deinstitutionalization) rather than suggesting ways to deal with this apparent conflict.

The 1978 state plan defined the chronically mentally ill as those who remain socially disabled after being treated for mental illness in private or public hospitals and those who "because of a combination of disabilities and poverty may be unable to manage their lives well enough to independently maintain their daily functioning." As such, mental illness according to the plan was not confined to specific symptoms but tied to the person's functional level. It implied that those who are in need of help to maintain their daily living are among the mentally ill.

The plan focused on the placement of patients whose current residence within the state hospital is no longer appropriate, and securing appropriate service for those previously placed without access to programs adequate to meet their needs. The overall goal was to "assure that all of our mentally ill citizens be successfully reintegrated into the mainstream of society." It was suggested that Phase II of the plan would deal with control of admission rates to avoid recurrence of the backlog in patients' census. The two plans in combination were expected to help control the input into facilities (admissions) and the output from facilities (separations and discharges). The second undeveloped phase of the plan that deals with regulating admission was not an integral part of the original plan.

1Appropriate Community Placement and Support, op. cit., p. 2.
2Ibid., p. VIII.
It is conceivable, in view of court orders, confusion in diagnosis, and community pressures that many people with problems who do not belong in state hospitals get access to their beds. The result is that "new patients" replace those that the state was trying to discharge to community care settings. The 1979 OMH Plan acknowledged this fact and stated that "census reductions will be achieved more through admission diversion than through discharge or 'deinstitutionalization.'" (emphasis provided). It is our firm belief that major gains can be made by preventing people from becoming state hospital clients in the first place.1

At one point, the plan seems to identify admission diversion as diverting clients from state hospitals to local general hospitals. The plan further states that "It should be noted that there may be some economic gains which occur from the success of such a strategy, given that the adult patient in the psychiatric hospital is not a Medicaid recipient but would become so in a general hospital setting."2 Other options for admission diversion mentioned in the plan are emergency housing, nursing home bed reservation and geriatric and non-geriatric mobile screening teams.3 The plan identified emergency housing as a short-term respite from crisis in cases where hospitalization per se is not clinically indicated. The "bed reservation program" is intended for diverting geriatric admissions. It includes the holding

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2Ibid., pp. 47-48.

3Ibid., p. 48.
of 800 beds in Long Term Care facilities with a guarantee that the QHR facilities will readmit the diverted patient if necessary and will provide direct and consultative service in the Long Term Care facility itself.¹ According to the plan, the geriatric and non-geriatric mobile screening teams are expected to provide case findings and assessment in the general population and referrals to geriatric and other facilities such as day treatment as needed.² The teams are also expected to provide community-wide consultation to non-psychiatric long term care providers.

The OMH 1980 Five Year Plan introduced what may be interpreted as its service boundaries under "Mission." The plan states that

In the face of limitless expectations and limited resources we must give priority to persons who are at risk of becoming socially and/or vocationally dysfunctional as a result of mental illness. It is, therefore, the policy of the OMH to direct its energies and resources primarily to that component of the general population whose disabling conditions interfere with normal role function. It is the mission of the agency to develop for geographically defined populations a network of care services programs of sufficient capacity and scope to provide services for this target population. Such services are to be targeted for unserviced, underserviced and inappropriately serviced populations, especially children and youth, the aged, the chronically mentally ill, racial or ethnic minorities, poor persons and persons in rural areas.³

It is noticeable that the boundaries outlined in the 1980 plan are broad enough to make the OMH 'mission' impossible to accomplish under

¹Ibid., p. 54.

²Ibid., p. 62.

existing monetary restraints. The stated mission, however, could be better understood in light of the fact that the state is gradually assuming more financial responsibility for the local community mental health centers. Since 1974, fourteen of these centers have "graduated" from federal to state and local funding. As a result, the boundaries of these centers became an integrated part of the "mission" of the State Office of Mental Health.

The plan also outlined the OMH progress in initiating alternative living programs. These programs were designed for the purpose of preventing unnecessary hospitalizations and to facilitate the discharge of patients who no longer need inpatient treatment. The stated first objective was "to prevent hospitalization for individuals experiencing a residual interpersonal, economic, or other types of social crisis." The plan lists among living alternatives, crisis residences which were designed to prevent unnecessary admission to inpatient services, particularly in cases where individuals are seeking admission because of housing, familial, or economic crisis.

The OMH Plan for 1981, again underscores the need for admission diversion in light of findings of a study conducted by its Bureau of Program Evaluation. The study was conducted on a sample

1Ibid., p. 77.
2Ibid., p. 110.
3Ibid., p. 112.
of admissions at 11 psychiatric centers. The results indicated that 22.6 percent of those admitted might be appropriately served in either "rehabilitative psychiatric environments or other current community programs." The study also suggested that a "variety of community support services, notably day treatment and emergency housing programs, among others, would have prevented the presentation for admission in approximately half of the cases screened." According to the study, the factor most predictive of admission was prior admission (emphasis provided). These findings implied that an error in a first admission is likely to result in a higher possibility of repeated readmission errors. The OMH study recommended that "pre-admission screening must revert to hands better able to consider diversion to other alternative forms of care." The study also recommended that a range of special and generic services must be available to effect suitable alternatives and that local assistance must assume a more active diversionary role.

The state plan for 1982 included among its implementation activities drafting, listing and finalizing criteria for admission to and discharge from state psychiatric centers. The plan further suggested

1Ibid., p. 28.
2Ibid., p. 29.
3Ibid., p. 29.
that lack of sufficient housing and community support services makes clients' maintenance in the community more difficult and, in turn, inflates readmission rate at inpatient facilities.1 The plan also referred to the ripple effects of federal cuts in generic human services that are "mainstays of the mentally ill living in the community."2

The OMH 1983 plan indicated that "methods of estimating the prevalence and incidence of mental illness in society and the need for mental health services are neither exact nor uniform."3 However, the plan adopted a National Institute of Mental Health estimate of annual prevalence of mental illness (number of people in a defined geographic area who are mentally ill at a point in time) as 15 percent or 2.7 million citizens. Ten percent of that number or 1.8 million citizens are identified as in need of services from the public system of mental health care.

In introducing the 1983 plan the Mental Health Commissioner noted that for the first time in more than twenty years there had been virtually no reduction in the census of state operated adult inpatient psychiatric centers. He attributed this phenomenon partially to "the secondary effects of unemployment which often

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1Ibid., p. 15.

2Ibid., p. 16.

3Five Year Comprehensive Plan for Mental Health Services: 1983, op. cit., p. 22. We noted that up to 1982 the State Office of Mental Health titled its plans as ". . ." "Plan for Services to the Mentally Ill Persons"—only the most recent plan was titled " . . .Plan for Mental Health Services."
precipitate admissions to psychiatric services among those who are already vulnerable to mental illness.\footnote{Ibid., p. 11.} The plan listed, among the objectives which are yet to be achieved, the integration of service delivery systems or the mainstreaming of mentally disabled individuals into the generic service systems. The plan indicated that in spite of significant efforts in that direction many services remain not accessible to former mental patients. As an example, the plan reported that "...although approximately 2,000 residents of state inpatient psychiatric facilities could be considered for primary skilled nursing or health related levels of care, it has been possible to place only one out of ten of these individuals from psychiatric centers into generic skilled nursing and health related facilities during 1981."\footnote{Ibid., p. 20.}

In the area of coordination between mental health services and social services, the 1983 plan indicated that the OMH and the Department of Social Services would establish an interagency agreement delineating their respective roles and responsibilities and those of their regional and local counterparts in the discharge planning process and the provision of community service to discharged patients.

The plan also referred to the OMH initiatives in the area of housing during the past five years. These initiatives resulted in an appropriation of $200,000 by the U.S. Department of Housing and Urban
Development to assist former OMH patients in meeting their housing needs.¹

Among the initiatives reported in the 1983 plan was Chapter 322 of the State Finance Law which was enacted in 1982. Chapter 322 allows the state to take over responsibility for paying the local Medicaid share. This responsibility included Medicaid costs for mentally disabled. At the local level predictions were that Chapter 322, according to OMH planners, would have a positive influence on the office’s efforts to encourage community-based services for the mentally ill.

For the next five year planning cycle, the 1983 plan recommended among other objectives the establishment of admissions and discharge criteria related to functional level.² The plan also recommended the “development of criteria for what constitutes serious mental illness.”³

In summary, over the past five years the state mental health planners have shown awareness of the boundary crossing problem and the importance of admission criteria that can better identify the population at risk. However, there is no evidence of any concrete planning or programming efforts that signify a change in the state policy regarding this issue. State planning efforts during the past five years have been directed toward discharge planning according to

¹Ibid., p. 38.
²Ibid., p. 67.
³Ibid., p. 71.
level of care surveys, or what we may call planning for the "output" of the state psychiatric facilities rather than the "input" to these facilities. It was also noted that the state's awareness of the boundary crossing problem was motivated by cost containment rather than clinical or service considerations. Cost containment may make it necessary for the state to restrict admissions to its psychiatric services to only those who can benefit from inpatient treatment. This action will result in census reduction. It has been estimated that a census decline of only one percent could result in a $3.2 million reduction in salaries alone by eliminating 200 positions.

State mental health officials are also concerned about the undesirable consequences of the current admission policy on third party reimbursement. Addressing the directors of state psychiatric facilities, the outgoing Commissioner of Mental Health voiced this concern and stated "...having failed to deliver on promises of global success, and having diluted its response to the truly mentally ill, the profession now suffers from a loss of credibility in the public's eye. The question now being asked by government and third party payers is why should treatment of those that may not be sick, or treatment perceived of as inconsequential, be supported."\(^1\)

There are reasons to believe that strict admission criteria may have little effect in reducing psychiatric admissions in state.

\(^1\)Ibid., p. 58.

hospitals unless needed social services are made available in the community. Okin¹ pointed to the relationship between the reduction in human services and hospitalization in state facilities. He cited as an example recent findings that showed an increase in the census waiting lists of some state hospitals in California a year after the enactment of Proposition 13. Proposition 13 which reduced the amount of property taxes available to counties resulted in cuts and reduction of many community services such as parks, recreation, libraries, probation services and supplemental school programs.²

3. The Local and State Hospital Scene:

State psychiatric services are provided at the local level in state mental hospitals or under their authorization in other community settings. Boundaries of state psychiatric services is a subject of constant controversy between state and local governments. The controversy erupts once a social problem becomes more visible and questions about government intervention are raised.

The problem of the "homeless" in New York City is an illustrative example of the state psychiatric service boundaries controversy between the state and local governments.

The plight of the homeless in New York City came to public focus after the Community Service Society of New York published a field report.


study about the problem in early 1981. The thrust of the study was to shift the focus of the problem from rehabilitation to welfare. Baxter and Hopper argued that "until basic needs have been met and the state of dependency granted some measure of dignity, rehabilitative efforts are premature and of limited value to homeless individuals."\(^2\)

The publication of this study resulted in concentrated media attention on the problem. Public hearings throughout the city demanded immediate action by the city and the state. A lawsuit was filed by a lawyer representing a group of homeless men against the City of New York. As a result, a state supreme court judge ordered the City to provide "a comprehensive plan for sheltering homeless men during the winter."\(^3\) Since the publication of this study, the issue of who should provide housing to the homeless and former mental patients has become a subject of intense public debate in New York City. City officials charge that as a result of the massive discharge of patients from state hospitals and tightening of admission criteria while failing to provide adequate community services, the state has flooded city streets with thousands of homeless individuals wandering aimlessly. City officials also argue that state policies of admission


\(^2\)Ibid.

and discharge of its mental patients further resulted in overcrowded municipal and voluntary hospitals and escalating costs to the city as it attempts to serve this population. A director of one of the city hospitals complained that a state hospital sends a screening team to the city hospital once a week to interview all of the patients over 60 years old who were recommended for transfer to the state hospital. The team rejects about half on the basis that the patients are not psychotic but senile. In this director's view, senility is a form of organic psychosis, and as such all recommended patients should be accepted by the state hospitals team.¹

A city comptroller's audit report also suggested that "the only beneficiary of the state's effort to send mental patients back to their local communities has been the New York State Treasury."²

State officials meanwhile suggest that the city argument is misleading. Their counter-argument is that the city housing policy and financial cuts of social service programs are responsible for the plight of most homeless people. State Commissioners of social services and of mental health outlined the New York State position regarding that issue and suggested that:

Contrary to the City's allegation, deinstitutionalization of the mentally ill was largely completed in this state prior to 1975. Since then, the decline in the State hospital inpatient population has slowed dramatically, limiting itself almost exclusively to the natural death of elderly inpatients.

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Over the past year, for example, the census declined state-wide by only 3.3 percent but increased in New York City where it has remained relatively constant since 1976. Part of the New York City rise is attributable to a three percent increase in admission, an indicator that the State is not more restrictive in its admission policies. In contrast, admissions to municipal hospital psychiatric wards have steadily declined over the last five years.

Furthermore, a number of State, City and independent reviews of the population living in SRO hotels and City shelters have revealed that only 25 percent are former psychiatric inpatients. Even among the 'street people' the Goddard-Riverside Outreach Project which screens, assesses and serves people in Manhattan's highly impacted Upper West Side, has found that only 27 percent of those contacted have demonstrated obvious mental disabilities.¹

State mental hospital officials interviewed during the course of this study² agree with the state position regarding the homeless issue. There was a consensus among hospital officials that housing as such is not a mental health problem. For persons who are either homeless or having a problem locating housing within their own means, the hospital in their view should not be expected to serve as a last resort.

The director of the Creedmoor Hospital indicated in an interview that it is not the responsibility of the Office of Mental Health to provide housing for any one. He also suggested that the state mental hospital's


²Officers interviewed by the investigator for the purpose of this study are:
- Y. Havaliwala, M.D., Creedmoor Hospital Director,
- L. Goldberg, Ph.D., Creedmoor Hospital Deputy Director for Community Services,
- A. Maggio, M.A., O.T., Creedmoor Linkage Unit Division Chief.
role is to provide mental health care to those who need it and not to house homeless individuals. The director of community services at the same hospital emphasized the fact that even for former mental patients it is the State Department of Social Services (and not OMH) that is mandated by law to provide appropriate living arrangements for discharged patients, especially for those who lack a supportive network such as families or relatives. It is the responsibility of the state hospital according to this official to insure that discharged patients are receiving needed outpatient treatment and follow-up. This responsibility also includes the insurance that those clients are living in a humane and sane condition. The state hospital officials interviewed, all agreed that there should be a clear boundary distinction between psychiatric services and non-psychiatric or social services.

The hospital, as well as the State OMH officials current concern is the impact of the federal budget cuts on welfare, food stamps and CETA programs. This concern stems from the fact that the federal cuts are in benefits going directly to individuals. As such, the cuts in their view, limit the ability of former mental patients to maintain themselves in the community. The end result is an increase in the readmission rate of this group of clients.

Recently it has been noted by state planners that the bulk of admissions to state hospitals are readmissions. These readmissions increases reflected" a current trend by "patients who continuously present themselves for admission because of breakdown in the community"(emphasis added).¹

The Boundary Crossing Phenomenon:

In brief, a review of the current mental health planning initiatives at the federal, state and local levels suggests that these initiatives did not address the boundaries issue and its relevance to service delivery. The neglect of such an important issue contributed to what we call "the boundary crossing phenomenon." This phenomenon is exemplified by clients who—on their own initiative or the initiative of others—seek admission or readmission to public psychiatric facilities to satisfy non-psychiatric needs.

Our review of the literature (Chapter II) suggests that boundary crossing could be a direct result of clinical, organizational, economic and political pressures which impact on the admission process in public psychiatric institutions.

There is also evidence to suggest that users and providers of psychiatric services tend to succumb to the above pressures instead of developing new strategies to effectively minimize their impact. This latter point will be further explored in Chapter IX.

This study is an attempt to explore the boundary crossing phenomenon and its implications for service users and providers. The study was conducted on a time sample of clients who sought (or were brought in for) admission or readmission to one of the state hospitals in New York City and were referred to an emergency housing program. A total of 100 clients were interviewed during a 10 month period. Staff working with the client sample were asked their opinions about clients' problems, needs, and level of function. Study data are presented in detail in the following chapters (Chapter IV through Chapter
The study data indicate that clients who attempted to gain entry to psychiatric services to satisfy non-psychiatric needs (the study sample) were mostly young, white, single, male, unemployed and had an education below high school level. The majority of clients were living with a relative or a friend at the time they sought admission to the state psychiatric facility. The majority of clients were seeking readmission though they indicated that they were able to function independently, and the staff assessment confirmed this fact.

The clients ranked their problems in the following order: Housing, financial, family, work, emotional and medical problems. The staff assessment of clients' needs matched clients' identified problems with reference to housing and financial assistance as the first two priorities. Statistically, there was a strong relationship between the problems priorities identified by clients and assessed by staff ($r_a = .9$).

The majority of clients expected the psychiatric facility to provide them with temporary shelter and to help them locate a permanent housing arrangement. They also expected the hospital staff to assist them with their financial and emotional problems.

The data assembled confirmed one of the study's implicit hypotheses that some clients do seek admission and readmission to the public psychiatric facility to obtain help with non-psychiatric problems. The data also pointed out that though these clients did not differ in demographic characteristics from those who needed inpatient psychiatric treatment, they differed in other significant
areas such as employment status, educational level and source of referral to the hospital.

The study did not confirm another implicit hypothesis that all clients who seek or are brought for admission to state psychiatric facilities are highly dependent and low-functioning individuals. The majority of the clients sampled, though they were candidates for admission to the state hospital, were according to self-assessment and staff assessment, able and willing to live independently in community settings.

The current investigation underscores the need for a clear boundary distinction between psychiatric services and social services. Such a distinction is a prerequisite for any planning endeavor which deals with the boundary crossing phenomenon. We outlined how such a distinction could be drawn in a later chapter (Chapter IX).

The study recommends some options which allow psychiatric services to operate within their boundary limits (the treatment of mental patients). These options also insure that all clients receive the services they need. One such option is the initiation of a community-based service delivery center in each locality. The rationale for and the functions of these centers as well as anticipated implementation problems are outlined in Chapter IX.
CHAPTER II

PSYCHIATRIC DIAGNOSIS AND ADMISSIONS

1. The Problem in Perspective:

There are indications that psychiatric admissions are inappropriately granted to many persons who seek admission to psychiatric in/outpatient facilities.¹

Our discussion of the consequences of inappropriate psychiatric admissions does not imply, as other investigators have advocated, that all psychiatric admissions should be avoided. The failure to admit a client who needs psychiatric treatment has dire consequences for the individual's well being, his or her family and the community at large. Such consequences have been cited by Kahn,² Mechanic,³

¹Statistics on admission to mental health facilities in the United States indicate that more than fifty percent of the persons admitted to outpatient psychiatric facilities in 1975 did not have psychiatric disorders. These statistics also indicate that 2.6 percent of the persons admitted to inpatient facilities did not have psychiatric disorders.


An underlying assumption of this study, however, is that persons who are inappropriately admitted to psychiatric facilities will face the same undesirable consequences that face those who required such treatment. Throughout history people have tended to reject others with a current or past history of mental illness. A parallel can be drawn between imprisonment and treatment in a mental hospital. It is a fact that persons who are unfairly imprisoned are subjected to the same punishment in prison and resentment by the community that the real criminals encounter. Similarly, persons who are admitted to psychiatric facilities are stigmatized regardless of whether they were appropriately or inappropriately admitted. Empirical evidence even suggests that a past history of imprisonment is more acceptable to employers than a history of psychiatric treatment.\(^3\)

Inappropriate psychiatric admissions to state hospitals also inadvertently inflate the numbers of service users. Consequently, these numbers could be misleading to planners and policy makers in setting service priorities and allocating resources.

This brief review of the literature is intended to put the issue of psychiatric diagnosis and admission in a current perspective.


\(^3\) *Tbid.*
There are many undesirable consequences of psychiatric mis-diagnosis and admissions. One of the consequences that concerns us in this study is locking the person into a career of mental patient.

Gerald Gordon in his sociological study "Role Theory and Illness" makes a clear distinction between two roles which are associated with illness status, the sick role, and the impaired role. Each of these roles has a different set of behavioral expectations. The sick role in Gordon's view occurs when the prognosis is believed to be serious and uncertain. This role serves to insulate and protect the ill person. The impaired role, meanwhile, occurs when prognosis is believed to be known and non-serious. This role helps the person maintain normal activities and involvement. Gordon pointed out that the appropriateness or inappropriateness of the role response to the ill person can delay, prevent or promote recovery.

It is a common practice that some clients - like those who were interviewed in this study - be evaluated by the admitting psychiatrist as not in need of inpatient psychiatric treatment. However, they are diagnosed as mentally ill and are referred to outpatient clinics. Following Gordon's line of thinking one would classify such clients as being impaired and not sick to require


2Ibid.
hospitalization. The paradox, is that while the impaired role is expected to help these clients maintain normal activities and involvement, the mental diagnosis reinforces the sick role with its adverse consequences on the client's life. After being diagnosed as mentally ill, clinicians begin to enroll these clients in disability benefit programs. In order to get them enrolled, the psychiatrist has to certify that the client will remain disabled for a period of not less than a year. Such a statement makes the client eligible for Supplemental Security Income (SSI). Social workers are instructed to stress the client's disabilities rather than his/her strengths and to note in the Social Service Assistance (SSA) application that the client will not be suitable for competitive employment for at least one year.¹

Clients who are inappropriately diagnosed as mentally ill whether they are admitted to an in or outpatient treatment facility enter the role of a mental patient. In such a role the client's financial incentive to remain as a psychiatric patient is much higher than the incentive to function independently. As a result, instead of promoting recovery, the impairment role fosters disability and dependency. Recently, Esroff, an anthropologist, studied a group of clients attending a psychiatric community treatment program in Madison, Wisconsin. The findings of her study suggested that "...the clients are enmeshed in a complicated system oriented to psychiatric disability - a system

in which their identities or roles as crazy people are the means by which they "make it" or "survive." \footnote{Sue Estroff. \textit{Making it Crazy}, (Berkeley, Cal.: University of California Press, 1981), p. 38.}

Historically, this problem began after the 1960 and the 1962 amendments to the Social Security Act which extended the aid for the disabled (AD) provision to patients in and convalescing from mental hospital care. In Oct. 1972 the Supplemental Security Income (SSI) program was enacted as part of amendments to the Social Security Act and went into effect in Jan. 1974. Generally, SSI is perceived as a landmark effort by the Federal government to revamp its welfare programs for the aged, blind and disabled. \footnote{Paul L. Grimald. \textit{Supplemental Security Program}, (Washington, D.C.: American Enterprise Institute for Public Research, 1980), p. 1.} The program replaced poorly organized state operated programs for the aged, blind and disabled persons with more equitable welfare payments administered by the Social Security Administration. The program was also instrumental in providing states with fiscal relief from escalating welfare costs.

Our special concern is that SSI entitles individuals with a chronic mental illness to receive cash benefits that are in most places substantially higher than previously received through the welfare system.

We should again differentiate between two groups of clients who are using the SSI mental disability benefits. The first group consists...
of persons who are chronically mentally ill. For this group of clients the SSI program has highly positive consequences. SSI provides them with the financial means to support themselves outside the mental hospital. SSI payments also help this group to gain access to community living arrangements and become less of a financial burden on their families and relatives if they choose to care for them after leaving the hospital.

The second group of clients are those who gain access to SSI benefits as a result of misdiagnosis and inappropriate admission to psychiatric treatment. For this group of clients continued eligibility for SSI and other financial support programs becomes contingent upon their maintaining their sick status. Lamb and Rogawski suggest that such a status hampers vocational rehabilitative efforts even for those who were mentally ill; in their view

When one includes Medicaid, food stamps and the supplement to the basic Federal grants supplied by a possibility of pooling one's resources with another recipient, the standard of living may not be so low. It is not surprising that a large percentage of the mentally ill remain 'disabled' and totally (or almost so) dependent on SSI. Most of these persons could be rehabilitated only into low-paying sheltered employment or low-level jobs even if they succeeded in overcoming their fear of venturing forth into the world of work. Moreover, they fear that such employment will result in a reduction of their already marginal standard of living and fear that they will lose one of the cornerstones of what little security they have, their SSI status.1

Such a system could also undermine the already reduced motivation of many mental patients, both schizophrenic and non-schizophrenic,

who could benefit from rehabilitative programs. As a result persons who may need general relief only for a limited time of crisis find themselves propelled into a system where, despite the perfunctory yearly SSI review, they may remain for years or for life.¹

Ozawa and Lindsey's² analysis of the problems led them to conclude that the SSI in dealing with the economic well being of the disabled poor helped ameliorate rather than rehabilitate and return them to the "mainstream" of society. They suggest that the government is using SSI to solve a major problem, namely "an inability to provide employment opportunities to marginal persons by offering income support to those who are diagnosed as physically or mentally 'disabled' (emphasis provided)."³ They also pointed to the short run financial gains vs. the long run psychological and economic loss that clients suffer as a result of being enrolled as SSI disabled; in their view "elements of irony and tragedy combine in the relative ease with which a person can be diagnosed as schizophrenic — correctly or not — and placed on SSI, and the difficulty of moving off SSI because the label "schizophrenic" is commonly irreversible. The relatively greater economic incentive to stay on SSI than on other types of welfare programs, and wide community acceptance of the program, combine in gentle entrapment of the disabled who might otherwise strive for

¹Ibid., p. 1223.


³Ibid., p. 48.
recovery and reentry into the community."¹

This entrapment is frequently reflected in former mental patients' accounts of their experiences. As an example, a former mental patient writes:

When I was a patient, I recall being loaded into a bus with other patients and unloaded in Alexandria, Virginia, to shop with about $2.00 in my pocket. We were sent in pairs with explicit instructions to return to the bus within an hour. The discomfort attached to being publicly identified as a patient from the funny farm in a place I had previously toured with my friends, became a driving force to return to the bus. My greatest need upon release from the hospital was to be with 'normal' people, to be accepted in places where I had been before. I resisted and resented group identity for months as a former patient. From my perspective, we must be careful not to create chronic mental illness by building support systems that reinforce the problems.²

Although some patients may resist such entrapment, many would identify with it as their only means for survival. This fact was made clear in an investigative report on a former patient of a State hospital. In that report Susan Sheehan quoted the patient as saying "Being a mental patient really is my profession. I get room and board, fringe benefits like Medicaid and Medicare, and I get paid by SSA and SSI."³ This entrapment is fostered again by the public attitude toward mental patients. As Rabkin suggested "...

¹Ibid., pp. 51-52.


overall, it seems unlikely that people identified to the general public as mental patients by their appearance, manner, behavior or even perhaps reputation, will ever be actively welcome in close social or physical proximity."\(^1\)

Research studies on labeling further suggest that labeling an individual as mentally ill contributes to the manifestation of mental illness\(^2\) and that the powerless are most likely to be labeled as mentally ill.\(^3\) The effect of labeling as Morrissey and Tessler indicate is "to lock the person into a career in which mental illness becomes a major social role in a life typified by recurrent hospitalizations."\(^4\)

Another factor which is mentioned frequently in the literature is the impact of mental hospitalization. It has been suggested that organizations such as the state mental hospital rob the individual of his sense of self direction and ultimately damage the capacity for it. Virtue in such institutions consists in having no preference about many things, in eating whatever is put on the table, in wearing what one is told to wear, or going to bed and rising again.


\(^4\)Ibid.
according to instructions, in making the best of things. The good institution member does not make choices or decisions. He submits and permits himself to be carried along as it were in a "moral automobile." When he returns to civil life, his suddenly uncorseted soul seems flabby and incapable of standing alone.¹

A second consequence of inappropriate psychiatric admissions is the role it plays in misallocation of public funds and an unbalanced system of service delivery. Future projections of the needs for social services are normally based on the number of clients who seek such services through social service programs. These projections, however, could be in error when many of these clients are inappropriately locked in state mental institutions or are receiving such services after being labeled as mentally disabled. There are also indications that at times of high unemployment the number of admissions to mental hospitals increases.² A drop in the rate of unemployment at a time of recession may be a reflection of a shift from unemployment rolls to the mental disability rolls without an improvement in the rate of employment. Lindsey and Ozawa's research in this area indicated that the implementation of SSI made it financially advantageous for the client to be classified as "totally and permanently disabled rather than merely poor or


unable to find work because in this way he or she should be eligible to participate in the SSI program. They further argue that the SSI provision coupled with the easily obtained psychiatric diagnosis for determining mental disability were instrumental in escalating psychiatric admissions and the number of mentally disabled persons on SSI roles.

Recently, the Senate Finance Committee Report on the Social Security Disability Amendments of 1980 referred to the fact that disability criteria differ from one state to another. As a result, the report indicates "it is easier (or more difficult) to meet the disability definition depending on where you live." The Steering Committee on the Chronically Mentally Ill Report to the Secretary of the Department of Health and Human Services agreed with the Senate Finance Committee findings and added that

The current SSA (Social Security Administration) definitions of mental disability is difficult to apply with uniformity and accuracy. This situation exists not only because of reliance on inexact medical findings and evidence of non-defined social behaviors, but because the connection between mental illness and ability to work is difficult to determine. SSA has not developed definitive decisional tables for vocational capacity for the mentally disabled, as it has for the physically impaired.


2Ibid., p. 121.


4Ibid., pp. 3-7.
Lindsey and Ozawa agree with Braginsky, et al., that since state hospitals are filled with those who want to drop out, or who no longer accept the usual demands placed on them by society, the Federal government ought to "recognize the dropout for what he/she is,"¹ and that "there is no need to stigmatize or castigate the individual for not remaining in his or her position in society."²

If the Federal government decides to sustain those who drop out, this might be done more effectively without resorting to psychiatric labeling. In fact, requiring the application of label may be dysfunctional because the individual may be forced into a career or role from which it is difficult to exit.³

Eighty-five percent of those in our sample were either unemployed (54%) or not in the labor force because of mental disability (31%). Almost all of those clients expected the hospital to provide them with shelter or help them locate permanent housing. When clients were again asked about their expectations from the hospital with reference to problems they said they had, the answers were consistent. Eighty-seven percent of the sample expected help from the hospital with their housing problem, 59 percent expected the hospital to help them with their financial problems. This somewhat lower percentage of financial expectants could be attributed to the fact that 45% of the sample were receiving SSI benefits. A lower percentage of clients expected

¹ Lindsey and Ozawa, op. cit., p. 124.
² Ibid.
³ Ibid.
help with their emotional problems (51%) or family problems (31%). Though a majority of 65 percent were out of work only 39 percent expected help with work-related problems.

We are aware of other possible interpretations of these data. One such interpretation is that clients being diagnosed as mentally ill have no clear understanding of their needs. However, empirical studies and the investigator's personal observations suggest as Ludwig indicates that "patients have a far better understanding of our social value system with its inherent limitations than we have of their's, they can employ a repertoire of behaviors that function as a push button to elicit the desired staff or social responses; thereby ensuring the attainment of their goals."  

Holzberg may have summarized the issue of inappropriate psychiatric admissions elegantly when he suggested that "... in examining the large proportion of patients who seek the mental hospital as a refuge. ..." we may yet discover that for many people whom we have labeled schizophrenic, we are merely "psychologizing" the social phenomenon of poverty, discrimination, and powerlessness. ..." and "that there is more than the suggestion that for many such people


hospitalization may be the only alternative to such debilitating social conditions."¹

Thus, there are indications to suggest that it is important that we begin to recognize clients' social service needs as they are. Such recognition will make it unnecessary to subject those clients to what has been referred to as "the degradation ceremonial of psychiatric examination, diagnosis, and prognostication,"² and unwarranted costly psychiatric treatment as a prerequisite to meeting those needs.

Based on current practices, predictions of increasing use of mental health facilities such as made by Kramer³ could be viewed as self fulfilling prophecies. An increase in inappropriate psychiatric admissions results in exaggerated monetary allocations in this area. At a time of decreasing appropriations for social services, many clients in need of such services are left with no choice other than to accept them under a psychiatric Banner. The numbers of these clients are again used as a justification for more allocations for mental health services.

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²Braginsky, et al., Ibid., p. 184.

Recently, many psychiatrists have begun to question the wisdom of spreading the umbrella of psychiatry over problems of living. Clients with social service needs are being perceived as "using the role of psychiatric patients as a ticket into a system of services,"¹ or, "making it crazy as a means of survival."² Addressing his colleagues about the future role of the state hospital, a leading psychiatrist pointed to the fact that open for all admissions to state psychiatric facilities on humanitarian grounds are financially disastrous and clinically invalid. He called for more selective admissions based only on psychiatric determination. His rationale was that "you do not carry somebody's torch when it starts to burn your fingers."³

2. The Admission Process:

Legal and clinical criteria of psychiatric admission in general and in state hospitals in particular vary to some degree from one state to another. However, for the purpose of our study we used New York State laws, regulations and practices as a principal source of our data. Creedmoor Psychiatric Center admission procedures are used to illustrate


²Sue Estroff. Making it Crazy, op. cit.

how the state policy is implemented at the local level.

State Mental Hygiene laws in New York State set three categories of admission to hospitals for the mentally ill: informal, voluntary and involuntary. According to the state law an informal patient is one who requests treatment and is admitted without making formal or written application. A voluntary patient is one who voluntarily makes written application for care and treatment. If the person is under sixteen years of age, the person may be received as a voluntary patient only on the application of the parent, legal guardian, or next-of-kin of such person. These persons are treated in children's hospital.

If the person is over sixteen and under eighteen years of age, the hospital director may, at his discretion, admit such person either as a voluntary patient on his own application or on the application of the person's parent, legal guardian, or next-of-kin. In order for a person to be suitable for admission to a hospital as a voluntary or informal patient, or for conversion to such status, he must be notified of and be able to understand:

1) that the hospital to which he is requesting admission is a hospital for the mentally ill
2) that he is making an application for admission
3) the nature of the voluntary or informal status, as the case may be, and the provisions governing release or conversion to involuntary status.

1State of New York, Department of Mental Hygiene, Department Policy Manual (Sections 400.1 - 406), 1974 - 1975.
A patient may be admitted involuntarily through three methods: on medical certification and by two types of emergency admission—a certificate made by the director of community services or on an emergency basis for immediate observation, care and treatment. All involuntary patients must be "in need of involuntary care and treatment." This means that the person has a mental illness for which care and treatment in a hospital is essential and that ordinarily the person's judgment is so impaired that he is unable to understand the need for such care and treatment. In all cases of involuntary admission, the need for hospitalization must be confirmed by a hospital staff physician before the patient is formally admitted.

Involuntary admission involves those persons judged through any of the above methods to have a mental illness for which immediate care and treatment in a hospital is appropriate and which is likely to result in serious harm, to self or others. The law defines "likely to result in serious harm" to mean:

1) substantial risk of physical harm to himself as manifested by threats of, or attempts at suicide or serious bodily harm or other conduct demonstrating that he is dangerous to himself, or

2) a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm. The need for immediate hospitalization shall be confirmed by a staff physician of the hospital prior to admission.
The law gives the police the power to take into custody a person who appears to be mentally ill and is conducting himself in a manner which is likely to result in serious harm to himself or others (MHL 9.41). The police also may transport the person to a designated facility or detain him in a safe and comfortable place while notifying the county health or mental health officials (MHL 9.39).

In summary, the main distinction between the types of psychiatric hospitalization is voluntary or involuntary. Voluntary hospitalization implies a) the client has sought treatment willingly and without compulsion, b) the client must be "in need of care and treatment" at an appropriate facility and is not necessarily harmful or dangerous, c) the facility is under no legal obligation to admit, and d) the client may leave the facility without notice at any time.

Involuntary hospitalization, meanwhile, implies a) the client's behavior indicates the presence of a diagnosable mental illness, b) the client's judgement is impaired, c) there is a likelihood of serious harm to self or others, and d) once admitted, the client may not leave the facility without consent.

Our study sample was drawn from persons who sought voluntary admission or re-admission to a state psychiatric hospital, namely to Creedmoor Psychiatric Center. The main sources of referral for

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1Effective March, 1974 all state hospitals in New York State were renamed as psychiatric centers including Creedmoor. In practice, state hospitals and psychiatric centers are used interchangeably. We used the two names "Center" and "Hospital" interchangeably throughout this study.
admission to Creedmoor Psychiatric Center are, self, family, or friends, courts, psychiatric units in the city general hospitals, outpatient clinics, police, private physicians and psychiatrists, other mental hospitals, residential facilities and nursing homes, and other information and referral agencies. Creedmoor is designated as the state mental hospital for Queens County.

The Queens County map is divided into fourteen county planning board districts (Appendix 5). These districts are grouped into nine health catchment areas (A through I) (Appendix 5B). The nine health areas are again grouped into three administrative units: ABC, EFG, and EHR or Western, Central, and Eastern Queens.

According to the hospital policy manual and current regulations, Creedmoor accepts direct referrals for admission of persons who were discharged or screened out by the hospital within the past 90 days, on a 24 hour a day, seven days a week basis. Individuals currently enrolled as Creedmoor outpatients are screened for admission or readmission regardless of the length of time since they were discharged. The hospital also assumes a 24 hour screening of patients for emergency admissions from Eastern Queens and one of the community health planning districts which is not covered by the county general hospitals psychiatric emergency rooms.

Individuals who present themselves or are brought by others at a municipal emergency room can be directed to Creedmoor if they are willing and capable of voluntary legal status. Persons from Western, and Central Queens are not admitted directly to Creedmoor but rather through municipal hospitals. After municipal hospitals make a serious
attempt to treat such persons, they may transfer them to Creedmoor for further treatment. Voluntary clients from Western Queens and Central Queens, not treated as inpatients at Creedmoor for the last 90 days are referred to the appropriate city hospital (Elmhurst and Queens General Hospitals).

Voluntary admission of clients age 65 and over are administered by mobile geriatric screening and after care teams. These teams see clients in health related facilities, skilled nursing facilities or at Creedmoor. Persons in this age group who live in adult homes are screened by the Community Support Services (CSS) Team, a separate state funded project. All criminal procedure outpatients are referred to a forensic unit in the hospital grounds.

Spencer and Mattson outlined clinical criteria for admission to a psychiatric hospital regardless of the person's legal status. These criteria include at least one of the following:

1) the patient poses an immediate physical danger to self or others

2) the patient is unable to care for self, and others are unable to care for him

3) the patient is experiencing psychiatric symptoms or exhibiting deviant behavior, the magnitude of which is not tolerable to him or society. The patient's behavior is a serious threat to his adaptation to life, and hospitalization at this time is necessary to control this behavior

4) physical illness required hospitalization, physical care can be provided in a psychiatric unit, and an associated psychiatric condition cannot be handled as well elsewhere

5) the patient needs a specific form of psychiatric treatment that
can be provided only in the hospital."¹

We noted that both the New York State Mental Hygiene Law and Spencer and Mattson's criteria for psychiatric admission are based on diagnosis of symptoms rather than on the person's level of functioning. As we will point out later, state hospitals in New York State are currently using the patient level function as a basic criteria for assessing the need for inpatient treatment.

3. Causes for Inappropriateness in Diagnosis, Admission and Re-admission to State Psychiatric Facilities:

Literature review and the investigator's personal observations during a period of more than ten years as a psychiatric social worker in a large state hospital suggest that many clients with no psychiatric problems seek admission and readmission to in and outpatient psychiatric treatment facilities. When they present themselves or are presented by others, such clients are likely to be given a psychiatric diagnosis and are admitted or readmitted to the hospital or are automatically referred to outpatient psychiatric clinics. The causes for inappropriate admissions to state facilities and to psychiatric treatment in general, could be grouped under the following categories:

- The lack of a clear definition of mental illness.
- The lack of defined boundaries of psychiatric and mental health services.

- Professional and clinical judgment errors.
- Internal and external organizational pressures.

A brief exploration of each of the above categories is in order. Current definitions of mental illness vary significantly. At one extreme are those who think that mental illness is a myth that should not be identified as illness.\(^1\) At another extreme are those who suggest that mental illness is common among all individuals and that "health is a fictitious concept in the psychic stratum."\(^2\)

There is an ongoing philosophical, medical, ethical, sociological as well as political debate concerning mental illness and mental health. It is beyond the scope of this study to cover all view points of this debate. However, a brief discussion of the definitions of mental illness may help illustrate the dilemma surrounding this issue.

Earlier, we referred to the fact that the latest Presidential Commission on Mental Health did not offer a definition of the term mental illness and simply stated that "opinions vary on how mental illness should be defined."\(^3\) Lack of such a definition is sometimes attributed to the fact that concepts or bodies of experience such as


health and disease are too elusive to submit to definitions.\(^1\) Wylie in offering this rationale also suggested that "a neat but inadequate definition may serve as an excuse to stop further thought."\(^2\) A strict definition in Wylie's view may even cramp the growth of a field and make it difficult to justify new and helpful pathways which seem outside the scope of the definition.

Standard textbooks of psychiatry and the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM) in its three editions did not provide a definition of mental illness and mental disorder. Spitzer,\(^3\) a psychiatrist and co-editor of the current DSM III, suggests that the reason for such omission is that no definition is needed. Coulter,\(^4\) Ullman and Krasner\(^5\) and other scholars in the field take an opposite view and insist on a usable operational definition of the term. As Coulter indicates, "a recurrent problem has been the polymorphous character of the


\(^2\)Ibid., p. 100.


concepts used by psychiatrists and others to ratify common-sense ascriptions of insanity and their resistance to meaningful operationalization."\(^1\)

Although there is no explicit universally accepted definition of mental illness, there are two main approaches which dominate the field. The first is the American approach which views mental illness broadly to include any significant deviation from an ideal state of positive mental health. The second is the European approach which is narrow in scope. These two approaches are built on the nature of a continuum of conditions from highly desirable (positive mental health) to highly undesirable (mental illness). The narrowness of the European approach according to Spitzer and Wilson, results from placing the cut-off point of mental disorder closer to the highly undesirable end of the continuum "so that only conditions clearly associated with suffering and disability are designated as illness or disorder."\(^2\)

Despite differences in scope, the two approaches seem to define mental illness as the absence of positive mental health, therefore, a definition of mental health is warranted as a prerequisite to follow the logic of either approach.

Current psychiatric dictionaries such as Campell\(^3\) identify

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\(^1\) Coulter, *op. cit.*, p. 4.

\(^2\) Spitzer and Wilson, *op. cit.*, p. 829.

mental health as:

Psychologic well being, or adequate adjustment, particularly as such adjustment conforms to community accepted standards of human relations. Some characteristics of mental health are: reasonable independence; self-reliance; self direction; ability to do a job; ability to take responsibility and make needed efforts; reliability; persistence; ability to get along with others and work with others; cooperation; ability to work under authority, rules and difficulties; ability to show friendliness and love; ability to give and take; tolerance of others and of frustrations; ability to contribute; sense of humor; a devotion beyond oneself; ability to find recreation as in hobbies. 1

This definition of positive mental health, is subject to criticism because of its apparent broadness, redundancy and exclusiveness. The main criticism, however, is that a definition of what constitutes positive mental health is no substitute for a separate definition of what constitutes mental illness, disease, or disorder. As Jahoda indicates, mental health and mental disease are qualitatively different, and the absence of mental disease is not a sufficient criterion of mental health. Jahoda also suggested that "no satisfactory concept of mental disease exists as yet and that little would be gained by defining one vague concept in terms of the absence of another which is not more precise." 2 Jahoda's criticism further suggested that the assumption that mental health be compatible with all high values is actually not necessary. Human beings in Jahoda's view can never serve all the highest values simultaneously and to deny conflict of values by setting up such global standards

1Ibid.

for mental health leads in her view to a denial of the condition
of being human.¹

Diagnostic symptoms of mental illness are subject to questions
as well. In his critique of the medical diagnosis of mental illness
Coulter² pointed out that

The symptoms of 'schizophrenia' for example are not bodily
complaints nor are they identified through the judicious
use of the props of medical technology even though medical
approaches come into play in treatment schedules. Rather
the symptoms are framed as the result of the application of
a disease model to people's talk and conduct, their beliefs
and communicated experiences. Either such talk and conduct
are understood as evidence of some disease process that
underlies them, or they are treated as the illness itself.

Thus, the current practice of psychiatry led observers to the
conclusion that the medical diagnostic approach lacks scientific
validity.³

The problem of defining mental disorder is further complicated
by the constant change in diagnostic concepts. Many examples are
cited in this regard such as sexual preferences and addiction to
certain drugs. Homosexuality as an example, was considered a mental
disorder according to the American Psychiatric Association Diagnostic
Manual until the 1970's, but was excluded in the current DSM III.
Such changes give credence to the view that people are diagnosed as
mentally ill when their personal conduct violates certain ethical,
political, and social norms. Since these norms are subject to change

¹Ibid.
³"Exploration of Mental Illness," an editorial. The Journal
of Nervous and Mental Disease, Vol. 166, No. 6, June 1978, p. 382.
so is the evaluation of the behavior associated with them.

Change in legal definitions of acts which are considered evidence of mental illness, also has a great impact on the decision to admit or not to admit a person to a mental hospital. As an example, a recent study conducted by the Laboratory of Community Psychiatry at Harvard Medical School found a significant decline in the number of psychiatric admissions in the State of Massachusetts. This decline occurred since 1971 after the implementation of the Massachusetts Mental Health Reform Act of 1970. The Massachusetts Mental Health Reform Act put into effect a "dangerousness" standard as the primary basis for involuntary civil commitment of the mentally ill. The new standard insisted that "commitment can result only if failure to hospitalize would create a likelihood of serious harm by reason of mental illness."  

Change in legal definitions also has its impact on discharging patients from mental hospitals. Recently, an increase in long stay mental patients census in New York State was attributed to changes in the Criminal Procedure Law (CPL) and state mental health regulations. It was reported that the new law and the Office of Mental

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2Ibid., p. 4.

Health regulations required a series of reviews and notifications before patients hospitalized under sections of CPL can be released or discharged to non-criminal legal status. These requirements were cited as the reason for prolonging the length of stay for this group of patients and resulted in the current census increase.

For the purpose of this study we have adopted an operational definition of mental illness to facilitate sample selection. This definition follows: "Mental illness or mental disorder is any illness or group of symptoms identified as such by a psychiatrist or a psychiatric treatment team during the course of examining a client as a candidate for psychiatric treatment." This operational definition is somewhat similar to a definition presented by Scott which states "mental illness may be defined, as exposure to psychiatric treatment."¹

We are aware of at least two basic problems with this definition. First, the majority of clients are brought to the psychiatrists' attention by relatives, police, school authorities, and neighbors; thus, while the diagnosis is decided by the psychiatrist, the decision as to who gets to be diagnosed is decided by others. As a result, behaviors that are not acceptable to the referring agent are the ones that are diagnosed by the psychiatrist. The risk here is that persons are likely to be admitted for psychiatric treatment on the basis of lay definitions of mental illness; as Mechanic

indicates "community persons are brought to the hospital on the basis of lay definitions, and once they arrive their appearance alone is usually regarded as sufficient evidence of illness." Solomon has suggested that not only the presence of individuals accompanying the client, but the attitudes of those individuals were of greatest impact on the admission decision. There is also the possibility that many clients are brought or sought admission to the state hospital out of the need for shelter, food, clothing, and financial aid. As we will indicate later, our study data gives credence to this latest assumption.

The issue of definitions is further complicated by the fact that American psychiatrists tend to follow a broad approach in defining and diagnosing mental disorder. Thus the likelihood of accepting a client with no psychiatric problem to treatment is higher than rejecting a client who needs such treatment.

Scheff analyzed rules, types of errors and their consequences in medical diagnosis. He demonstrated that in uncertain legal cases decisions are made according to the explicit rule that a man is innocent until proven guilty. Likewise his findings suggest that physicians tend to follow a decision rule "when in doubt, diagnose illness." Scheff argues that this decision rule may be acceptable


in purely medical matters, but in psychiatry as a medicine specialty, diagnoses can cause irreversible harm to the patient's social status."\(^1\)

All the 100 clients who participated in our study were screened by the admitting psychiatrists at the state hospital. Though all clients were judged as not in need of psychiatric inpatient treatment, 93 of them were given a psychiatric diagnosis. Only 7 clients had their diagnosis deferred. Mechanic reported in an earlier study in two mental hospitals over a period of three months that he never observed a case where the psychiatrist advised the patient that he did not need treatment. Rather all persons who appeared at the hospital were absorbed into the patient population regardless of their ability to function adequately outside the hospital.\(^2\)

The tendency to be on the disease side in diagnosis could be further explained in light of the physician's orientation in diagnosing health and disease. Eric Cassell of Cornell University Medical College defends such a broad sickness approach in stating that "every physician has seen how devastating it is to the sick person to be told that nothing is wrong. Such patients are enormously relieved when even serious disease is found because to deny a person's own fundamental perception of 'themselves' (sic) as functioning or not, is to deny the person."\(^3\) One could argue that clients are equally

\(^1\)Ibid., p. 212.


relied when they are given what they consider a 'clean bill of health' based on the professional judgment of their physicians. Another argument is that many patients do not fit clearly defined psychiatric syndromes that can be reliably identified. These patients are seen by many experts in the field as having a variety of problems of living whose classification as diseases does little to promote effective treatment.¹

In another vein, the definition issue is influenced by the personal convictions of those responsible to undertake such a task by their professional organization. As a case in point, Spitzer the principal editor of the current American Psychiatric Association "Diagnostic and Statistical Manual of Mental Disorders" advocates an expanded definition of mental disorder. In an earlier article with Wilson, Spitzer and Wilson² see no need for a definition of mental illness and suggest that psychiatric problems are not necessarily "diseases" but disorders treatable in a medical mode. In their view these psychiatric disorders could include those conditions of human suffering and disabilities that respond to medical treatment.

Inappropriate use of psychiatric facilities is also attributed to lack of defined boundaries of psychiatric and mental health treatment services and the broadness of the mental illness definition in the United States.³ The boundary issue as we reported earlier has

¹Exploration of Mental Illness, op. cit., p. 383.
²Spitzer and Wilson, op. cit., p. 827.
³Spitzer and Wilson, op. cit., p. 79.
been the subject of a lengthy debate since the early 1960's and the implementation of the Community Mental Health Center Act. Many scholars in social work, sociology, psychiatry, and psychology offer different perspectives in dealing with the issue.

Kahn's view, which is shared by many scholars in social work, sociology, and psychology, is that psychiatry cannot claim itself an authority on all social problems and deviance. In his view, much of social research, policy and planning in this general realm "belongs in other domains and to other professions, while psychiatry should concentrate on its care, treatment and control assignments."¹

Mechanic adopted a similar view and suggested that "problems such as drop-outs, experimenting with drugs and un-wed mothers are problems rooted in the influences and definitions of the society, rather than in the conditions of individuals."² Such problems in Mechanic's view are not in the domain of psychiatry unless the person is also mentally ill in the more narrow sense. The psychiatrist's function in Mechanic's view is to provide help to individuals who are disabled because they suffer from the specific kinds of problems which psychiatrists are uniquely trained to handle.

On the other hand, there are those who proclaim that problems of daily living are subject to psychiatric intervention. Many

²David Mechanic, *op. cit.*, pp. 31-33.
scholars see this practice as boundary busting\(^1\) and the medicalization of social problems.\(^2\) Kahn's attributes this phenomenon to the general tendency in the American culture to humanize, and even to psycho-logise our approach to most social institutions.\(^3\) Kahn's analysis of the boundaries issue from the planning and practice perspectives suggested that "the key to the boundaries problem is where medical control and responsibility are required for intervention or where professional and public definition, self perceptions and institutional rules support it, the service is provided under the auspices of community psychiatry. Otherwise one turns to counseling, guidance and other activities within the general non-medical social service system."\(^4\)

Kahn and Mechanic's views on the boundaries issue are shared by many in the psychiatric profession, though they are in the minority. Some prominent psychiatrists such as Busse, a former president of the American Psychiatric Association, argue that "psychiatric services should not be the tool for restructuring society or solving economic problems or for determining new human values. Psychiatric services should be continued as patient oriented activities designed to reduce pain and discomfort and to increase the capacity of the

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\(^3\) Alfred J. Kahn, *op. cit.*, p. 20.

individual to adjust satisfactorily."¹ In his presidential address to the first Pacific Congress of Psychiatry, David Maddison of the University of New Castle in New South Wales, offered a similar view when he told his audience that during the opening years of the 20th century, it was clear to everyone what the psychiatrists task should be, and that there were clearly defined boundaries over which nobody expected the psychiatrist to step. In his words, "the business was clear, to treat mad people, the madder the better. Nobody expected you to do very much good, and certainly no one would have dreamed of asking your advice about problems in human living other than those that were made manifest in the overt forms of psychosis. . . .²

The majority of American psychiatrists, however, do not share the view of a limited disease model for psychiatric practice. To cite an example, Bertram Brown, the past Director of the National Institute of Mental Health, writes

the opportunity of mental health's dual nature lies in our capability to go where the action is, to meet or attempt to meet the needs of people across the board. Our willingness and ability to accommodate problems of living is, whether in the clinical mental sphere or in social problem 'care' (emphasis provided), strongly justify our tendency to go where the funds are, where the popular support is. If such flexibility is described as opportunism, then it is the best

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kind of opportunism. The trick is to recognize and accept
the vectors that are working, perhaps at odds, and to
channel the energy constructively into a simple stream that
is good for "mental health" (emphasis provided).¹

In the introduction of their synopsis of contemporary psy-
chiatry, Ulett and Goodrich² acknowledge the fact that it is often
not clear, just where the boundaries of psychiatry rest. Mean-
while, Schulberg and Baker refer to the consequences of expanding
boundaries of psychiatric institutions and state that "if the
expanding clientele and program trends of psychiatric institutions
continue in such directions, mental hospitals will in point of fact
be accepting the very inputs deemed characteristic of human service
centers. Their clientele will include "individuals with a variety
of social and physical problems, and the category of individuals
whom we now define as psychiatrically ill will be but one of those
served by these emerging centers."³

It is interesting to note that at the time of boundary expan-
sion of psychiatry and mental health in the United States a con-
trasting trend was taking place in other countries such as Canada.

¹Bertram S. Brown, M.D. "Conflict and Detente between Social
Issues and Clinical Practices," American Journal of Orthopsychiatry,

²George A. Ulett and Wells D. Goodrich. A Synopsis of Contemp-
orary Psychiatry, third edition,(St. Louis: The C.V. Mosby Co.,
1965), p. I.

³Herbert C. Schulberg and Frank Baker. The Mental Hospital and
Williams and Luterbach pointed out "that the changing boundaries of psychiatry in Canada was necessary to rationalize services so that availability and accessibility can be assured within reasonable cost limits." They also pointed to the fact that psychiatry in Canada is moving from a position of prominence to being a consulting specialty within the large system.

A current view in psychiatry and mental health in the United States is reflected in Langsley's critical review of Community Mental Health Centers practices. Langsley (the current President of the American Psychiatric Association) notes "that the Community Mental Health System (CMHS) has been moving steadily away from its health focus and towards a social service model." The best solution in his view is to re-affirm the original intent of the Community Mental Health System - the treatment of the mentally ill. That solution will require that the Community Mental Health Centers be given clear responsibility for dealing with professionally diagnosed psychiatric illness and that charge be their highest priority.

Langsley's view is logical, providing that the current psychiatric diagnosis is valid. However, until some of the questions about the validity of psychiatric diagnosis are cleared, Langsley's

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2Ibid., p. 22.


4Ibid.
argument may be interpreted as enhancing the professional turf of psychiatrists in CMHS rather than limiting inappropriate psychiatric admissions. Such an interpretation is based on the professional, social, legal, and financial incentives for physicians to foster the decision rule "when in doubt diagnose illness." The end result of such a rule is an influx of inappropriate admission to the mental health center as well as to the public and private psychiatric facilities.

Psychiatric admissions and readmissions are also subject to the clinical judgment of the admitting clinician as a determining factor in increasing or decreasing the volume of inappropriate admissions. A study by Solomon and Doll for example, found that psychiatrists vary in their assessment according to their length of experience in the hospital and clinical orientation. The findings of their study indicates that "doctors with fewer years of experience tend to admit more patients than do those with longer tenure. Those with higher status in the hospital admit fewer patients than those with lower status and those who are predisposed toward treatment in the community admit less often than those with more faith in the controlled treatment environment of the hospital."¹

In most state hospitals admissions are usually assigned to newly hired psychiatric residents. Under such circumstances,

and in view of Solomon and Doll's findings, one would expect a higher rate of inappropriate psychiatric diagnoses, admissions, and readmissions to state mental hospitals.

An equally important factor which was stressed by Mechanic, Coulter and many others is that psychiatric assessment of pathology depends on the clinician's judgment and is not subject to the objective investigatory procedures which are commonly used in physical medicine assessment. Such subjective judgment opens the door for errors in admission decisions regardless of given definitions. Solomon in her study in two state hospitals in Cleveland, Ohio found that in one of the hospitals the admission rate was lower. She attributed the low admission rate in that hospital to the fact that it had social workers pre-screening applications during the day. During the pre-screening process, the social workers rejected some applicants and referred the remaining applicants to psychiatrists for further evaluation. Solomon further indicates that "it appears that the social workers helped prevent hospitalization for some clients since, as determined by the interviews, they were more knowledgeable about community alternatives than were the psychiatrists. Furthermore, the social workers job was to make referrals. Psychiatrists attitudes toward, and lack of knowledge of community

1 David Mechanic. Mental Health and Social Policy, op. cit., p. 17.
2 Coulter, op. cit.
alternatives helps explain why the availability of community resources was not significantly related to decisions regarding hospitalization.¹ Solomon's findings confirmed the findings of previous studies which were conducted by Mendel and Rapport² and Streiner et al³ that non-medical clinicians especially social workers admit fewer patients than medically trained staff, particularly psychiatrists.

Many questions have been raised in the literature concerning the validity of psychiatric judgment as a method of admission to mental hospitals. These questions were intensified after the publication of Rosenhan's study in mid-1970.⁴ Rosenhan organized a group of eight persons who posed as patients in 12 mental hospitals located in five different states. All were admitted, and stayed an average of 19 days each. Hospital staff did not notice that the "pseudo patients" were not mentally disturbed, although patients often did.

Rosenhan's study suggests that psychiatric diagnosis may be considered reliable, since all the medical staff in the hospitals studies agreed that the pseudo-patients were mentally ill, but all of them

1Ibid., p. 408.


were wrong. The study also suggested that the diagnoses were invalid since the psychiatrists did not actually detect what they claim to detect. Ingleby extended this argument to suggest that since there is no agreed upon definition of mental illness "there is no explicit definition of precisely what it is that they are detecting. Consequently, there is no way of demonstrating precisely that they have succeeded in detecting it."1 It is interesting to note that some psychiatrists such as Robitscher suggest that if patients in Rosenhan's study had been denied admission, this "would have been seen as evidence of psychiatric inhumanity."2

The reliability of psychiatric diagnosis was questioned again in 1978 when a mass killer was diagnosed as psychotic by two psychiatrists and a third psychiatrist reached an opposite conclusion and found the killer not mentally ill. After he was convicted, the mass killer admitted that his story about demons controlling his acts was a hoax, well planned and thought out.3

Thirty percent of the subjects of our study sample were referred to Creedmoor Psychiatric Hospital by general hospitals. These clients were judged as in need of psychiatric inpatient treatment by the practicing psychiatrists in the general hospital. However, the same clients were found not in need of such inpatient psychiatric treatment

and were referred to the Emergency Housing Program by psychiatrists practicing at Creedmoor. These findings seem to point again to the subjectivity of the psychiatric assessment. One has to assume a subsequent change in patients' behavior once she/he arrived at Creedmoor State Hospital, in order for both assessments to be considered reliable.

The issue of psychiatric diagnosis was identified by Ingleby as a lack of knowledge. Ingleby agrees with Coulter that "the literature on mental disorders is quite out of proportion to the adequacy of our knowledge about them." The search for knowledge in this area is again hampered in Ingleby's view by the "psychiatric profession's own categorical insistence that there are none there."2

Recently, a mental patient from the setting of our study was investigated by a national magazine reporter.3 The reporter's account of the case could be used as an illustration of the state of knowledge concerning the causes and treatment of mental illness. According to the reporter, the patient was first admitted to Creedmoor State Hospital in 1969 when she was 15 years old. She had started receiving treatment in a private psychiatric center after a suicidal attempt a year and a half before she was admitted to the hospital. The patient was in and out of Creedmoor Hospital, other state mental hospitals, psychiatric wards in general hospitals, private psychiatric


2Ibid., p. 27.

hospitals, and private and public outpatient psychiatric clinics for sixteen years. During that period, the patient was treated by scores of psychiatrists and other mental health clinicians. During the course of treatment she was given several psychiatric diagnoses and was exposed to a wide range of treatment modalities. It is interesting to note that many of the psychiatrists who dealt with her case offered different judgment on disease symptoms, diagnosis and treatment. Not only did psychiatrists differ in their judgment, but they were highly critical of one another's approach. Commenting on the treatment given by one of his colleagues at the same hospital, a psychiatrist was quoted by the reporter as stating

He thought that he could cure her. He was taught in medical school that schizophrenia is incurable, and he should not have forgotten that a patient with Miss Frumkin's case history could not fail to do anything but decompensate if she was taken off drugs, and that is why Miss Frumkin has always decompensated when she stopped taking her medication herself. It always amazes me how many psychiatrists think of major mental illnesses as conditions that are curable, when most illness in our field and others is not curable. If you look at the average internist's practice, you will see that he's dealing with such things as heart ailments, arthritis, and diabetes— all of them chronic illnesses, like schizophrenia. What you try to do with most illness is to keep it under control. You don't try to cure it, because you can't, certainly not with currently available therapies, although it is likely that someday cures will be found.1

This rationale, however, is in conflict with the current view which does not perceive mental illness as a disease entity that the person has, but, as something he does or is. A National Institute of Mental Health

1Susan Sheehan, Ibid., Part IV, June 15, 1981, p. 73. See also, Susan Sheehan, Is There No Place on Earth for Me?, op. cit., p. 284.
publication states that "a person does not have schizophrenia as he might have an ulcer in his stomach or a cold in his head. He is schizophrenic; he is the disorder. It pervades his entire being." 

Our discussion of clinical errors in psychiatric diagnosis demonstrates the need for corrective measures to deal with this problem. The lack of such measures increases the likelihood of inappropriate admissions to psychiatric hospitals and to psychiatric services in general.

Current writings on psychiatry recommend the reassertion of the profession to its medical identity. This recommendation is based on the fact that "...it is training in medicine that distinguishes the psychiatrist from others in the mental health arena" and as Popkin suggests, "to forego the physician's mantle is to honor the suggestions that psychiatry offers no skills beyond those of psychology, social work and other mental health disciplines." It is our belief that the boundary question may find a partial answer in psychiatrists' acceptance of Popkin's recommendation.


3. Ibid.
Internal organizational pressures also have an impact on the admission process in the mental hospital. Availability of beds, availability of personnel to handle newly admitted patients, internal hospital admission and discharge policies and the need to utilize existing facilities despite a drastic decrease in the hospital's census represent a few examples of such pressures.

Chodoff recently reminded his psychiatric colleagues of their responsibility toward society and referred to the fact that state hospital psychiatrists are acceding without protest to holding on to patients for too long or too short a period of time in response to outside pressure.

The current short term care policy which is implemented throughout New York state mental hospitals could be cited as another example of the external pressure on the admission process. This policy is currently criticized for creating what is known in the field as the "revolving door." The implementation of this policy resulted in high rates of admission and readmission while the hospital census decreased.

Today's mental hospitals are not immune from outside political pressures. As public institutions, these hospitals are financially dependent on appropriations approved by elected bodies in the executive and legislative branches of the state government. The

hospitals are also subject to many federal laws and regulations as well as the rules and standards of many accrediting bodies.

At the local level the state hospital is under mounting pressure to readmit patients shortly after their discharge. Local communities use the state hospital as a ready alternative to problems of shelter and food for destitutes instead of supporting them through local means. As Morrissey indicated, "state hospitals started out as a limited purpose institution and were transformed into a general purpose solution to the social welfare burdens of a society undergoing rapid industrialization and stratification along social class and ethnic lines." ¹

The literature review and our personal observation during the past ten years leads us to agree with Morrissey that "for years, the latent social function of state hospitals was to serve as a 'dumping ground' for residual social problem cases who were unwanted by families, rejected by other health and welfare agencies, or otherwise regarded as 'public nuisances.'"² Recent empirical studies also refer to the impact of such problems in psychiatric admissions. As an example, a time series study conducted on admissions, discharges, and number of patients on mental hospital books


²Ibid., p. 13.
in Ontario, Canada between 1875 and 1977 found a clear relationship between the rates of unemployment and inflation and the levels of admission, discharge, patients on books, vacancy rates and number of available beds in the hospital. The study concluded that "planning and design options can only be developed and comprehended when situated within the wider political economy of social services provisions."

The mental hospital scene is currently an arena of conflicting laws, laws that advocate the right to treatment and laws that advocate the right to refuse treatment, the right not to be committed to an institution, and the right to treatment vs. the right to treat. Laws that govern the admission process to the mental hospital are also contributing to an increasing number of inappropriate admissions. A state hospital superintendent's testimony in a court case gives credence to this point. In his testimony, the superintendent stated that "state mental hospitals are a creature and occasional victim of legislative fiat... The administration and staff have no meaningful control over the facilities and resources at their disposal. Likewise, they must accept every patient sent to them under a valid commitment order." The superintendent's point, though a valid one, is not relevant to voluntary admissions.


This study explores clients' attempts to utilize voluntary admission to a state hospital to satisfy non-psychiatric needs. The state hospital admission policies and practices are at the core of this problem.
CHAPTER III
THE PROBLEM AND ITS SETTING

The Problem

During the past two decades voluminous research has been conducted on institutionalization and deinstitutionalization of persons with psychiatric problems. Most, if not all, the studies have focused on the impact of the institutionalization and deinstitutionalization process on the patients, the patients' families and local communities. Scant attention has been given to the admission and readmission process as the starting point in the institutionalization/deinstitutionalization cycle. There are indications that a significant number of persons admitted to in-and out-patient psychiatric facilities do not have psychiatric disorders¹ or do not need to remain in such facilities.²

¹Statistics on admission to mental health facilities in the United States indicate that more than fifty percent of the persons admitted to outpatient psychiatric facilities in 1975 did not have psychiatric disorders. These statistics also indicate that 2.6 percent of the persons admitted to inpatient facilities did not have psychiatric disorders. See: Report to the President from the President's Commission on Mental Health, vol. II, Task Panel on the Nature and Scope of the Problems (Washington, D.C.: Government Printing Office, 1978), p. 102.

In 1979, an initial survey of admissions and readmissions at Creedmoor Psychiatric Center (CPC), a state mental hospital in Queens Village, New York, found that 10 to 15 percent of persons seeking admission or readmission to the Center were in need of temporary or permanent housing rather than being admitted to the hospital.\(^1\) This phenomenon warranted investigation. A main objective of the present investigation is to further explore the causes as well as the consequences of inappropriate admission and readmission to state psychiatric facilities and to psychiatric treatment in general.

1 - The Study Question

The study poses and attempts to answer the following questions:

1. What are the characteristics, problems, needs and expectations of clients who sought admission or readmission to the state hospital and were found in need of other services such as housing rather than inpatient psychiatric treatment?\(^2\)

2. At what level are these clients able to function independently in their opinion and in the opinions of staff who work with them?\(^3\)

3. What are the differences, if any, between the above group of clients and patients who were admitted to the hospital during the same period?\(^4\)

4. To what extent are these clients aware of community resources that they could use to solve their problems?\(^5\)

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\(^1\) Creedmoor Psychiatric Center: Creedmoor Emergency Housing Proposal. Internal memorandum, March 1980.
5. What are the opinions of staff concerning these clients' problems and needs?

6. To what extent do the staff assessments of needs, problems and level of function differ from clients' self assessment?

7. What are the opinions of officials at the state psychiatric facility regarding the boundaries of their services? Also, what are the opinions of these officials regarding their role in helping clients who seek admission to the hospital to satisfy non-psychiatric needs such as housing?

8. What are some of the alternatives in dealing with the "boundary-crossing phenomenon" as exemplified by clients' attempts to utilize psychiatric facilities to satisfy their need for shelter, food, clothing and financial assistance?

9. Finally, could the subjects of the study be viewed as clients in need of social services, or should they be classified as patients in need of psychiatric treatment? Also, why such distinction is warranted?

It was also expected that the study could be useful in developing future policy and planning endeavors concerning the delivery of mental health and social services.

The selection of a descriptive research design was based on its appropriateness for the above purposes. We should also note that scholars in the fields of social work (Finestone and Kahn, 1

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Tripodi, et al.,¹ and in sociology, (Lin,² Merton,³) agree that
descriptive research designs are most appropriate for investigating
policy and planning issues.

2. The Study Site

Introduction: At the time the investigator was searching for
a suitable site to conduct the study, Creedmoor Psychiatric Center,
a New York State psychiatric institution in Queens Village, New
York, was undergoing a reorganization of its services. As a result
of the reorganization, all voluntary adult admissions to the Center
were centralized in one building. It was also found, as mentioned
earlier, that ten to fifteen percent of persons who sought admission
or readmission to the Center were in need of temporary or permanent
housing rather than admission to the hospital. As a result, an
Emergency Housing Program was initiated on the hospital grounds.
Clients whose primary need at the time of admission was temporary
or permanent housing were referred to the new program. The majority

¹Tony Tripodi, P. Fellin and H.J. Meyer, The Assessment of
Social Research (Ithaca, Ill.: F.E. Peacock Publishers, 1969),
p. 49.

²Nan Lin, Foundation of Social Research (New York: McGraw Hill,

³Robert K. Merton, The Sociology of Science, "Technical and
Moral Dimensions of Policy Research," (Chicago: University of
of clients who were referred to the Emergency Housing Program met a set of criteria pertinent to our study objectives. Those clients sought voluntary admission or readmission to the psychiatric facility. After being screened for admission, those clients were found not in need of psychiatric admission but needed a temporary and/or permanent place to live. The main function of staff at the Emergency Housing Program was to assess the needs of these clients and help them locate permanent housing.

A secondary but important factor that influenced the selection of Creedmoor as a site for the study was the investigator's familiarity with the site. The investigator had been working at Creedmoor as a psychiatric social worker and program coordinator for the past ten years. He also participated in implementing the new Emergency Housing Program. As such he was assured of easy access to clients, staff and records which were vital in conducting the study. Easy access to clients eliminated the problem of sample dropout since clients were residing temporarily on the hospital grounds at the time they were being interviewed.

To elaborate, the study site will be described in two parts:

A. Creedmoor Psychiatric Center as an entry point of clients seeking admission to the state mental hospital.

B. The Creedmoor Emergency Housing Program as an initiative to deal with the problem of clients who otherwise would be inappropriately admitted to the hospital due to lack of temporary or permanent housing arrangements in the community.
A. Creedmoor Psychiatric Center (CPC)

Creedmoor is a New York State Psychiatric Institution. Its current certified bed capacity is 1,700. The hospital services the population of Queens, one of the five boroughs of New York City. According to the State Mental Hygiene Law, Creedmoor, like other state hospitals is mandated to provide adequate care and treatment of the mentally disabled and be involved in research and teaching in the science and skills required for the care and treatment of such mentally disabled persons.

CPC History: The hospital construction began on its current location in Queens Village in 1912. The location was then an isolated tract of land on the outskirts of Queens County. The choice of the location came as a direct result of homeowners' objections to four other locations which were closer to community residences.¹ Currently, the hospital occupies approximately 400 acres of land in the eastern part of the county. Services to inpatients are provided in 73 buildings scattered on the hospital grounds.

Until the 1960s, the hospital was a semi-placid organization, and a self-sustaining, feudal, manorial system. It owned and operated its own farm, broom shop, mattress shop, shoe repair shop, bakery, laundry, etc. These services were manned by patients at the hospital. At that time, the hospital also required that its duty personnel, utility workers, and professional staff accept housing on the hospital

grounds as part of their salary. This structure made the hospital immune to local environmental pressures for change. The only formal environmental influence exerted on the hospital was apparently the economic and political control of funds provided by the State Department of Mental Hygiene. Creedmoor's hierarchy was a typical bureaucratic horizontal structure with a superintendent at the top.

In the early 1960s, the state mental hospitals' ideology and practices were challenged by the advocates of the community mental health movement. The hospitals were accused of being responsible for isolating patients from their communities, undermining their motivation to return to normal lives, retarding their skills and inducing a level of disability above and beyond that resulting from their condition. The introduction of newly discovered psychotropic drugs also facilitated the management of many mental patients and made it easier to treat them on an outpatient basis. The enactment of the Community Mental Health Act in 1963 also enforced this new community treatment ideology at the state level. The New York State Department of Mental Hygiene directed its old large institutions to decentralize to geographic units, and to provide aftercare along with its inpatient services. Consequently, by 1968 Creedmoor as a State hospital was decentralized into nine geographic units along the lines of the New York City Community Health Planning districts. Each unit was assigned a Chief of Services who reported to a Deputy

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Director. The Unit Chief had considerable jurisdiction over program and personnel decisions in his/her unit within the general hospital policy. Each unit was further divided into geographic neighborhoods headed by treatment team leaders who, with their staff, were directly involved with the patients. The rationale for the change was to allow for close teamwork within a large organization and to facilitate broad treatment programs.

**CPC Current Organizational Structure:** In the Spring of 1979 Creedmoor was again reorganized according to a patient's Level of Care Survey (along with the geographic units). Historically, Level of Care assessment has been conducted periodically by the New York State Department of Mental Hygiene through Level of Care Surveys (LOCS) since 1976. These surveys began when the Commissioner of Mental Hygiene appointed a task force to examine alternative methods of care for the aged and chronically mentally ill. The task force suggested that the diverse needs of the total patient population might be better served if state psychiatric centers were used as focal points to offer several levels of psychiatric and medical care.¹ As a result of this recommendation a level of care survey was conducted to assess patients' needs in all state psychiatric centers in 1976. The needs assessment survey is based on the patient's functional status rather than psychopathology or psychiatric diagnosis. Functional

status is defined as "the degree to which disability related limitations impact upon individual performance in socially allocated roles specified in behavioral terms." As Furman and Lund explain,

...a patient may manifest the constellation of symptoms that comprise the criteria for application of a diagnostic label such as schizophrenia, and yet be perfectly capable of functioning within the community or at a level of care less restrictive than 24 hour inpatient care. What does matter, then, is the degree to which such symptoms manifest interference with the patient's ability to perform activities of daily living or to function within his socially allocated roles.

The new reorganization of Creedmoor is based on the Level of Care Survey data and the recommendations of two reorganization committees for in- and out-patients services. The major purpose of the reorganization is to group patients according to their level of functioning, focus attention on the needs of the patient, and encourage the development of highly specialized therapeutic approaches. The hospital is reorganized into Short Term Care (STC), Intermediate Care (IC), Geriatric Care (GR), and Special Care Divisions (SCD).


2Ibid., p. 30.

The Short Term Care Division, deals with all admissions, and is designed to provide acute psychiatric intervention and return clients to the community as soon as possible.

The Intermediate Care Division serves the needs of patients who have been hospitalized for a long period. The problems of this population have their origins in mental illness, institutionalization and the side effects of medication, which interfere with placement in the community. The division is divided into three units, each serving a target population with unique treatment needs.

The Geriatric Care Division is divided into three functional units, again according to level of care. The services for patients in this division are geared to provide physical as well as psychiatric care required for each individual. The Medical Infirmary is functionally connected with this division.

Several functional units, which had been in place prior to reorganization, are organized under one division known as Special Care. These units are Adolescents, Multiple Disabilities and Forensic. During implementation, the need for other specialized units were identified and resulted in the addition of the SSTU (Social Skills Training Unit), a secure unit designed to treat aggressive and highly disruptive patients. At the time this study was conducted, Creedmoor was also affiliated with New York Medical College, and jointly operated an Intensive Psychiatric Care Unit (IPCU). IPCU’s purpose is to explore under precise methodologies new treatment modalities for individual patients who have so far not improved with current treatment approaches.
The reorganization of Creedmoor also included the initiation of a Community Linkage Unit (CLU). The new unit consists of an aggregate of crises and residential services. As a boundary spanning unit, Community Linkage is designed to monitor and impact on the flow of system input and output, as the boundary is crossed from community to the hospital and from inpatient to the community. The primary function of the unit is focused on two major organizational goals: admission diversion and reduction in length of stay in order that clients' needs are met in the least restrictive setting.\(^1\) The unit provides services through a countywide mobile crises team for geriatric and adult populations, a 24-hour hot line and the Emergency Housing Program.

The admissions screening process at Creedmoor operates through four admissions units located in a single building on the hospital grounds. During daytime hours (8:00 AM to 4:00 PM), each unit is responsible for evaluating adult persons seeking admission from their designated health planning districts. Screening for admission is usually conducted by a unit psychiatrist and a social worker with occasional participation by a psychologist or a nurse. During nights and weekends, screenings are conducted on a centralized basis for all four units by the psychiatrist on call (either a staff psychiatrist or one of the part-time psychiatrists hired for this purpose) and a nurse. Geriatric and forensic screening are conducted by the staff of each designated unit. The Community Linkage Unit

\(^1\text{Ibid.}, p. 3.\)
at Creedmoor also participates in the screening process through its mobile pre-screening teams. These teams evaluate patients at the local receiving general hospitals prior to their arrival at Creedmoor. Patients who are pre-screened at general hospitals and are found suitable for admission are then brought to Creedmoor by a transport agent from the hospitals involved.

The reorganization of CPC also included its outpatient services. Intensive day treatment centers (day hospitals) were to be initiated in each of the nine geographical areas. The aim was to provide alternative psychiatric care to inpatient admissions. Presently three of these centers are operative along with the outpatient clinics in the community. The Community Linkage Unit was part of the reorganization of outpatient services to facilitate work flow between in- and out-patient services.

CPC Staff Structure: The staff hierarchical structure at Creedmoor is a typical pyramid shaped hierarchy with the director at the top and mental health therapy aides representing the wide flat bottom of the pyramid.

The Director of Creedmoor is appointed by the Commissioner of Mental Health and is designated as the chief executive officer. S/he appoints the employees and manages the facility in accordance with the law and the rules of the State Civil Service Commission. S/he is responsible for the humane treatment of patients and must investigate every case of alleged abuse or mistreatment. A board of visitors is appointed by the governor and the senate for four year terms. Its seven members must be residents of the community.
served by Creedmoor, reflecting its composition and the interests of the patients. This board has the power to investigate charges against the director and all alleged patient abuse or mistreatment. It has no executive authority and its members receive no compensation for their services.

Following the director in line function are three deputy directors, nine chiefs of service, and the heads of departments (psychiatry, psychology, social work, nursing, rehabilitation and education and training). Together with the director they form the hospital cabinet and central administration.

Shortly after the reorganization in 1980, the administration of the hospital was restructured to comply with the organizational changes. The Deputy Director, Clinical, had been responsible for all inpatient areas and the Deputy Director of Community Services for all outpatient areas. As the reorganization progressed, these areas of responsibility were altered and the Deputy Director of Community Services also became responsible for the Short Term Care Division in order to assure better communication and continuity of care. The major component of administrative reorganization was the development of the Office of Standards and Monitoring, with direct responsibility for overseeing quality assurance and the research and evaluation of all program components at the hospital.

All the divisions and units created through reorganization have been formed with representation from the key clinical disciplines in order to assure that inter-disciplinary treatment planning and intervention continue to focus on the essential medical, psychological,
social, spiritual and vocational needs of the patient. This holistic approach has been augmented through assignment of extra resources to match the new model of treatment. The State Office of Mental Health is currently implementing the Creedmoor model for all psychiatric facilities in New York State.  

The final report of the Committee on Reorganization of Inpatient Services pointed out that

Many of the current systems for organizing patient care at Creedmoor were instituted in anticipation of the existence of an extensive network of community mental health services; a network that has endured through New York City budget cutbacks, federal austerity, and relative non-responsiveness of New York State budget planning systems to Creedmoor's enormous volume of outpatient activity, a network that provides services, but primarily as an aftercare system, not as a preventative alternative to the 3,000 patients admitted by Creedmoor each year.  

The report also indicated that because of non-development of an alternative care system from other than the hospital resources, Creedmoor has to face the issue of whether to be an organization in a configuration with an unlikely regeneration of alternative care resources or whether it should identify what it can do by itself and what it can expect from others.  

Creedmoor has a staff of 2,500 employees of which 1,800 are classified as "clinical" and 700 as "supportive." The clinical

1Ibid.

2Creedmoor Psychiatric Center, The Report of the Ad Hoc Planning Committee on Inpatient Care, internal memo April 30, 1979, p. 5.

3Ibid., p. 6.
staff includes over 1100 ward aides and therapy aides, 257 nurses, 88 psychiatrists and residents, 45 physicians and dentists, 68 psychologists and 123 social workers plus teachers, occupational, recreational, physical and rehabilitative therapists.

Staff salaries are established by the Civil Service Commission of New York State and range from $6,000 a year for a housekeeping employee to $60,000 for a senior psychiatrist.

Dentists and physicians are assigned to the medical-surgical division, headed by a board certified internist and surgeon, serving patients who in addition to their psychiatric problems suffer from medical and neurological illnesses. A small number of employees from all disciplines are engaged in research. The rest are distributed in inter-disciplinary teams throughout the center. Many professionals hold administrative or supervisory positions. During the past six years there has been a nine percent decrease in the center staff. Most of the decrease falls in the category of mental health aides (28%). There was an increase in the number of nurses, speech therapists, recreational therapists, social workers and psychologists. The staff/inpatient ratio in 1981 was .8 to 1.1

**CPC Budget:** All funds for the operation of Creedmoor are provided by the State of New York through its Division of Mental Health Budget. The center budget of FY 1981 totaled $50.8 million. The center received approximately $9.5 million of this money from

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Medicaid, Medicare, private insurances, other third party payments and direct patient charges and $.3 million from the state community support services funds. Eighteen percent of the budget is spent on supplies, maintenance, food, laundry, grounds, etc., and 82 percent is spent on personnel services (salaries). The center spends approximately 90 cents of each dollar on inpatient services and 10 cents out of every dollar on outpatient services. Fees for services to patients are on a sliding scale in accordance to ability to pay, ranging from a maximum of $40 per day to a waiving of all fees. Fees are set and collected by the Bureau of Patient Resources, a state agency independent of Creedmoor.

Despite the decrease in inpatient population over the years, the center budget continued to increase. The center budget for FY 1981-1982 is almost 100 percent higher than it was in FY 1969-70. There are at least four interpretations of this phenomenon. The first is the additional cost of implementing new outpatient and rehabilitation programs. Second is the upgrading of the quality of care by hiring professionals at higher salaries. A third reason relates to inflation costs as reflected in the budget, and fourth and more important is the fact that the hospital shifted from an economy of scale treatment to an individualized treatment in less crowded wards. Since patients still occupy most of the center buildings there is no significant savings in maintenance costs. This may also explain the fact that support services staff has decreased by five percent during the past six years while the patient population decreased by 16 percent during the same period. The high
cost of patient care at Creedmoor, however, does not deviate from
the New York State Office of Mental Health estimate of cost per
patient. Recently, the state estimated the cost per inpatient
treated in its hospitals to be $44,000 per year.1

TABLE 1
CREEDMOOR PSYCHIATRIC CENTER'S BUDGET IN GIVEN YEARS

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<th>Fiscal Year</th>
<th>Budget $</th>
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</tbody>
</table>

Source: Creedmoor Records

1Robert Cohen, "Delivery of Services: "Fiscal and Policy
Restraints." Paper presented at the AITRA Health and Rehabilitation
Services Symposium on "The Role of the Social Worker and Chronic
Patient treatment and census trends: Like other state hospitals around the country, Creedmoor did not have a uniform method of treatment until the early 1950s. During the early years patients' behavior was controlled through strait jackets, sedatives, moist cool sheets wrapped around the patient, and other means such as heat lamps, massages, and whirlpool baths. Electric shock therapy was introduced as a treatment modality in the late thirties and early forties, along with insulin coma therapy. In 1952 lobotomy surgery was performed on some patients, and in 1956, the newly discovered antipsychotic drugs were used. The new drugs facilitated patient management. According to the New York State Department of Mental Hygiene's 1956 Annual Report, there was a 50 percent reduction in the amount of restraint and seclusion necessary to keep extremely disturbed patients from harming themselves and others. The new drug treatment did not have an immediate impact in reducing the number of the hospital inpatients. The number of hospital inpatients in 1956 was 6,000 and by 1966, the number had increased by 46 percent to 8,800. The actual decrease in the inpatient population began in 1970, with the number of inpatients dropping from 7,000 in 1969 to 2,300 in 1970, a decrease of 67 percent. During the past ten years the hospital inpatient population further decreased to the current census of 1,312 patients. Also, during


this period the Center's outpatient population has increased from 500 in 1970 to 6,000 patients in 1981.

**TABLE 2**

**CREEDMOOR PSYCHIATRIC CENTER**

Number of Inpatient Admissions, Re-Admissions, First Admissions and Discharges from 1972 to 1982

<table>
<thead>
<tr>
<th>Year</th>
<th>Admissions</th>
<th>Re-admissions</th>
<th>First Admissions</th>
<th>Discharges</th>
<th>Number of Inpatients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1972</td>
<td>1737</td>
<td>982</td>
<td>755</td>
<td>3339</td>
<td>2300</td>
</tr>
<tr>
<td>1973</td>
<td>1845</td>
<td>1057</td>
<td>788</td>
<td>2684</td>
<td>2250</td>
</tr>
<tr>
<td>1974</td>
<td>1963</td>
<td>1082</td>
<td>881</td>
<td>2137</td>
<td>2196</td>
</tr>
<tr>
<td>1975</td>
<td>2280</td>
<td>1254</td>
<td>1026</td>
<td>2378</td>
<td>1942</td>
</tr>
<tr>
<td>1976</td>
<td>2651</td>
<td>1491</td>
<td>1160</td>
<td>2684</td>
<td>1730</td>
</tr>
<tr>
<td>1977</td>
<td>2791</td>
<td>1626</td>
<td>1165</td>
<td>2595</td>
<td>1735</td>
</tr>
<tr>
<td>1978</td>
<td>2898</td>
<td>1766</td>
<td>1132</td>
<td>2862</td>
<td>1716</td>
</tr>
<tr>
<td>1979</td>
<td>2642</td>
<td>1891</td>
<td>751</td>
<td>2349</td>
<td>1675</td>
</tr>
<tr>
<td>1980</td>
<td>2693</td>
<td>1994</td>
<td>699</td>
<td>2671</td>
<td>1460</td>
</tr>
<tr>
<td>1981</td>
<td>2761</td>
<td>1820</td>
<td>941</td>
<td>2809</td>
<td>1312</td>
</tr>
<tr>
<td>1982</td>
<td>3126</td>
<td>1989</td>
<td>1137</td>
<td>2333</td>
<td>1452</td>
</tr>
</tbody>
</table>

* Source: Creedmoor records.

The general trend in the hospital census since 1972 is a gradual decrease in inpatient population, an increase in discharges to outpatient clinics and an increase in readmissions. The increase in readmissions and discharges came as a result of implementation of a
short term hospitalization policy. Creedmoor's statistics show that the majority of patients stayed less than 27 days in 1981 (Table 3). As a policy, short-term care is recommended by the State Office of Mental Health.

**TABLE 3**

CREEDMOOR PSYCHIATRIC CENTER
PATIENT LENGTH OF STAY
APRIL 1981 - MARCH 1982

<table>
<thead>
<tr>
<th>Length of Stay</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 3 days</td>
<td>247</td>
<td>8.6</td>
</tr>
<tr>
<td>4 - days</td>
<td>719</td>
<td>25.0</td>
</tr>
<tr>
<td>11 - 25 days</td>
<td>806</td>
<td>28.0</td>
</tr>
<tr>
<td>26 - 60 days</td>
<td>494</td>
<td>17.2</td>
</tr>
<tr>
<td>61 - 90 days</td>
<td>183</td>
<td>6.4</td>
</tr>
<tr>
<td>91 - days</td>
<td>429</td>
<td>14.9</td>
</tr>
<tr>
<td>Total</td>
<td>2878</td>
<td>100.0</td>
</tr>
</tbody>
</table>

*Source: Creedmoor Psychiatric Center Records

Hospital statistics also indicate that the number of male patients is slightly higher than females. The majority of the patients are between 21 and 64 years of age; 32 percent are over 65 years of age. Forty-three percent of the patients are not covered under the federal Medicare, Medicaid system or the state deinsti-
tutional benefits in chapter 620 and/or 621 of the state law (Senate bills 10538 and 10537 of 1973). Chapter 620 mandates that the state reimburse localities for 100 percent of the cost of mental hygiene services rendered in accordance with an approved local services as unified services plan for persons who were patients or residents of Department of Mental Hygiene facilities during the period from January 1969 through December 1973. The purpose of the legislation was to provide full support for lifetime care if necessary to discharged, long term residents or patients. Chapter 621 mandates that the state assume for a five year period the cost of public assistance, medical assistance and social services for persons who return to the community after five years of institutionalisation.\(^1\) The majority of Creedmoor patients were admitted voluntarily during 1981.

According to a 1981 inpatient level of care survey 11.5 percent of the patient population were found suitable for discharge to independent living, and 5.3 percent could be placed in health-related facilities (HRF) or skilled nursing facilities. Table 4 summarizes the findings of the level of care survey of 1981.\(^2\)

Hospital statistics for 1982 also indicate that 4533 clients were screened for admission and that 69 percent of those clients screened were admitted as inpatients (3126).

---

\(^1\) New York State Department of Mental Hygiene; 1974 Annual Report, June 1975, p. 3.

\(^2\) Creedmoor Psychiatric Center: 1981, Level of Care Survey Report, internal memorandum, p. 3.
<table>
<thead>
<tr>
<th>LEVEL OF CARE **</th>
<th>NUMBER</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent Living</td>
<td>146</td>
<td>11.5</td>
</tr>
<tr>
<td>Domiciliary Care Facility and Private Proprietary Home for Adults</td>
<td>163</td>
<td>12.9</td>
</tr>
<tr>
<td>Health Related Facility</td>
<td>45</td>
<td>3.6</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>23</td>
<td>1.8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LEVEL OF CARE **</th>
<th>NUMBER</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domiciliary Care Facility and Rehabilitative Psych. Environment</td>
<td>208</td>
<td>16.4</td>
</tr>
<tr>
<td>Health Related Facility and Rehabilitative Psych. Environment</td>
<td>56</td>
<td>4.4</td>
</tr>
<tr>
<td>Skilled Nursing Facility and Rehabilitative Psych. Environment</td>
<td>114</td>
<td>9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LEVEL OF CARE **</th>
<th>NUMBER</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domiciliary Care Facility</td>
<td>350</td>
<td>27.6</td>
</tr>
<tr>
<td>Health Related Facility</td>
<td>64</td>
<td>5</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>99</td>
<td>7.8</td>
</tr>
</tbody>
</table>

TOTAL | 1268 | 100 |

*Source: Creedmoor Records.
**See Appendix 6 for definition of terms.
During the same year a total of 2,333 were discharged from the hospital. Patients were discharged to different living arrangements. The majority of discharged patients were placed in supervised living arrangements.

Table 5 illustrates discharge placements during 1982.

**Table 5**

<table>
<thead>
<tr>
<th>Living Arrangement*</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alone</td>
<td>285</td>
<td>12</td>
</tr>
<tr>
<td>Unsupervised living arrangement</td>
<td>1287</td>
<td>55</td>
</tr>
<tr>
<td>Private Proprietary home for Adults</td>
<td>173</td>
<td>7</td>
</tr>
<tr>
<td>Community Residence</td>
<td>73</td>
<td>3</td>
</tr>
<tr>
<td>Foster Care</td>
<td>23</td>
<td>1</td>
</tr>
<tr>
<td>Health Related Facility</td>
<td>45</td>
<td>2</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>28</td>
<td>1</td>
</tr>
<tr>
<td>Other hospital</td>
<td>220</td>
<td>10</td>
</tr>
<tr>
<td>Left on his/her own and unknown</td>
<td>199</td>
<td>9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2333</td>
<td>100</td>
</tr>
</tbody>
</table>

*Source: Creedmoor Records

**See Appendix 6 for definitions of terms.**
B - The Emergency Housing Program: As we indicated earlier, Creedmoor Hospital had undergone a reorganization of its services by the end of 1979. As a result of the reorganization, admissions to the hospital were centralized in one division. The reorganization also resulted in the creation of a new linkage unit with the purpose of coordinating in- and out-patient services. The Emergency Housing Program was one of the services provided by the new unit.

The Emergency Housing Program (EHP) or crisis residence was established at Creedmoor in March 1980. The guidelines for establishing the program were set by the New York State Office of Mental Health Program Operations Division. According to stated guidelines,\textsuperscript{1} the purpose of the program is to provide supervised housing for clients who are in crisis with respect to their living situation but who do not require the extensive treatment and restrictive supervision of an inpatient setting. The stated primary goal is a timely return of the client to a suitable living situation in the community, having averted the necessity of an inpatient admission. The program is also to serve as a respite function for clients who need temporary lodging away from their permanent living situation, to prevent further deterioration.

The program is located on the fourth floor of building 38 on the grounds of Creedmoor Psychiatric Center. The site was previously

\textsuperscript{1}See: Memorandum 80-6 from William Morris, Deputy Commissioner on the subject of Crisis Residence Program dated March 11, 1980 to the Office of Mental Health Regional Directors, pp. 1-2.
an inpatient ward and required renovation to change it from an "institutional" setting to a more home-like group living situation.

Partitions were installed to provide separate sleeping areas for males and females as well as grouping within the sexes. Wardrobe dividers are utilized to provide further division so that each sleeping space has privacy. These also provide for private storage of personal effects. Each sleeping area includes a bed, a chair, and a large wardrobe divider. Immediately adjacent, separated by partitions, are 2 large living areas. These contain couches and easy chairs, magazine racks and cabinets for games and other reading materials. A color T.V. is placed in this area. Immediately adjacent to the living areas are the toilets, male and female, and a combination office/snack area. A window was cut into the wall between the office and the living/sleeping area to allow for staff observation of the area at all times. The snack area is equipped with an electric range, a sink, a refrigerator and kitchen cabinets. This allows the room to be used for the preparation of complete meals as part of the Rehabilitation Program.

Though the Emergency Housing Program is located in a renovated ward on the hospital grounds, residents of the program are on outpatient status and are treated as lodgers. They are free to leave on their own to participate in daily activities outside the hospital such as locating a place to live, job interviews and clinic appointments and recreation activities.

However, regular meals are served by Creedmoor Psychiatric Center nutrition service in a central dining room. This is due to
the fact that the combination office/snack room presently houses the locked cabinets necessary for the medication storage. Next to this combination room is a special locked clean linen room which is used to store sheets/towels and other linens.

A short distance down the hall is the laundry room which is equipped with a washer, dryer, several laundry carts, a double sink, and a hopper for cleaning soiled linens. All laundry for the program is done by the clients in this room with staff assistance.

The Emergency Housing Program gets its referrals from Creedmoor screening teams. The clients are referred to the program after they are found inappropriate for inpatient admission and have no place to stay. The clients must be at least 18 years of age and free from conditions requiring inpatient medical care. Clients may be in crisis with respect to their economic, familial, or residential situation, but may not exhibit behavior which is dangerous to self or others. The length of stay was initially set at a maximum of 10 days and was extended to 21 days after four months of operation. As mentioned earlier, clients are essentially treated as lodgers waiting to locate a permanent housing arrangement with the assistance of the program staff.

Clients are discharged from EHP under the following circumstances:

- after the mandated length of stay has expired;

- for behavioral/psychiatric reasons if the client constitutes a serious threat to self or others or becomes unmanageable or seriously psychotic;

- in cases of serious illness or injury;
- if the client refuses to participate in his/her placement arrangements.

At the time this study was conducted, staff at the Emergency Housing Program included:

- a certified social worker with a master's degree in social work and a master's degree in counselling (coordinator);
- two social worker assistants, one with one year of study in a graduate school of social work after her BSW, and the other with a BSW degree;
- two community mental health nurses, one registered nurse and one practical nurse;
- a case manager and three mental health aides;
- a rehabilitation assistant with a master's degree in rehabilitation counselling;
- a part-time psychiatrist (acting as consultant) and
- a psychologist (acting as consultant).

The nature of the setting permitted overlap of roles and functions for many staff members, especially at the early stage of implementation. However, after the first four months, more distinctive roles developed. Staff roles and functions were enforced once a job description for staff was put into effect. These roles and functions were monitored by the coordinator of the program.

While nurses and other staff provide the in-house care and supervision of clients, the program guidelines indicate that the social worker bears primary responsibility for developing a service plan and assuming responsibility for its implementation after it is approved by the team. The same guidelines also indicate that the social worker becomes the client's primary link with all community
services. However, if the client is capable of seeking and arranging some services on his/her own behalf, she/he is encouraged and assisted in doing so.

The recreation program provided within the residence is the responsibility of the rehabilitation assistant who works from 10 AM to 6:30 PM daily. Recreation supplies, i.e., reading materials, T.V., games, etc., are available in the residence itself. Clients are allowed to keep radios as long as their use does not interfere with or disturb other clients. The rehabilitation assistant also occasionally plans off-grounds recreation. However, the primary purpose of the residence is finding new housing and/or stabilizing previous housing. Consequently, the recreation program is designed in such a way as not to interfere with that purpose.

As a result of strict safety codes and regulations, the EHP was not certified by the City at the time of the study. Such regulations are frequently cited as an impediment to developing similar residences not only inside hospital grounds but in the community as well. Writing on the law and mental health in community services, Dybwad pointed out for example that

Fire laws are such that before you put these patients into this community residence you have to have a fire escape, a closed staircase 'which in some houses just isn't possible', (emphasis provided) permanently lighted exit signs, and a sprinkler system. You could say to the Fire Marshal, "But, please, the people being put in this house are people who will leave at 8:00 every morning
with lunchboxes, go to some employment or some sheltered workshop, and come back later." And he says to you, "Buster, were they in the hospital? It says here they are patients."  

In mid 1983 the EHP changed its location to the first floor of Building 38 at Creedmoor Psychiatric Center. The new program site complies with the New York City Life Safety Code (L.S.C. 101). A critical review of the EHP suggests that the program could be described as an open ward in a state mental hospital rather than being an alternative living arrangement. The staffing pattern and the extensive clinical and support services provided to clients further enforce this view.  

We should note, however, that the EHP staff are also responsible for providing services at a night hospital program and manning telephones at an around-the-clock crisis intervention and counseling hot line. This may help explain the fact that a large number of staff were working at the program site, so they could provide the above services as well.  

Another equally important fact is that the EHP clients are considered outpatients and as such they could leave the residence at

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any time to be involved in their day to day activities in the community.

As we mentioned earlier, the program was relocated in mid 1983. The new location allowed clients more privacy in double occupancy rooms. The treatment and recreation rooms were recently re-located within some distance from the sleeping areas. The new location also has its own separate entrance and exit. These recent changes made the EHP acquire a more home-like environment.

Finally, we should note that at the time the EHP was selected as the site of this study there were similar programs in 13 different psychiatric centers across New York State.¹

CHAPTER IV
THE STUDY METHOD

1. Preliminary Activity:

During the formulation phase of the study proposal, the investigator conducted informal discussions with clients and staff of the Emergency Housing Program (EHP). These discussions focused on the clients' needs and expectations from the hospital where they sought admission. The discussion also dealt with the staff observations, activities and difficulties in working with this group of clients.

These early discussions with clients and staff helped the investigator to formulate questions for the study questionnaires and to test the degree of staff cooperation in using the program as the study site. The staff was receptive to the idea and upon the approval of the initial proposal the investigator started to interview clients through an open-ended questionnaire. The client questionnaire was pre-tested on 10 clients before it was redesigned with close-ended questions. Close-ended questions were necessary to compute the data quantitatively.

Using the pre-test data, another questionnaire was formulated to obtain information from staff. An open-ended staff questionnaire was distributed to professional and paraprofessional staff who were working with the 10 clients involved in the pre-test period. The
staff questionnaire was then redesigned using close-ended questions. Prior to interviewing the first client, two orientation sessions were conducted for staff working in the day (8:00 AM to 4:00 PM). These and two evening (4:00 PM to 12:30 AM) sessions were conducted to inform the staff about the study goals and to explain their role in implementing them. The staff members were willing to take part in the study, especially when they learned that the main goal was to gain more understanding of the clients' problems and not to evaluate staff performance.

2. Sampling Procedure:

In order to insure that the sample was representative of the population under study, the sample was drawn under the following preset conditions:

1. The client should have sought or was brought for voluntary admission or readmission to the psychiatric facility during the period of the study.

2. The client should have been judged as not in need of inpatient psychiatric treatment by the screening and admission team.

3. The client was in need of service other than inpatient psychiatric treatment such as shelter, food, clothing, and medical attention.

4. The staff participating in filling out staff questionnaires about individual clients should have worked with the client involved individually for a period of time long enough to allow them to formulate opinions about the client's needs and problems.
3. The Study Sample

A. Client Sample

The client sample included persons who sought or were brought for voluntary admission or readmission to Creedmoor Psychiatric Center and met conditions numbered two and three in the sampling procedure. The sample was selected during an uninterrupted period that ended when the sample reached 100 subjects. As such, persons included in the study represented an "incidental sample" of 100 clients who were admitted to the Emergency Housing Program between October 1980 and July 1981. This number constituted all clients who were admitted to the program during that period with the exception of those who were readmitted to the program or stayed in the residence for less than 24 hours (47 clients).

The study period was limited only by the completion of interviewing the first one hundred clients who joined the program. Data collection ended immediately after the one hundredth subject of the sample was interviewed.

All clients were interviewed by the investigator. Each client was interviewed after she/he spent at least one night at the residence. Interviews were conducted during late afternoons, evenings and weekends. This arrangement was made to accommodate the client's scheduled day activities and the investigator's regular work schedule.

Prior to the interview, the investigator explained the study purposes as outlined in the consent form (Appendix 1). The client was then given the consent form to read and sign. The investigator encouraged the client to ask any question she/he might have before the

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1 We use incidental, time, or accidental sample to mean a non-probability sample as defined by Chein. "In accidental sampling, one simply reaches out and takes the cases that fall to hand, continuing the process until the sample reaches a designated size." See: Isidor Chein, "An Introduction to Sampling" in C. C elitiz and M. Jahoda, (eds.) Research Methods in Social Relations, (New York: Holt, Rinehart and Winston, 1959) p. 516.
start of the interview. During the interview, some of the questions were further explained when such an explanation was requested by the client. Interviews proceeded with no significant resistance from clients. A number of clients told the investigator that the interview helped them personally in understanding their difficulties. This positive side effect was not intended. The interview time ranged between 30 to 40 minutes with a median of 35 minutes per interview.

B. Staff Sample:

The staff who were working with the client sample during the day (8:00 AM to 4:30 PM) and the evening (4:00 PM - 12:30 AM) were asked to complete the staff questionnaire after the investigator completed his interview with the client. The investigator assigned the questionnaire to the staff member who was working closely with the client at the time of the interview.

Table 6 presents staff who participated in the study according to occupation and participation in filling out Parts I and II of the staff questionnaire.

The three staff members who participated in filling out Part II only of the questionnaire were not working with individual clients on a day to day basis. For this reason, they were not given Part I of the questionnaire which deals with each individual client of the sample (with the exception of the psychiatrist who gave an assessment of only one client).

Table 7 represents staff educational status at the time they participated in the study. We should also note that four staff members were enrolled in post-graduate and graduate programs at that time.
<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number participating in Parts I &amp; II</th>
<th>Number participating in Part II only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric social worker</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Psychiatric social worker assistant</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Nurse</td>
<td>6*</td>
<td>-</td>
</tr>
<tr>
<td>Psychologist</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Rehabilitation counselor</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Case manager</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Mental Health Aide</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>14</strong></td>
<td><strong>3</strong></td>
</tr>
</tbody>
</table>

*Number of nurses was higher due to some resignations and changes in nurses' positions during the period of the study.
TABLE 7
EDUCATION STATUS OF STAFF WORKING AT EMERGENCY HOUSING PROGRAM (EHP)

<table>
<thead>
<tr>
<th>Educational Status</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ph.D., M.D.</td>
<td>1</td>
</tr>
<tr>
<td>Master's degree</td>
<td>5</td>
</tr>
<tr>
<td>College degree or post graduate</td>
<td>4</td>
</tr>
<tr>
<td>Some college</td>
<td>3</td>
</tr>
<tr>
<td>High school</td>
<td>4</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>17</strong></td>
</tr>
</tbody>
</table>

As a group the staff has considerable experience in the mental health field. Table 8 presents the years of work experience of staff members.

TABLE 8
YEARS OF WORK EXPERIENCE IN MENTAL HEALTH OF STAFF WORKING AT EHP

<table>
<thead>
<tr>
<th>Years of Experience</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nine years or more</td>
<td>10</td>
<td>59</td>
</tr>
<tr>
<td>Four to less than nine years</td>
<td>4</td>
<td>.23</td>
</tr>
<tr>
<td>Two to less than four years</td>
<td>3</td>
<td>18</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>17</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
The majority of questionnaires were completed by social work staff since social workers were the main service providers in the program. Placing clients in a permanent housing arrangement was their main responsibility. Table 9 presents the number of questions completed by staff according to staff discipline.

<table>
<thead>
<tr>
<th>Staff Discipline</th>
<th>Number of Questionnaires filled out</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social work</td>
<td>45</td>
</tr>
<tr>
<td>Nursing</td>
<td>20</td>
</tr>
<tr>
<td>Mental Health Aide</td>
<td>13</td>
</tr>
<tr>
<td>Rehabilitation Counsellor</td>
<td>12</td>
</tr>
<tr>
<td>Case Management</td>
<td>9</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Unstructured interviews with the hospital director and two of his deputies were conducted to elicit their opinions on the services provided by the state psychiatric center.¹

¹Officers interviewed by the investigator for the purpose of this study were:
- Y. Haveliwala, M.D., Creedmoor Hospital Director
- L. Goldberg, Ph.D., Creedmoor Hospital Deputy Director for Community Services
- A. Maggio, M.A., O.T., Creedmoor Linkage Unit Division Chief
The interviews were conducted in the offices of the three officers, after a letter was sent to each of them explaining the purpose of the interview with a summary of the study proposal.

4. **Data Collection Instruments:**

Data for the study were collected mainly through structured and unstructured interviews with clients, program staff, and hospital officials. Table 10 presents the number of questions included in each instrument and the average length of time that was spent in completing one instrument.

**TABLE 10**

**NUMBER OF QUESTIONS INCLUDED IN STUDY INSTRUMENTS AND COMPLETION TIME**

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Number of Questions</th>
<th>Completion Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Questionnaire</td>
<td>29</td>
<td>30-40 minutes</td>
</tr>
<tr>
<td>Staff Questionnaire, Part I</td>
<td>10</td>
<td>20-30 minutes</td>
</tr>
<tr>
<td>Staff Questionnaire, Part II</td>
<td>4</td>
<td>30-40 minutes</td>
</tr>
<tr>
<td>Officers Interviewed</td>
<td>open</td>
<td>40-60 minutes</td>
</tr>
</tbody>
</table>

Copies of client and staff questionnaires are attached as Appendices 2 & 3, and a brief description of each instrument follows.

The client questionnaire covered the following content categories:
– client identifying information
– psychiatric hospitalizations
– referral information
– employment, housing, income, Medicaid benefits
– service expectations from the hospital
– reasons for temporary homelessness
– functional abilities
– ongoing problems and expectations from the hospital with regard to these problems
– knowledge of existing community services and the utilization of such services

The staff questionnaire consisted of two parts, the first part included ten close-ended questions and covered the following content categories:

– assessment of client's level of functioning
– assessment of client’s social and health problems
– assessment of client’s need for personal social services; psychiatric services and other services
– assessment of client’s housing needs
– obstacles in providing services to the client

The second part of the staff questionnaire was open-ended and covered the following categories:

– the staff opinion’s concerning the reasons for clients’ difficulties in obtaining personal social services and other services as well
– the staff assessment of services needed for clients involved in the study
- the staff assessment of the Emergency Housing Program in meeting clients' needs;
- the staff opinion concerning the reason that clients are unable to be sustained in a community living arrangement.

Part II of the questionnaire was filled in only once by each staff member.

5. Other Data Sources:

Literature search relating to topics such as mental hospital admissions, problems of alternative living arrangement for former mental patients, housing and deinstitutionalization as well as statistical data about Creedmoor Psychiatric Center was facilitated through computer data search. The search was conducted upon the request of the investigator from the following sources:

1. Columbia University, School of Public Health, Computer Search Center
2. New York State Library, Data Base Services
3. National Institute of Mental Health, National Clearinghouse for Mental Health Information (NCMHI)
4. Creedmoor State Hospital, Medical Record Computer Systems

6. Data Collection and Processing:

The data for the study were collected from clients, staff and hospital officers during the period between October 1, 1980 and July 31, 1981. Data on admissions to Creedmoor Hospital during the same period were requested from the hospital medical records department in late September, 1981 and were received on October 13, 1981.

Data on admission were sorted by name and used to construct statistical
Tables covering the nine variables which correspond with similar variables on the client sample questionnaire. These variables were:

- Age
- Sex
- Ethnicity/race
- Education
- Current marital status
- Religion
- Present employment status
- Household composition
- Source of referral

The investigator also requested information on patients' type of residence at the time of admission but such information was not available. Information on type of residence was not stored in the computer terminal and consequently could not be retrieved.

Data on the client and staff questionnaires were precoded by the investigator. The data were then processed through the Statistical Package for the Social Sciences (SPSS) computer program at Columbia University's Teacher College. The data analysis included the usual descriptive statistics, simple frequency distributions, and cross-tabulations. Spearman's Rank Order Correlation Coefficient and Chi-Square Tests on the study sample and hospital admissions during the period of study were conducted by the investigator.
CHAPTER V
CLIENTS' PROFILES

Introduction

Clients in this study were among those who sought voluntary admission or readmission to Creedmoor Psychiatric Center (CPC) during a ten month period in 1980-1981. Clients arrived at Creedmoor by themselves or accompanied by others. Each client was screened by a psychiatric team for possible admission to the psychiatric center. However, the team decided in each case that the client did not need to be admitted. The team also found that the client did not have a temporary or permanent place to stay and consequently referred him/her to the Emergency Housing Program (EHP) which was located on CPC grounds.

A profile of the characteristics of this group of clients follows. The main objective of this profile is to draw a descriptive picture of persons who sought admission to psychiatric facilities, though their condition did not warrant such admission. A second part of the characteristics profile will point to the similarities and differences between the above group and clients who were admitted to the psychiatric center during the period of the study.

Study data, data from CPC records and data obtained from the New York State Office of Mental Health were used to compile the clients' profiles.
TABLE 11

CLIENTS' STATUS BY SELECTED CHARACTERISTICS
(N=100 unless indicated otherwise)

<table>
<thead>
<tr>
<th>Selected Variables</th>
<th>Number</th>
<th>Selected Variables</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex:</strong></td>
<td></td>
<td><strong>Education:</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>38</td>
<td>Attended Elementary School</td>
<td>18</td>
</tr>
<tr>
<td>Female</td>
<td>42</td>
<td>Attended High School</td>
<td>24</td>
</tr>
<tr>
<td><strong>Race:</strong></td>
<td></td>
<td>Completed High School</td>
<td>37</td>
</tr>
<tr>
<td>White</td>
<td>49</td>
<td>Attended Voc. School</td>
<td>2</td>
</tr>
<tr>
<td>Black</td>
<td>38</td>
<td>Attended College</td>
<td>13</td>
</tr>
<tr>
<td>Hispanic E.-A.</td>
<td>7</td>
<td>Completed College</td>
<td>4</td>
</tr>
<tr>
<td>American Indian</td>
<td>6</td>
<td>Attended Graduate School</td>
<td>2</td>
</tr>
<tr>
<td><strong>Age:</strong></td>
<td></td>
<td><strong>Monthly Income:</strong></td>
<td></td>
</tr>
<tr>
<td>Less than 20</td>
<td>4</td>
<td>Less than $50</td>
<td>26</td>
</tr>
<tr>
<td>20 - 39</td>
<td>42</td>
<td>$50 - $149</td>
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<tr>
<td>30 - 39</td>
<td>24</td>
<td>$150 - $249</td>
<td>15</td>
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<td>40 - 49</td>
<td>16</td>
<td>$250 - $349</td>
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<td>50 - 59</td>
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<tr>
<td>60 - 69</td>
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<td>Over 70</td>
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<td>Over $650</td>
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<tr>
<td><strong>Marital Status:</strong></td>
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<tr>
<td>Married</td>
<td>11</td>
<td><strong>Religion:</strong></td>
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<tr>
<td>Never married</td>
<td>61</td>
<td>Catholic</td>
<td>44</td>
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<tr>
<td>Divorced</td>
<td>14</td>
<td>Protestant</td>
<td>29</td>
</tr>
<tr>
<td>Separated</td>
<td>9</td>
<td>Jewish</td>
<td>12</td>
</tr>
<tr>
<td>Widowed</td>
<td>5</td>
<td>Other &amp; Unknown</td>
<td>15</td>
</tr>
<tr>
<td><strong>Employment:</strong></td>
<td></td>
<td><strong>Employment:</strong></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>10</td>
<td>N = 10</td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>34</td>
<td>Employed full time</td>
<td>4</td>
</tr>
<tr>
<td>Not in Labor Force</td>
<td>36</td>
<td>Employed part time</td>
<td>6</td>
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<tr>
<td><strong>Reason for not being in the Labor Force:</strong></td>
<td>N = 36</td>
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<td></td>
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<tr>
<td>Illness</td>
<td>31</td>
<td><strong>Source of Income:</strong></td>
<td></td>
</tr>
<tr>
<td>Homemaker</td>
<td>3</td>
<td>SSI</td>
<td>47</td>
</tr>
<tr>
<td>Student</td>
<td>1</td>
<td>Public Assistance</td>
<td>10</td>
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<tr>
<td>Retired</td>
<td>1</td>
<td>Work only</td>
<td>6</td>
</tr>
<tr>
<td>No source of income</td>
<td>23</td>
<td>No source of income</td>
<td>23</td>
</tr>
<tr>
<td>Relatives + part time</td>
<td>8</td>
<td>Relatives + part time</td>
<td>8</td>
</tr>
<tr>
<td>Own savings or retirement</td>
<td>3</td>
<td>Own savings or retirement</td>
<td>3</td>
</tr>
<tr>
<td>Unknown</td>
<td>3</td>
<td>Unknown</td>
<td>3</td>
</tr>
</tbody>
</table>
### TABLE 11 continued

<table>
<thead>
<tr>
<th>Selected Variables</th>
<th>Number</th>
<th>Selected Variables</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Client Sought:</strong></td>
<td></td>
<td><strong>Medical Benefits:</strong></td>
<td></td>
</tr>
<tr>
<td>New admission</td>
<td>29</td>
<td>Medicaid</td>
<td>50</td>
</tr>
<tr>
<td>Readmission</td>
<td>71</td>
<td>Medicare</td>
<td>6</td>
</tr>
<tr>
<td><strong>Source of referral to CPC:</strong></td>
<td></td>
<td>Medicaid &amp; MediCare</td>
<td>4</td>
</tr>
<tr>
<td>Self</td>
<td>23</td>
<td>No medical benefits</td>
<td>40</td>
</tr>
<tr>
<td>Family/friend</td>
<td>12</td>
<td><strong>Living Arrangements Prior</strong></td>
<td></td>
</tr>
<tr>
<td>Police</td>
<td>8</td>
<td>to Seeking Admission:</td>
<td></td>
</tr>
<tr>
<td>Outpatient facility</td>
<td>17</td>
<td>Own home or apartment</td>
<td>25</td>
</tr>
<tr>
<td>General Hospital</td>
<td>30</td>
<td>Home of relative or friend</td>
<td>43</td>
</tr>
<tr>
<td>Mental Hospital</td>
<td>1</td>
<td>Hotel or rooming/boarding house</td>
<td>17</td>
</tr>
<tr>
<td>Resident facility</td>
<td>3</td>
<td>Community residence</td>
<td>8</td>
</tr>
<tr>
<td>Voluntary agency</td>
<td>1</td>
<td>Psychiatric Hospital</td>
<td>3</td>
</tr>
<tr>
<td>Private psychiatrist</td>
<td>1</td>
<td>Homeless</td>
<td>4</td>
</tr>
<tr>
<td>Other and unknown</td>
<td>4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1. **Admission seekers who did not need to be admitted:** Data gathered from the study sample indicated that the majority of clients were male, white, Catholic, and between the ages of 20 and 30 years old. The majority also were never married, had education below high school level, were unemployed and had an income or allowance of less than fifty dollars a month. The majority were seeking readmission to the hospital, were recipients of public assistance and/or SSI disability benefits (57%), or had no income of their own (23%).

Sixty percent of the sample said they were receiving Medicaid and/or Medicare benefits and 40 percent said they received no such benefits.

The majority of clients were living with a relative or a friend at the time they sought or were brought for admission or readmission to the hospital. Twenty-five percent were living in their own homes or apartments and 18 percent were living in supervised living arrangements such as community residences, boarding homes, private proprietary homes for adults (PPHA) or were residing in psychiatric hospitals. Only 4 percent of the sample were homeless.

Table 11 illustrates clients' status by selected characteristics.

2. **A look at clients' charts:** After the data were collected, a number of clients' charts (who were subjects in the study) were reviewed. A brief summary of each of these clients' charts follows:

   It should be noted that each summary is limited to the client's demographic characteristics and his/her reason(s) for seeking admission or readmission to the hospital. The purpose of these summaries is
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to complement the clients' statistical profiles. Facts concerning clients' characteristics and problems were summarized as reported in the clients' charts without interpretation on the part of the investigator.\(^1\)

**Case 1: Family Problem**

P.B. is a 30 year old, single, white, Catholic male. The client sought readmission to Creedmoor because of problems with his family. After the client was screened, he was referred to the EHP. At the age of 28 the client had been hospitalized at Creedmoor for six months and upon his discharge he lived with his parents.

The client attends a Creedmoor day treatment hospital on a regular basis. He also applied for Medicaid and SSI benefits. The client completed high school and began his first year of college. He dropped out of college because he did not want to take the necessary courses to complete his degree. The client is currently unemployed. He has worked in various restaurants and retail stores. The client has made several attempts to live independently in shared apartments or hotels.

**Case 2: The Possessive Landlady**

Client B.C. is a 52 year old, white, Protestant, divorced male. He sought readmission to Creedmoor and was referred to the EHP. At the time the client sought readmission he was living in a furnished room which he left on his own because of interpersonal conflicts with his landlady. The client described the landlady as being excessively concerned about him and interfering in his affairs. The client was described as being capable of handling his affairs with a minimal amount of supervision.

The client is currently involved in the work-for-pay program at Creedmoor. He also attends a Creedmoor out-patient clinic. The client receives $384.00 per month from SSI benefits.

\(^1\)Sixteen clients were picked through a simple procedure. All 100 names of the clients interviewed were written on separate slips of paper. All slips were then placed in a jar. The jar was shaken several times and the 16 slips were picked from the jar. The charts of the names which appeared on these slips were then summarized. Client's initials were altered and other minor changes in names of places were necessary to protect clients' identity. No attempt was made to alter any client's characteristics or the circumstances that led to his/her referral to the EHP.
Case 3: No Other Place to Go

Client M. L. is a 19 year old, single, Hispanic, Catholic male. The client had returned from Puerto Rico where he stayed with his mother for a few months. Upon his return, the client had hoped that his uncle would allow him to stay with him, but the uncle refused. He was unable to locate his other relatives and finally, he came to Creedmoor requesting assistance with housing and financial aid. Subsequently the client was referred to the EHF. The client has had one psychiatric hospitalization at Queens General Hospital which lasted 21 days. The client attends a Creedmoor day hospital and has applied for SSI benefits.

Case 4: The Mother Does Not Want Him Back

Client M.R. is a 21 year old, white, single, Protestant male. The client's early development was apparently normal. He completed grammar school and then successfully completed three years at a marine biological high school. He attended a regular high school for his fourth year but was unable to graduate.

The client's parents were separated when he was eight years old and divorced when he was nine. The client has never been able to resolve the anger he has felt toward his parents since their divorce. He has felt that his mother is not supportive of him and has felt abandoned by his father who has had no contact with him. When the parents were separated the father took the client's older brother to live with him. Since the incident, the client has felt that his father cared more for his brother than for him.

The client's first hospitalization occurred when he was 17 years old. At that time he felt he had to protect his mother from their building superintendent. The building superintendent misinterpreted the client's action of waving a hammer in the air and reacted as if the client had attacked him with the hammer. The client was confused and frightened and not able to cope with the situation. He was subsequently hospitalized at Creedmoor Psychiatric Center for 3½ months. Upon his discharge he went to live with his brother in another state. The client worked in a print shop but was terminated from his job because he was unable to get to work on time.

He then joined the Navy but did not like the discipline and was discharged after a month when he revealed his psychiatric hospitalizations. When he came back to New York he got into an argument with his mother at the airport. The mother tried to grab a radio he was carrying,
and he grabbed at her neck. She became hysterical and called for help; she claimed that the client was attacking her and described him as a psychiatric patient, whereupon the police took him to Elmhurst General Hospital. He was transferred to Creedmoor and stayed for one month.

The client was discharged and went to a private psychiatrist for four months, but his attempt at therapy was unsuccessful. He was living with his mother at the time. The client was very angry with his mother and said she had no confidence in him. He became discouraged at the difficulty he was having with his mother and stopped taking his medication.

The client was brought by his mother for readmission to Creedmoor after he allegedly menaced a woman with a board when she was walking in the street. Subsequently, the client was referred to the Emergency Housing Program by the screening team at Creedmoor. The mother did not want the client to live with her. She feared that he might hurt her, himself or others.

**Case 5: Cannot Stay at the Adult Home**

Client K.C. is a 44 year old, single, white, Jewish male who sought readmission to Creedmoor and was referred to the EHP. The client was living in a boarding home which had no heat or hot water. As a result, the client was unable to shower. When he appeared for admission at Creedmoor, he was disheveled and infested with lice.

The client had had several previous admissions to Creedmoor. The client's living situation has been marginal since his mother's death several years ago. He has resided in adult homes, welfare hotels and the men's shelter. The client receives $224 as SSI benefits and attends a Creedmoor day treatment center.

**Case 6: An Incident at the Airport**

Client A.R. is a 22 year old, white, Moslem, male, who is a subject of a foreign country in the Middle East. The client was sent by Queens General Hospital for admission to Creedmoor via a transfer agent. Subsequently, the client was referred to the EHP after he was found not in need of inpatient psychiatric treatment.
The client reported that he had come to New York City to fly home because he was homesick. The client had a student visa and was enrolled at an upstate college. The client apparently neglected to take his passport with him to the airport. Consequently, he was not permitted to leave on his scheduled flight that evening. The client waited at the airport until the following day when a friend brought him the passport. A new reservation was made for the client.

The client stated that he heard voices that were telling him that people wanted to kill him. The client became disturbed and tore up his plane ticket at the gate. The client then proceeded to leave the airport, obtained his car from the parking lot and drove out of the airport. While driving, he felt that he was being followed. At this point, he abandoned his car and walked back to the airport. Feeling that he needed assistance, the client called an ambulance and was taken to Queens Hospital Center.

The psychiatric consultant at the EHP suggested that the client had been using drugs and was experiencing some LSD flashbacks. The client remained at the EHP for 6 days during which the social worker arranged another flight for him after contacting his embassy.

Case 7: The Mother’s House is Sold

Client S.A. is a 46 year old, single, Catholic male who was attending one of the Creedmoor outpatient clinics for the past 6 years. The client was living in a house owned by his mother. On the day the house was sold the client was referred to Creedmoor by a worker at the outpatient clinic. The client was found not in need of inpatient admission and consequently he was referred to the EHP.

Case 8: No Heat or Hot Water

Client S.J. is a 37 year old single, white, Jewish, unemployed male. The client sought readmission to Creedmoor as he was unable to continue to reside in the furnished room where he was living for the past year. The room evidently did not have heat or hot water for several months. The client was found not in need of inpatient treatment and subsequently was
referred to the EHP. The client had a history of psychiatric hospitalization at Creedmoor and other hospitals since he was 13 years old. The client had resided in several adult homes and welfare hotels. He left some of these homes and sought readmission on his own every time he "ran out of money." He also had stayed at the Men's Shelter for a few months. The client attends a Creedmoor day treatment center. He also receives $393.00 per month on SSI disability benefits.

Case 9: The Nephew Said No

Client G.C. is a 48 year old, divorced, white, Protestant female who had had 7 prior psychiatric hospitalizations at Creedmoor and other city hospitals during the past four years. In August 1980 the client was taken to Elmhurst General Hospital by police. The client was living with her nephew at the time and her condition was described as acting bizarre, undressing herself and hallucinating. She spent two days at Elmhurst and was brought to Creedmoor by a transfer agent. At Creedmoor she was found to be coherent, relevant, oriented, and without suicidal or homicidal intention. Consequently, the client was screened out and was referred to the EHP. The client's nephew refused to have her return to his home. The client had been on public assistance for the past ten years (AFDC), and her application for SSI was denied three times prior to her referral to the EHP.

Case 10: The Parents Do Not Want Him Back

Client G.R. is a 28 year old, white, Jewish, single male who is unemployed and had been living with his parents. The client was seeking readmission to Creedmoor for the first time. However, he had a history of psychiatric treatment by private psychiatrists and had been hospitalized at a private psychiatric hospital several times since he was 18.

Upon his discharge from Creedmoor he was referred to EHP due to the fact that his parents did not want him to live with them any longer. Prior to his readmission to Creedmoor the client had been looking for an apartment but had not had any success in finding one. He had been attending a city college and had completed 106 credits of his school work. He was also employed as a bookkeeper in a law firm on a part-time basis.
Case 11: The Brother Got Married

Client A.B. is a 24 year old, Black, single, Catholic male who was residing with an older brother. The client sought readmission to Creedmoor when his brother got married and could no longer provide him with shelter in his home. The client is attending one of Creedmoor's day treatment programs and is receiving $123 a month in public assistance.

Case 12: It Is Much Safer Here

Client G.M. is a 33 year old white, Catholic, single, male who was unemployed and living in the Booth House in the Bowery at the time he sought readmission to Creedmoor. The client has had multiple hospitalizations during the past five years mainly because of alcoholism problems. He attends one of Creedmoor's outpatient clinics and Alcoholism Anonymous group meetings. In seeking readmission to the hospital the client mentioned that it is much safer at the hospital than living in the men's shelter. The client was robbed more than three times while he was living in the men's shelter.

Case 13: The Hospital Is My Home

Client P.A. is a 34 year old, single, Black, Protestant, female. The client was readmitted voluntarily to CPC and was hospitalized for three weeks. The client was unemployed and had no address at the time she was admitted to the hospital. She was referred to the EHP upon her discharge. The client was one of the first referrals to the EHP. (It is likely that her hospitalization could have been averted if the EHP was in operation at the time she sought admission to the hospital.)

The client's record indicated that she was born in Philadelphia and was raised in a foster care home until she was 14 years old. She had had several psychiatric hospitalizations both in Philadelphia and in New York City. During her first interview at the EHP, the client mentioned that she left Philadelphia because she had "used up all the hospitals as far as medication and usefulness". The client's application for SSI had been denied three times. When the EHP social worker asked the client about her feelings at the time she requested readmission to the hospital, the client's answer was "I felt I was coming back home...I have no place else to go."
At the time the client was residing at the EHP she was preparing to take the High School Equivalency Diploma Examination. The client mentioned that she would have no problem finding a job once she obtains her diploma. The client's main complaint while in the EHP was that she could not control her anger.

Case 14: She Wants a Place of Her Own

S.J. is a 34 year old, white, Jewish, single, female, who had no prior admission to Creedmoor. The client however had a history of psychiatric hospitalization and outpatient treatment at a nearby private hospital for the past 11 years.

The client originally sought admission to the private hospital but was turned down because "her Medicaid benefits had run out." She was transferred to Queens General Hospital. The general hospital in turn referred the client to Creedmoor via a transfer agent. Subsequently, the client was referred to the Emergency Housing Program (EHP) after it was decided that she did not need inpatient psychiatric treatment.

At the time the client was referred to the EHP she was studying for her college degree in psychology at a nearby college. The client was also living with a boyfriend at that time. The client felt unhappy with her relationship with the boyfriend and wanted to have a place of her own. The client is receiving $301 in SSI disability benefits.

Case 15: No Place to Live

Client G. C. is a 27 year old, unemployed Black, single male who has never been hospitalized at Creedmoor. The client has 3 years of college education. He had been living with his sister, brother-in-law and their four children. The client had a very brief psychiatric hospitalization at a nearby private hospital and at Pilgrim Psychiatric Center. These two hospitalizations were, according to the records, due to feelings of depression after starting a new job and dropping out of college.

The client sought voluntary admission to Creedmoor and was referred to the Emergency Housing Program "for reasons of financial difficulties and having no place to live." The client's public assistance had been
terminated because he had no place to live and his sister refused to allow him to continue to live in her apartment.

During his stay at the Emergency Housing Program the client's public assistance was restored. He is currently receiving $260 from public assistance and has Medicaid benefits.

Case 16: She Does Not Want To Go Back Home

Client S.M. is a 32 year old, single, Black, Catholic, female. She is a high school graduate and was employed for several years. At the time she sought admission to CPC she was unemployed except for an occasional temporary job.

In recent years the client has been unable to maintain steady employment. This in part - as reported by the client - was due to the fact that she has had multiple psychiatric hospitalizations during the past ten years.

It was reported that the client has difficulty getting along with her mother and younger sister and "it appeared that the family support system has collapsed." During her last admission to Creedmoor the client maintained much ambivalence about returning home as opposed to a placement alternative. There was no community placement available for the client at the time of her discharge. Consequently, the client was referred to the EHP until a placement alternative could be arrange. The client receives $334 in SSI disability benefits.

3- Psychiatric Admissions vs. Referrals to Emergency Housing

Creedmoor data on persons who were admitted or readmitted during the period of the study point to areas of similarities and differences between the study and the hospital in-patient population. Analysis of variance indicated no significant differences between the study sample and the hospital population with reference to the age, sex, race, marital status and religion distributions of both groups. Table 12 illustrates this fact.
<table>
<thead>
<tr>
<th>TABLE 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLIENTS' STATUS IN COMPARISON TO PATIENTS WHO WERE ADMITTED TO CREAMDOOR PSYCHIATRIC CENTER (CPC) BY SELECTED CHARACTERISTICS</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Client Sample N = 100</th>
<th>CPC admission percentage N = 2796 p/e = 100</th>
<th>X²</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>58</td>
<td>59</td>
<td>0 P &lt; .05 1dF</td>
</tr>
<tr>
<td>Female</td>
<td>42</td>
<td>41</td>
<td></td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>49</td>
<td>51</td>
<td>7.18 P &lt; .05 4dF</td>
</tr>
<tr>
<td>Black</td>
<td>38</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>Hispanic W. &amp; B.</td>
<td>4</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>American Indians</td>
<td>6</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 20 years</td>
<td>4</td>
<td>3</td>
<td>2.27 P &lt; .05 6dF</td>
</tr>
<tr>
<td>20 - 29</td>
<td>42</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>30 - 39</td>
<td>24</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>40 - 49</td>
<td>16</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>50 - 59</td>
<td>9</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>60 - 69</td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Over 70</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catholic</td>
<td>44</td>
<td>40</td>
<td>3.07 P &lt; .05 3dF</td>
</tr>
<tr>
<td>Protestant</td>
<td>29</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>Jewish</td>
<td>12</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>15</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>11</td>
<td>13</td>
<td>2.7 P &lt; .05 4 dF</td>
</tr>
<tr>
<td>Never married</td>
<td>61</td>
<td>56</td>
<td>(-Unknown)</td>
</tr>
<tr>
<td>Divorced</td>
<td>14</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Separated</td>
<td>9</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Widowed</td>
<td>5</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>9</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Significant differences though were noted between clients in the study sample and those who were admitted to Creedmoor. These differences were evident in many variables such as admission status, employment status, education.
status and source of referrals. Sample data on financial status and living arrangements prior to seeking admission could not be tested due to lack of comparable data from CFC admission records.

As Table 13 indicates, the majority of the study sample were seeking readmission to the hospital, while the majority of those who were admitted to the hospital were seeking admission for the first time. One interpretation of these data is that, though their condition did not warrant readmission to the hospital, many of the client sample considered the hospital as the only accessible place to help them with their problems. As one client put it during an interview, "I only come to the hospital when I run out of money, and I usually leave when the social worker sends my 'green form' to the Welfare Office and tells the landlord that my rent will be paid." We should note that the Emergency Housing clients were not admitted or readmitted to the hospital when they appeared for screening. As such they are considered "potential" first admissions or "potential" readmissions in comparison with those who were admitted or readmitted to the hospital during the period of the study.

Another significant difference between the study sample and the hospital in-patient population was the source of referrals to the hospital. As Table 14 indicates, the majority of clients who were referred to EHP (The Study Sample) were either self-referred or were referred by family or friends (40%). Meanwhile, only 13 percent of those who were admitted to the hospital were self referred or were brought by family or friends. Also the percentage of referrals by out-patient clinics was three times higher among EHP clients than the CFC in-patient population.
### Table 13

<table>
<thead>
<tr>
<th>Actual or Potential Admissions Status</th>
<th>E.H.P.</th>
<th>C.P.C.</th>
<th>Remarks*</th>
</tr>
</thead>
<tbody>
<tr>
<td>First admission</td>
<td>29</td>
<td>56</td>
<td></td>
</tr>
<tr>
<td>Readmission</td>
<td>71</td>
<td>39</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

*CPC total represents number of admissions including repeated admissions during same period.

**$\chi^2 = 39.2$ p > .05 2df (Unknown)**

### Table 14

<table>
<thead>
<tr>
<th>Source of referral</th>
<th>EH N = 100</th>
<th>CPC N = 2796</th>
<th>Remarks *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
<td>23</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Family or Friend</td>
<td>12</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Police</td>
<td>8</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Out-patient Facility</td>
<td>17</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>General Hospital</td>
<td>30</td>
<td>55</td>
<td></td>
</tr>
<tr>
<td>Mental Hospital</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Residential Facility</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Voluntary Agency</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Private Psychiatrist</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>4/1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Alcoholism Program</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>14</td>
<td></td>
</tr>
</tbody>
</table>

* $\chi^2$ p > .05 8dF (Alcoholism and Unknown referrals).
Table 14 also shows that 30 percent of the study sample were general hospital referrals while 55 percent of Creedmoor in-patient admissions were referred by general hospitals. The high referral rate from general hospitals is due, in part, to the fact that in New York City, general hospitals are "receiving hospitals" for most psychiatric admissions. However, because of their limited psychiatric bed capacity the majority of general hospital psychiatric admissions are subsequently referred to state hospitals such as Creedmoor. An equally important reason for the higher rate of general hospitals referrals is that, at the time the study was conducted, general hospitals in Queens County were also responsible for receiving all patients who were discharged from CPC and were out for at least a 3-month period. These rules, however, have undergone changes since then and Creedmoor has also become a receiving hospital.

Educational and employment status were two other areas in which the study sample and inpatient population differed significantly. A comparison between sample data and hospital data showed that twice as many (42%) of those referred to the EHP attended elementary and high school than those who were admitted to the hospital (21%). However, a higher percentage of the hospital inpatients were able to complete high school or college (52%) in comparison with the EHP clients (41%). Table 15 illustrates these figures in more detail.
### TABLE 15

**COMPARISON BETWEEN THE STUDY SAMPLE AND CREEDEMOOR IN-PATIENT POPULATION WITH REFERENCE TO EDUCATIONAL STATUS**

<table>
<thead>
<tr>
<th>Educational Status</th>
<th>E.H. Sample N = 100</th>
<th>CPC Percentage N = 1981</th>
<th>Remarks*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attended elementary school</td>
<td>18</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Attended high school</td>
<td>24</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Completed high school</td>
<td>37</td>
<td>44</td>
<td></td>
</tr>
<tr>
<td>Attended vocational school</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Attended college</td>
<td>13</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Completed college</td>
<td>4</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Attended graduate school</td>
<td>2</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>100</strong></td>
<td><strong>100</strong></td>
<td></td>
</tr>
</tbody>
</table>

*\( \chi^2 = 16.25, \ p > .05 \) 6 df (-Unknown)*

Data on employment status showed that a majority of 54 percent of the EHP clients were unemployed while only 6 percent of the in-patient population were unemployed (Table 16). The data also revealed that while the majority of EHP clients were unemployed, 72 percent of the inpatients were unemployable due to illness. Only 31 percent of the EHP clients were unemployable due to illness. Table 17 presents these figures in more detail.
EHP CLIENTS' AND CPC INPATIENTS' EMPLOYMENT STATUS

<table>
<thead>
<tr>
<th>Variable</th>
<th>E.H. Clients (N = 100)</th>
<th>C.P.C. Inpatients (N = 1981)</th>
<th>Remarks*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>10</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>54</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Not in labor force</td>
<td>36</td>
<td>90</td>
<td></td>
</tr>
</tbody>
</table>

*x² p > .05 2 df

While 31 percent of the EHP client sample were considered unemployable due to their mental disability, 72 percent of those who were admitted to the hospital fell in that category.

The data also indicated that none of the EHP clients were physically disabled while 11 percent of CPC admission were classified as such. Table 17 presents these facts in detail.

TABLE 17

EHP CLIENTS' AND CPC IN-PATIENTS' REASONS FOR NOT BEING IN THE LABOR FORCE

<table>
<thead>
<tr>
<th>Reasons for Unemployability</th>
<th>E.H. Clients</th>
<th>C.P.C. Inpatients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N = 36</td>
<td>p = 1.783</td>
</tr>
<tr>
<td></td>
<td>X = 36</td>
<td>X = 90 *</td>
</tr>
<tr>
<td>Illness</td>
<td>31</td>
<td>72</td>
</tr>
<tr>
<td>Homemaker</td>
<td>3</td>
<td>1.5</td>
</tr>
<tr>
<td>Student</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Retired</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Disability (physical)</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>3.5</td>
</tr>
</tbody>
</table>

*x² P > .05 5 df
Findings of the current study can be compared with Morrissey and McGreevy's recent study on "Admission Screening at New York State Psychiatric Centers." Morrissey and McGreevy's findings are drawn from a time sample from Creedmoor and Hutchings Psychiatric Centers. The study data were collected during a ten week period in late 1980. Sample selection and the timing of Morrissey and McGreevy's study make their findings relevant for comparison with our study.

We noted that both studies have found no significant differences between admissions and non-admissions with reference to sex, marital status and ethnicity. However, according to our findings, there were significant differences between admissions and non-admissions with reference to education and employment. Morrissey and McGreevy's study did not detect a significant difference with reference to those same two variables.

Differences in findings between the two studies could be attributed to the fact that while Morrissey and McGreevy's study reflect the characteristics of the non-admission population, in general, our study was dealing with only one segment of this population, namely those who were found to have a pressing need for temporary or permanent housing. Our findings suggest that those clients are likely to be unemployed rather than being unemployable and also are educated at lower levels than those who were admitted to the hospital.


2Ibid., p. 16.
It should be noted that many clients who mentioned that they were unemployed could be classified in the "out of the labor force" category since they were not seeking employment at the time they were interviewed. In light of this fact, more persons could be added to the sample's "out of the labor force" number, and the number of unemployed persons may actually be less than reported.

In general, the clients' profiles presented a group of clients with more than their share of emotional, financial, educational, social and housing problems.

The clients' self assessments and the staff assessment of clients' needs (Chapters VI - VII), explores the above problems and lists clients' needs and expectations in reference to these problems.

We should point out, however, that these clear indications of clients' needs do not imply a need for admission to state mental hospitals in order to satisfy these needs. Clients' needs, as presented in this chapter, do not justify admission for inpatient psychiatric treatment.
CHAPTER VI

THE CLIENTS' SELF ASSESSMENTS

Introduction

One of the implicit hypotheses of this study is that many clients who arrive on their own or are brought by others for admission or readmission to state psychiatric facilities have problems, needs and expectations well beyond the psychiatric facility's domain of service. Problems such as housing, unemployment, family conflicts and lack of financial means are common among clients seeking psychiatric admission. In many cases clients expect the mental hospital to handle these problems for them at least temporarily. Clients expect the hospital staff to help them "make it" upon discharge by legitimatizing their entitlement to financial and medical disability benefits. Our review of the literature gives credence to this hypothesis and the data of this study seem to partially confirm it.

At the outset it is important to remind the reader that the client sample had sought admission to the state psychiatric facility and were found not in need of inpatient psychiatric treatment. Furthermore, clients did not have temporary or permanent housing at the time they were screened at the hospital. Consequently, they were referred to the Emergency Housing Program. With this fact in
mind, the data here represents problems, needs and expectations of clients at the time they sought admission to the psychiatric hospital prior to their referral to the Emergency Housing Program. The number of clients' responses is also a percentage since the sample (N) is 100 clients.

1. **Clients' problems:** The rank order of problems according to clients' sample (Table 18) is: housing, financial problems and family problems. Ninety clients said that they had a housing problem; 82 clients said they had financial problems, and 57 clients mentioned family problems.

Other problems which were mentioned less frequently by clients included work-related problems (53 clients), emotional problems (53 clients), and medical problems (39 clients).

Seventeen clients mentioned that they had problems in community residences and boarding homes. This number represents 74 percent of clients who lived in these residences prior to seeking psychiatric admission or readmission.

Despite the fact that the Emergency Housing Program rules prohibited the acceptance of persons with drug or alcohol problems, 8 clients with such problems managed to enroll in the program.

When asked about the causes of their housing problems, 62 clients said they had difficulties living with friends or relatives. A similar number indicated that they could not find housing on their own. Fifty-nine clients said they did not have money to pay for rent; 16 clients said that the owners of residences objected to their
Table 18 illustrates clients' reasons for being temporarily or permanently homeless.

staying at the place they were living in; very few said the reason was that they preferred to stay in the hospital (5 clients) or would rather be homeless in the street (2 clients).

Table 19 illustrates clients' reasons for being temporarily or permanently homeless.
TABLE 19

CLIENTS' REASONS FOR BEING TEMPORARILY
OR PERMANENTLY HOMELESS

<table>
<thead>
<tr>
<th>Reasons for Being Homeless</th>
<th>Number of Responses</th>
<th>Percent of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannot find housing</td>
<td>62</td>
<td>29.5</td>
</tr>
<tr>
<td>Had difficulties living with friends or relatives</td>
<td>62</td>
<td>29.5</td>
</tr>
<tr>
<td>Do not have money</td>
<td>59</td>
<td>28.1</td>
</tr>
<tr>
<td>Had problems with owners of residence</td>
<td>16</td>
<td>7.1</td>
</tr>
<tr>
<td>Wanted to stay in the hospital</td>
<td>5</td>
<td>2.4</td>
</tr>
<tr>
<td>Wanted to be on the streets</td>
<td>2</td>
<td>1.0</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>1.9</td>
</tr>
<tr>
<td>TOTAL</td>
<td>210</td>
<td>100</td>
</tr>
</tbody>
</table>

2. Clients' needs: The fact that all clients were referred to an emergency housing program indicated that they needed housing at least on a temporary basis. The study data confirmed that housing was the most needed service for this group of clients. When asked about their preferences, a majority of 70 clients preferred to have their own home or apartment, although only 25 clients stated they had been living in their own home or apartment prior to being referred to EHP. Six clients preferred to live with a relative or a friend, a decrease of 86 percent from those who originally lived with relatives and friends prior to joining the program. Twenty-one
clients preferred to live in a boarding or residential home, 19 percent less than those who lived in these settings before they were referred to EHP. Two of four clients who were homeless preferred to remain homeless. Three clients who were newly discharged from mental hospitals did not want to be readmitted. Table 20 shows data on clients' preferences for living accommodations after leaving the EHP, in comparison to living arrangements before they joined the program.

TABLE 20

CLIENTS PRIOR LIVING ACCOMMODATIONS AND THEIR PREFERENCES

<table>
<thead>
<tr>
<th>Housing Arrangement</th>
<th>Prior Living Accommodation</th>
<th>Preferred Living Accommodation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Own home or apartment</td>
<td>25</td>
<td>70</td>
</tr>
<tr>
<td>Home of relative or friend</td>
<td>43</td>
<td>6</td>
</tr>
<tr>
<td>Rooming house, boarding house, hotel</td>
<td>17</td>
<td>12</td>
</tr>
<tr>
<td>Community residence, adult home</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Psychiatric hospital</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Homeless</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>
### TABLE 21

|                      | 1.  | 2.  | 3.  | 4.  | 5.  | 6.  | 7.  | 8.  | 9.  | 10. | 11. | 12. | 13. | 14. | 15. | 16. | 17. | 18. | 19. | 20. | 21. | 22. | 23. | 24. | 25. | 26. | 27. | 28. | 29. | 30. | 31. | 32. | 33. | 34. | 35. | 36. | 37. | 38. | 39. | 40. | 41. | 42. | 43. |
|----------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| **OWN HOME**         |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
| **APARTMENT**        |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
| **FRIEND/FAMILY**    |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
| **BOARDING HOUSE**   |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
| **HOTEL/ROOM**       |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
| **COMMUNITY RESIDED**|     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
| **PROPERTY FOR AD**  |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
| **STATE PSYCH.Chtr** |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
| **CERT.PSYCH.Chtr**  |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
| **IMMELESS**         |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |

<table>
<thead>
<tr>
<th><strong>Column</strong></th>
<th>70</th>
<th>60</th>
<th>70</th>
<th>20</th>
<th>70</th>
<th>1.0</th>
<th>1.0</th>
<th>3.0</th>
<th>2.0</th>
<th>1.0</th>
<th>100.0</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>70.0</td>
<td>60.0</td>
<td>70.0</td>
<td>20.0</td>
<td>70.0</td>
<td>1.0</td>
<td>1.0</td>
<td>3.0</td>
<td>2.0</td>
<td>1.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Chi square = 63.73400 with 72 Degrees of freedom. Significance = 0.7484.

\[
\sqrt{2 \times 72} = 1 - \sqrt{2 \times 63.7} = 0.67
\]
Table 21 shows, there was no significant relationship \((X^2 p > .05)\) between the client's prior housing arrangement and his/her preferred living accommodations after leaving the ERP.

A rank correlation coefficient between the clients' housing preferences and the staff assessment of the clients' housing needs suggested a strong relationship between clients' preferences and staff assessment \((r_s = .9)\). These results will be further explored in the following chapter.

3. **Clients' expectations from CPC**: Clients were asked about their general expectations from Creedmoor Psychiatric Center (CPC). The highest number of clients expected Creedmoor to provide them with temporary housing (97 responses) followed by the expectation that the hospital provides information and referral (89 responses) and locates permanent housing (87 responses). Seventy-three of the responses expected Creedmoor to offer counselling and a similar number expected the hospital to provide them with medication.

Fifty clients expected Creedmoor staff to help them collect disability benefits.

When clients were again asked about their expectations from Creedmoor Psychiatric Center in relation to problems they said they had, the results were constant with reference to housing. Eighty-seven clients expected the hospital to help them with their housing problems; 59 clients expected the hospital to help them with their financial problems. Fifty-one clients expected the hospital to help with their emotional problems; 39 clients looked upon Creedmoor to assist them with their work related problems. Thirty-one clients
expected the hospital to help them with their family problems and a similar number expected help with their medical problems. Table 23 lists clients' expectations from Creedmoor Psychiatric Center with reference to their specific problems.

With the exception of help with emotional problems clients' expectations from the psychiatric facility are unrealistic. In that regard the data suggested that many clients do seek admission to the state hospital with problems, needs and expectations beyond the realm of services that the hospital can provide.
TABLE 23

CLIENTS' EXPECTATIONS FROM CREEDMOOR PSYCHIATRIC
CENTER WITH REFERENCE TO PROBLEMS THEY ENCOUNTERED

| Problems Presented         | Number of Respondents Having Problems | Number of Respondents Who Expect CPC Help | Percentage of Responses "Expectations"
|----------------------------|----------------------------------------|------------------------------------------|----------------------------------------
| Housing                    | 90                                     | 87                                       | 28                                     |
| Financial                  | 82                                     | 59                                       | 19                                     |
| Family                     | 57                                     | 31                                       | 10                                     |
| Work related               | 53                                     | 39                                       | 12.5                                   |
| Emotional                  | 53                                     | 51                                       | 16.4                                   |
| Medical                    | 39                                     | 30                                       | 9.6                                    |
| Residential home problems  | 17                                     | 4                                        | 1.3                                    |
| Drug or alcohol related    | 8                                      | 6                                        | 1.9                                    |
| Other                      | 11                                     | 4                                        | 1.3                                    |
| TOTAL                      | 410                                    | 311                                      | 100.0                                  |
4. Clients' knowledge of service available in the community. Clients unrealisitic expectations from the state hospital could be interpreted in part as a reflection of clients' lack of knowledge about agencies that could help them with non-psychiatric problems. When clients were asked if they knew of such agencies, a majority of 75 percent stated that they did not know about these agencies. Only 25 percent knew of the existence of the community agencies and of these, 22 percent had contacted them. This small number of clients had contacted social welfare agencies (12 clients), community mental health clinics (8 clients), health agencies (4 clients) and the city housing department (1 client). The majority of clients who made such contacts said that they were not able to get help from agencies involved.

5. Clients' level of functioning: In the mid-1970s functional service deficiencies became a determining factor in admission, readmission or retention of patients in state psychiatric facilities in New York State. Functional definitions serve a purpose different from that of diagnostic definitions. Instead of defining a condition or impairment in terms of the underlying pathology or cause, a functional definition points to the effect of an impairment on the person's ability to perform one or more life activities, such as self care, communication, learning or mobility.¹

As we indicated earlier, a level of care survey is conducted at Creedmoor each year to determine which patients should be discharged from the hospital and who should remain to be cared for on the hospital grounds. The survey sheet scores patients according to their ability to perform certain tasks independently without the help of others. In designing the questionnaire for our study we included many of the level of care survey questions. We directed these questions to clients as well as staff who work with them in the Emergency Housing Program. Our aim was to explore whether all clients who seek psychiatric admission are low-functioning and dependent individuals and unable to care for themselves. Such a notion is accepted as a fact by many who work in and outside the mental health field.

In the study questionnaire (Appendix 2) clients were asked to assess their ability to walk, bathe, dress, feed, groom and use the toilet by themselves. All clients responded that they could perform these tasks independently. Only on the question of grooming did one client state that he needed some assistance; the other 99 clients said that they are able to groom themselves independently.
CHAPTER VII
THE STAFF ASSESSMENT OF INDIVIDUAL CLIENTS

Introduction

The clients' perspectives and assessments of their problems, needs and level of functioning were presented in the previous chapter. However, one could argue that the clients' self-assessments may represent their wants rather than needs. It could also be argued that many of these clients lack understanding of their real problems. In order to test these notions, we asked staff who worked with the clients to identify the clients' problems and needs. We also asked staff to assess the clients' level of function. We then, whenever possible, statistically tested the clients' own assessments and the staff assessments for any significant variations.

1. Identification of Clients' Problems

Staff responses listed highly significant problems among the majority of clients as: housing, financial, psychiatric and family

---

1 We acknowledge the fact that it is difficult to separate needs from wants, since a stated need may imply the desirability of a higher order end. Gates' example clarifies this point: "I need a pencil, implies that it is needed to fill some higher order desire, presumably that I want to write ... the logic of need can easily be expanded to include higher order ends." Given that I want to survive, I need a job, I need to publish, I need to write, and therefore I need a pencil." See, Bruce L. Gates, Social Program Administration - The Implementation of Social Policy (Englewood Cliffs, N.J.: Prentice-Hall Inc., 1980), p. 102.
problems. Problems that were considered less significant by the staff were lack of home support such as homemaker services, lack of knowledge about services, legal, job-related and medical problems. Table 24 illustrates these data in more detail.

**TABLE 24**

<table>
<thead>
<tr>
<th>Problems</th>
<th>Highly Significant</th>
<th>Significant</th>
<th>Less or Not Significant</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Clients</td>
<td>Number of Clients</td>
<td>Number of Clients</td>
</tr>
<tr>
<td>Housing</td>
<td>83</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Financial</td>
<td>52</td>
<td>11</td>
<td>37</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>40</td>
<td>33</td>
<td>27</td>
</tr>
<tr>
<td>Family</td>
<td>39</td>
<td>25</td>
<td>36</td>
</tr>
<tr>
<td>Lack of knowledge about services</td>
<td>24</td>
<td>24</td>
<td>52</td>
</tr>
<tr>
<td>Job related problems</td>
<td>14</td>
<td>9</td>
<td>77</td>
</tr>
<tr>
<td>Medical</td>
<td>11</td>
<td>13</td>
<td>76</td>
</tr>
<tr>
<td>Legal</td>
<td>5</td>
<td>4</td>
<td>91</td>
</tr>
<tr>
<td>Lack of home support services</td>
<td>6</td>
<td>3</td>
<td>91</td>
</tr>
</tbody>
</table>

Staff and clients, interviewed separately, placed housing and finances as the top two problems facing clients at the EHP. This match of responses disputes the notion that clients seeking psychiatric
admission may not be able to identify their real problem as the staff perceives them.

As Table 25 indicates, clients' responses totally matched staff responses in ranking housing, financial and medical problems in order of priority. There was a slight difference, though, between clients and staff ranking order of family, psychiatric and work-related problems.

<table>
<thead>
<tr>
<th>Problems</th>
<th>Clients' Response</th>
<th>Clients' Rank</th>
<th>Staff Response</th>
<th>Staff Rank</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing</td>
<td>90</td>
<td>1</td>
<td>83</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Financial</td>
<td>82</td>
<td>2</td>
<td>52</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>57</td>
<td>3</td>
<td>39</td>
<td>4</td>
<td>r_s = .9*</td>
</tr>
<tr>
<td>Work-related</td>
<td>53</td>
<td>4.5</td>
<td>14</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Emotional and psychiatric</td>
<td>53</td>
<td>4.5</td>
<td>40</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>39</td>
<td>6</td>
<td>11</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

*Spearman's rank order correlation coefficient test indicated a strong relationship between clients and staff rank of problems (r_s = .9)
2. Causes of Clients' Current Problems

The staff were asked to relate clients' problems to certain causes. They were also asked to rate these causes as having a highly significant, moderately significant, low or no significant impact on clients' problems.

According to staff responses the causes of clients' problems could be grouped as illustrated in Tables 26 and 27.

It is understandable that the lack of homemaker service and the lack of family counselling for marital conflicts were not seen as contributing to client's difficulties. The majority of clients were young, and, single, and therefore least likely to need such services.

The data, however, supported the view that clients do seek admission to the state psychiatric facility to alleviate problems such as housing and financial need.

Staff responses also listed clients' inability to live on their own for a prolonged period of time as a factor contributing to their problems. It seems that the staff had interpreted "inability to live on their own" in financial rather than functional terms. This inference is based on the fact that a higher number of responses indicated that clients' inability to function in community living arrangements was among the factors which has low or no significant impact on the clients' problems. Also, as we will indicate later, the staff assessment of clients' level of function suggested that the majority of clients are able to function independently.
## TABLE 26
**STAFF ASSESSMENT OF CAUSES WITH HIGH TO MODERATE SIGNIFICANCE ON CLIENTS' PROBLEMS**

<table>
<thead>
<tr>
<th>Cause</th>
<th>No. of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of housing arrangements.</td>
<td>59</td>
</tr>
<tr>
<td>Client's inability to live on his own for a prolonged period of time.</td>
<td>57</td>
</tr>
<tr>
<td>Client's limited financial means and his/her inability to live within these means.</td>
<td>55</td>
</tr>
<tr>
<td>Client's lack of motivation</td>
<td>55</td>
</tr>
<tr>
<td>Client's relatives' unwillingness to have him/her back due to fear of what she/he might do.</td>
<td>49</td>
</tr>
</tbody>
</table>

## TABLE 27
**STAFF ASSESSMENT OF CAUSES WITH LOW OR NO SIGNIFICANT IMPACT ON CLIENTS' PROBLEMS**

<table>
<thead>
<tr>
<th>Cause</th>
<th>No. of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of homemaker service.</td>
<td>88</td>
</tr>
<tr>
<td>Client's unwillingness to live with his family.</td>
<td>85</td>
</tr>
<tr>
<td>Lack of family agencies that can help with marital and family problems.</td>
<td>77</td>
</tr>
<tr>
<td>Confusion as to who is responsible for providing and monitoring services needed for client.</td>
<td>76</td>
</tr>
<tr>
<td>Client's continuing resistance to any suitable placement in the community.</td>
<td>75</td>
</tr>
<tr>
<td>Client's inability to function in a community living arrangement.</td>
<td>66</td>
</tr>
</tbody>
</table>
3. Clients' Needs

Staff were asked to assess clients' need for certain services. Again, housing was at the top of services needed, followed by the need for psychiatric outpatient services, counselling services, financial assistance, and employment. The least needed services for the majority of clients according to the staff assessment were homemaker services, meals on wheels, day care, legal services, nursing aides, admission to psychiatric facilities, and general health services. A review of the clients' profiles may help explain why such services were least needed by this group of clients. As indicated previously, the majority of clients were young, male, singles who are unlikely to need day care for children or meal on wheels and nursing aides services (Table 28).

In assessing the individual client's housing needs, the staff responses suggested that the majority of clients needed independent, non-supervised residences such as private homes, apartments, boarding and rooming houses (59 clients). Thirty clients were assessed as needing supervised residences such as transitional group homes, supervised group homes, health-related facilities, supervised apartment and family foster homes. Three clients were assessed as in need of readmission to the hospital and one mentally retarded adult was assessed as needing placement for the mentally retarded. There were two clients who were picked up from Kennedy International Airport, and needed to join their families in their own countries.
<table>
<thead>
<tr>
<th>Services</th>
<th>Highly needed No. of clients</th>
<th>Needed No. of clients</th>
<th>Less or not needed No. of clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing</td>
<td>85</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Psychiatric outpatient</td>
<td>78</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Counselling</td>
<td>74</td>
<td>23</td>
<td>4</td>
</tr>
<tr>
<td>Financial assistance</td>
<td>56</td>
<td>9</td>
<td>35</td>
</tr>
<tr>
<td>Employment</td>
<td>41</td>
<td>25</td>
<td>34</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>34</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recreation services</td>
<td>20</td>
<td>58</td>
<td>22</td>
</tr>
<tr>
<td>Health services</td>
<td>15</td>
<td>23</td>
<td>62</td>
</tr>
<tr>
<td>Educational services</td>
<td>13</td>
<td>41</td>
<td>46</td>
</tr>
<tr>
<td>Admission to state hospital</td>
<td>12</td>
<td>8</td>
<td>80</td>
</tr>
<tr>
<td>Legal services</td>
<td>8</td>
<td>9</td>
<td>83</td>
</tr>
<tr>
<td>Homemaker services</td>
<td>4</td>
<td>9</td>
<td>87</td>
</tr>
<tr>
<td>Nursing aide services</td>
<td>2</td>
<td>5</td>
<td>95</td>
</tr>
<tr>
<td>Day care for children</td>
<td>3</td>
<td>0</td>
<td>97</td>
</tr>
<tr>
<td>Meals on wheels</td>
<td>1</td>
<td>0</td>
<td>99</td>
</tr>
</tbody>
</table>
Staff assessment of clients' housing needs indicated that the majority of clients (70%) needed to live independently, either in private homes or apartments or other housing arrangements. Staff assessment also suggested that 23 clients needed to live in a supervised living accommodation such as adult homes and transitional services programs. Only 7 clients needed to live with their families or friends according to the staff assessments. Though staff assessment did not deviate from clients' preferences with regard to the need for independent living, staff choices seemed more realistic in view of the clients' limited resources. Rooming houses, boarding houses and co-op living accommodations were recommended by staff more often than clients' preferences of private homes or apartments.

**TABLE 29**

**HOUSING OPTIONS PREFERRED BY CLIENTS AND RECOMMENDED BY STAFF**

<table>
<thead>
<tr>
<th>Housing Options</th>
<th>Clients' Preference</th>
<th>Staff Needs Assessment</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Own home or apartment</td>
<td>70</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>Independent living arrangements (hotel, motel, rooming house, etc.)</td>
<td>12</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>Supervised living arrangements (adult homes, foster homes, transitional programs, CPC, etc.)</td>
<td>10</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Friend or relative's home</td>
<td>6</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Remain homeless</td>
<td>2</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>100</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>
As Table 29 shows, there was a strong relationship between clients' housing preferences and staff assessment of clients' housing needs. This relationship is confirmed through the use of Spearman's Rank Order Correlation Coefficient test ($r_s = .9$)

4. **Clients' Level of Functioning**

In order to examine clients' self-assessment of their abilities to perform certain tasks, we directed the same questions to the staff who work with them. The data indicated that staff assessment of clients' level of functioning did not differ significantly from clients' self-assessment. According to staff responses 88 to 90 percent of the clients were able to bathe, groom and dress themselves.

The staff assessment of each individual client's level of function also indicated that the majority of clients were able to perform the following tasks independently:

- Use of public transportation in familiar and unfamiliar routes;
- Perform household chores and preparation of own meals;
- Maintaining prescribed medications programs and adequate diet;
- Outside shopping and management of available money;
- Engagement in leisure time activities and socializing with others;
- Seeking assistance with personal problems.

Table 30 lists staff assessment of clients' ability to perform certain tasks.
TABLE 30
STAFF ASSESSMENT OF CLIENTS' ABILITY TO PERFORM CERTAIN TASKS

<table>
<thead>
<tr>
<th>TASK</th>
<th>Ability to perform</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Independently</td>
</tr>
<tr>
<td>1. Uses public transportation on familiar routes</td>
<td>77</td>
</tr>
<tr>
<td>2. Uses public transportation on unfamiliar routes</td>
<td>64</td>
</tr>
<tr>
<td>3. Manages available money</td>
<td>53</td>
</tr>
<tr>
<td>4. Maintains prescribed medication program</td>
<td>60</td>
</tr>
<tr>
<td>5. Bathes and grooms self</td>
<td>90</td>
</tr>
<tr>
<td>6. Dresses self appropriately</td>
<td>88</td>
</tr>
<tr>
<td>7. Performs household chores (e.g. cleans, makes bed, does laundry)</td>
<td>75</td>
</tr>
<tr>
<td>8. Can or does prepare or obtain own meals</td>
<td>62</td>
</tr>
<tr>
<td>9. Can or does maintain adequate diet</td>
<td>64</td>
</tr>
<tr>
<td>10. Engages in leisure time activities</td>
<td>66</td>
</tr>
<tr>
<td>11. Shops outside the residence</td>
<td>65</td>
</tr>
<tr>
<td>12. Socializes with others</td>
<td>70</td>
</tr>
<tr>
<td>13. Takes initiative or seeks assistance with problems (e.g.</td>
<td>53</td>
</tr>
<tr>
<td>contacts physician, social security, case workers or friend)</td>
<td></td>
</tr>
</tbody>
</table>
The staff also assessed certain aspects of clients' behavioral problems. This part of staff assessment dealt with problems that affect the client's relationship with others, such as relatives, neighbors, employers, etc. Indicators of the existence of such problems included:

- had trouble at work or at school
- caused community complaints
- lost temper or self control
- had trouble with the law
- destroyed property
- did nothing most days
- behaved in a bizarre or unusual fashion
- disturbed others with unacceptable sexual behavior
- abused alcohol
- abused drugs
- stole property
- being dangerous to self
- being dangerous to others

As Table 31 indicates the majority of clients (excluding "not applicable" and "don't know" answers from the score) did not have behavioral problems which seriously affected their level of function. The only problem which was considered mild to severe among the majority of clients was complaints from household members about the behavior of the client. Also, a sizable number of clients were found to lose temper or self control (23 clients) and behave in a bizarre or unusual fashion (21 clients).
<table>
<thead>
<tr>
<th>Within the last month has the client:</th>
<th>No (N=700)</th>
<th>Yes, mild problem</th>
<th>Yes, serious problem</th>
<th>Not applicable</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had trouble at work or at school</td>
<td>24 (57%)</td>
<td>10</td>
<td>8</td>
<td>53</td>
<td>5</td>
</tr>
<tr>
<td>Caused complaints from household members</td>
<td>24 (28%)</td>
<td>33</td>
<td>30</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>Caused community complaints</td>
<td>65 (83%)</td>
<td>10</td>
<td>3</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>Lost temper or self control</td>
<td>42 (44%)</td>
<td>30</td>
<td>23</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Had trouble with the law</td>
<td>74 (87%)</td>
<td>5</td>
<td>6</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Destroyed property</td>
<td>70 (81%)</td>
<td>9</td>
<td>7</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Did nothing most days</td>
<td>45 (52%)</td>
<td>23</td>
<td>19</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Behaved in a bizarre or unusual fashion</td>
<td>43 (47%)</td>
<td>27</td>
<td>21</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Disturbed others with unacceptable sexual behavior</td>
<td>90 (97%)</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Abused alcohol</td>
<td>74 (97%)</td>
<td>4</td>
<td>7</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Abused drugs</td>
<td>87 (93%)</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Stole property</td>
<td>84 (94%)</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Been dangerous to self</td>
<td>85 (83%)</td>
<td>6</td>
<td>5</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Been dangerous to others</td>
<td>78 (82%)</td>
<td>6</td>
<td>11</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>
In assessing the clients' ability to communicate their thoughts and needs to others, the staff suggested that a majority of 74 percent of the clients had no difficulty or mild limitations in performing that function. Eighteen clients were assessed as having moderate limitations and six as having severe limitations. Only one client, (a mentally retarded male) was assessed as unable to have meaningful communication with others.

In general, as Table 32 indicates, staff assessment to individual clients' ability to function was that 67 percent were functioning at a high to moderate level, 19 percent were functioning at what the staff perceived as a low level and 10 percent were judged as not able to function on their own upon leaving the program.

### TABLE 32

**STAFF ASSESSMENT OF CLIENTS' FUNCTIONAL ABILITY AFTER LEAVING THE EMERGENCY HOUSING PROGRAM**

<table>
<thead>
<tr>
<th>Functional Ability</th>
<th>Number of clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate to high level</td>
<td>67</td>
</tr>
<tr>
<td>Low level</td>
<td>19</td>
</tr>
<tr>
<td>Cannot function on his own</td>
<td>10</td>
</tr>
<tr>
<td>Unsure of clients' potential</td>
<td>4</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
5. Client's Level of Functioning 
   in Relation to His/Her Problems 
   and Other Characteristics

Recent New York State mental health plans suggested that "The concept of chronic mental disability implies not only particular diagnoses or symptoms, but also a major impairment of adult role functioning."

Though this is a descriptive study, we thought that the data could be used to gain understanding of the relationship between some of the variables mentioned earlier. We tested the study data on clients' level of functioning against some clients' characteristics and problems. Characteristics selected include, client's admission status, client employment status and client's educational level.

Clients' problems included in this analysis were, housing, legal, medical, psychiatric, financial, job-related and client lack of knowledge about services.

The relationship between the above variables and client's level of functioning were tested using $X^2$ as a test of significance.

Results of the $X^2$ tests are presented in the following order:

- client's admission status
- client's employment status
- client's educational level
- client's housing and placement problems

---

- client's legal problems
- client's medical problems
- client's psychiatric problems
- client's job related problems
- client's lack of knowledge about services as a problem

Accordingly, the analysis of variance (X^2) brought the following results:

A. The relationship between client level of functioning and his/her admission status was not significant.

### TABLE 33

<table>
<thead>
<tr>
<th></th>
<th>HIGH LEVEL</th>
<th>MIDDLE LEVEL</th>
<th>LOW LEVEL</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NEW ADMISSION</td>
<td>4</td>
<td>10</td>
<td>7</td>
<td>21</td>
</tr>
<tr>
<td>READMISSION</td>
<td>8</td>
<td>14</td>
<td>7</td>
<td>39</td>
</tr>
<tr>
<td>Column Total</td>
<td>12</td>
<td>24</td>
<td>16</td>
<td>52</td>
</tr>
</tbody>
</table>

Chi square = 2.07449 with 2 degrees of freedom. Significance = 0.3544

All X^2 tests were considered significant at .05 level and below.
B. The relationship between the client's employment status and his/her level of functioning was not significant.

| TABLE 34 |
| CLIENT'S EMPLOYMENT STATUS AND LEVEL OF FUNCTIONING |

<table>
<thead>
<tr>
<th>CLIENT'S EMPLOYMENT STATUS</th>
<th>LOW LEVEL</th>
<th>MIDDLE LEVEL</th>
<th>HIGH LEVEL</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMPLOYED</td>
<td>1</td>
<td>2</td>
<td>6</td>
<td>21</td>
</tr>
<tr>
<td>UNEMPLOYED</td>
<td>1</td>
<td>4</td>
<td>27</td>
<td>32</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CLIENT'S EMPLOYMENT STATUS</th>
<th>LOW LEVEL</th>
<th>MIDDLE LEVEL</th>
<th>HIGH LEVEL</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMPLOYED</td>
<td>20.0</td>
<td>60.0</td>
<td>20.0</td>
<td>100</td>
</tr>
<tr>
<td>UNEMPLOYED</td>
<td>30.0</td>
<td>40.0</td>
<td>30.0</td>
<td>100</td>
</tr>
</tbody>
</table>

C. The relationship between the client's Highest Educational Level and his/her level of functioning was significant.
| TABLE 35 |

CLIENT'S EDUCATIONAL LEVEL AND LEVEL OF FUNCTIONING

<table>
<thead>
<tr>
<th>Count</th>
<th>84</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIGH LEVEL</td>
<td>MODERATE LEVEL</td>
</tr>
<tr>
<td>Total</td>
<td>169</td>
</tr>
<tr>
<td>CI2</td>
<td>1</td>
</tr>
<tr>
<td>HIGH SCHOOL</td>
<td>27.8</td>
</tr>
<tr>
<td>COLLEGE</td>
<td>14.5</td>
</tr>
<tr>
<td>MUIS</td>
<td>4.8</td>
</tr>
<tr>
<td>Total</td>
<td>14.7</td>
</tr>
</tbody>
</table>

| Raw Chi square | 11.10628 with 6 degrees of freedom | Significance | 0.0527 |
| Continuity coefficient | 0.24134 |
| Lambda (symmetric) | 0.22000 with CI2 dependent. | 0.00000 with 84 dependent. |
| Uncorrelated coefficient (asymmetric) | 0.27117 with CI2 dependent. | 0.00000 with 84 dependent. |
| Kendall's Tau b | 0.08413. Significance = 0.1031 |
| Kendall's Tau c | 0.10346. Significance = 0.1031 |
| Gamma + | 0.12570 |
| Gamma - (asymmetric) | 0.25154 |
| Cramer's V | 0.25154. Significance = 0.0000 |
| Phi | 0.21147 with CI2 dependent. | 0.00000 with 84 dependent. |

Number of missing observations = 4
D. The relationship between the client's level of functioning and his/her housing and placement problems was not significant.

TABLE 36

CLIENT'S HOUSING AND PLACEMENT PROBLEMS AND LEVEL OF FUNCTIONING

<table>
<thead>
<tr>
<th>Level of Functioning</th>
<th>Col 1</th>
<th>Col 2</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>12</td>
<td>41</td>
<td>53</td>
</tr>
<tr>
<td>Low</td>
<td>72.6</td>
<td>95.4</td>
<td>168</td>
</tr>
<tr>
<td>Total</td>
<td>84</td>
<td>142</td>
<td>226</td>
</tr>
</tbody>
</table>

TABLE 36: CONTINGENCY TABLE OF 84 CLIENTS

<table>
<thead>
<tr>
<th>Housing Category</th>
<th>Low</th>
<th>High</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>2</td>
<td>41</td>
<td>43</td>
</tr>
<tr>
<td>Level 2</td>
<td>12</td>
<td>72</td>
<td>84</td>
</tr>
<tr>
<td>Total</td>
<td>142</td>
<td>84</td>
<td>226</td>
</tr>
</tbody>
</table>

Chi-square (2 degrees of freedom) = 1.79807, significance = 0.4086

Cramer's V = 0.1346

Snedecor coefficient = 0.13326

Lambda (symmetric) = 0.0059 with 2701 dependent, = 0.0059 with 84 dependent

Uncertainty coefficient (symmetric) = 0.0104 with 2701 dependent = 0.0076 with 84 dependent

Kendall's tau b = 0.13426, significance = 0.0726

Number of clients' observations = 84
E. The relationship between the client's level of functioning and his/her legal problems was not significant.

**TABLE 37**

**CLIENT'S LEGAL PROBLEMS AND LEVEL OF FUNCTIONING**

<table>
<thead>
<tr>
<th></th>
<th>High Level Moderate Level Low Level</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>12.8</td>
<td>10.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C Probable</td>
<td>Significant Level</td>
<td>Total</td>
</tr>
<tr>
<td>No</td>
<td>12.8</td>
<td>10.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>16</td>
<td>22.9</td>
</tr>
</tbody>
</table>

Chi square = 0.73283 with 2 degrees of freedom. Significance = 0.6872

Cramer's $V = 0.0872$

Lambert (correction) = 0.06083 with EFG  dependent.

Uncertainty coefficient (correction) = 0.0560 with EFG  dependent.

Hendall's $T = 0.02529$, Significance = 0.4329

Cramer's $V$ (correction) = 0.05779 with EFG  dependent.

Uncertainty coefficient (correction) = 0.05232 with EFG  dependent.

Cramer's $V$ = 0.06729 with EFG  dependent.

Bonferroni's $R = 0.06123$, Significance = 0.4329

Number of critical observations = 4.
F. The relationship between the client's level of functioning and his/her medical problems was not significant.

| TABLE 38 |
| CLIENT’S MEDICAL PROBLEMS AND LEVEL OF FUNCTIONING |

<table>
<thead>
<tr>
<th>LEVEL OF FUNCTIONING</th>
<th>HIGH</th>
<th>MODERATE</th>
<th>LOW</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDICAL PROBLEMS</td>
<td>15</td>
<td>14</td>
<td>11</td>
<td>39</td>
</tr>
<tr>
<td>HIGH</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>MODERATE</td>
<td>10</td>
<td>11</td>
<td>5</td>
<td>26</td>
</tr>
<tr>
<td>LOW</td>
<td>10</td>
<td>3</td>
<td>5</td>
<td>18</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COLUMN</th>
<th>12</th>
<th>39</th>
<th>10</th>
<th>9</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Column 1</td>
<td>12</td>
<td>39</td>
<td>10</td>
<td>9</td>
<td>52</td>
</tr>
</tbody>
</table>

Raw Chisquare = 1.29478 with 6 degrees of freedom. Significance = 0.9722

Contingency coefficient = 0.17343

Lambd (proportional) = 0.00000 with 0.00000

Lambd (independent) = 0.00000

Contingency coefficient (independent) = 0.00000

Contingency coefficient (proportional) = 0.00000

Degrees of freedom = 1

Number of missing observations = 4
G. The relationship between the client's level of functioning and his/her psychiatric problem was significant.

<table>
<thead>
<tr>
<th>TABLE 39</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLIENT'S PSYCHIATRIC PROBLEMS AND LEVEL OF FUNCTIONING</td>
</tr>
</tbody>
</table>

| GROSS TABULATION OF |
| 8704 SIGNIFICANCE PSYCHIATRIC |
| by 84 CLIENT ABILITY TO FUNCTION POSTTRIAU |

<table>
<thead>
<tr>
<th>Count</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Row X</td>
<td>10</td>
<td>9</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Col X</td>
<td>10</td>
<td>9</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
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<td>36</td>
<td>36</td>
<td>36</td>
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<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>HIGH LEVEL</td>
<td>20</td>
<td>9</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>MODERATE LEVEL</td>
<td>10</td>
<td>9</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>LOW LEVEL</td>
<td>10</td>
<td>9</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>36</td>
<td>36</td>
<td>36</td>
<td>36</td>
</tr>
</tbody>
</table>

Row Chi square = 10.45486 with 4 degrees of freedom. Significance = 0.0252
Cramer's V = 0.32777
Contingency coefficient = 0.21072
Lambda (asymmetric) = 0.1249 with 8704 dependent. = 0.02323 with 84 dependent.
Lambda (symmetric) = 0.07276
Uncertainty coefficient (asymmetric) = 0.02222 with 8704 dependent. = 0.00799 with 84 dependent.
Uncertainty coefficient (symmetric) = 0.02446
Kendall's Tau b = 0.22572. Significance = 0.0028
Kendall's Tau c = 0.24514. Significance = 0.0028
Gama = 0.20521
Evers' D (asymmetric) = 0.27104 with 8704 dependent. = 0.24663 with 84 dependent.
Evers' D (symmetric) = 0.25542
Eta = 0.27104 with 8704 dependent. = 0.31777 with 84 dependent.
Pearson's R = 0.37649 Significance = 0.0022

Number of missing observations = 4.
H. The relationship between the client's level of functioning and his/her financial problems was not significant.

### TABLE 40

**CLIENT'S FINANCIAL PROBLEMS AND LEVEL OF FUNCTIONING**

<table>
<thead>
<tr>
<th></th>
<th>HIGH</th>
<th>MODERATE</th>
<th>LOW</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Row 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Col 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIGH</td>
<td>10</td>
<td>20</td>
<td>13</td>
<td>43</td>
</tr>
<tr>
<td>MODERATE</td>
<td>17</td>
<td>19</td>
<td>12</td>
<td>48</td>
</tr>
<tr>
<td>LOW</td>
<td>23</td>
<td>21</td>
<td>12</td>
<td>56</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>50</td>
<td>37</td>
<td>137</td>
</tr>
</tbody>
</table>

**Row Chi square = 4.17853 with 2 degrees of freedom. Significance = 0.1243**

Cramer's V = 0.20949

Continuity coefficient = 0.20464

Lambda (asymmetric) = 0.08798 with 8705 dependent.
Lambda (symmetric) = 0.03270

Uncertainty coefficient (asymmetric) = 0.02274 with 8705 dependent.
Uncertainty coefficient (symmetric) = 0.03282

Kendall's Tau b = 0.16479. Significance = 0.0446
Kendall's Tau c = 0.17668. Significance = 0.0446

Gama = 0.25649

Reeves' D (asymmetric) = 0.15066 with 8705 dependent.
Reeves' D (symmetric) = 0.15207

Eta = 0.200423 with 8705 dependent.

Pearson's R = 0.17703 Significance = 0.0402

Number of missing observations = 4
I. The relationship between the client's level of functioning and his/her job-related problems was not significant.

### Table 41

**CLIENT'S JOB RELATED PROBLEMS AND LEVEL OF FUNCTIONING**

<table>
<thead>
<tr>
<th>Description</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Significant</td>
<td>21.7</td>
<td>49.7</td>
<td>15.3</td>
<td>24.0</td>
</tr>
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<td></td>
<td>31.3</td>
<td>27.4</td>
<td>15.3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5.7</td>
<td>10.6</td>
<td>5.1</td>
<td></td>
</tr>
<tr>
<td>No Significance</td>
<td>15.1</td>
<td>49.5</td>
<td>20.6</td>
<td>79.0</td>
</tr>
<tr>
<td></td>
<td>49.1</td>
<td>70.6</td>
<td>87.7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11.8</td>
<td>27.9</td>
<td>27.1</td>
<td></td>
</tr>
</tbody>
</table>

Total: 16  21  27  94

Chi-square = 4.34953 with 2 degrees of freedom. Significance = 0.1193

Pearson's R = 0.12576 Significance = 0.2346

Number of missing observations = 4
J. The relationship between the client's level of functioning and his/her lack of knowledge about services available was not significant.

**TABLE 42**

**CLIENT'S LACK OF KNOWLEDGE ABOUT SERVICES AND LEVEL OF FUNCTIONING**

<table>
<thead>
<tr>
<th>Count</th>
<th>HIGH LEVEL</th>
<th>MEDIATE LEVEL</th>
<th>LOW LEVEL</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>10</td>
<td>11</td>
<td>22</td>
</tr>
<tr>
<td>MOST SIGNIFICANT</td>
<td>4.3</td>
<td>45.0</td>
<td>30.5</td>
<td>22.9</td>
</tr>
<tr>
<td></td>
<td>4.3</td>
<td>17.0</td>
<td>27.9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.1</td>
<td>10.4</td>
<td>11.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>10.8</td>
<td>32.0</td>
<td></td>
</tr>
<tr>
<td>MODERATE SIGNIFICANCE</td>
<td>21.7</td>
<td>40.8</td>
<td>34.8</td>
<td>23.8</td>
</tr>
<tr>
<td></td>
<td>31.3</td>
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</tr>
<tr>
<td></td>
<td>5.3</td>
<td>10.4</td>
<td>8.3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>37.6</td>
<td>21.4</td>
<td>21.4</td>
<td>21.4</td>
</tr>
<tr>
<td>NONE SIGNIFICANCE</td>
<td>16.2</td>
<td>40.2</td>
<td>17.4</td>
<td>53.9</td>
</tr>
<tr>
<td></td>
<td>38.2</td>
<td>29.2</td>
<td>30.3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10.4</td>
<td>25.3</td>
<td>10.4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>16.4</td>
<td>55.4</td>
<td>10.9</td>
<td>55.4</td>
</tr>
<tr>
<td>Column</td>
<td>16</td>
<td>33</td>
<td>39</td>
<td>98</td>
</tr>
<tr>
<td>Total</td>
<td>16.7</td>
<td>23.1</td>
<td>39.2</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Row Chi square = 0.67996 with 4 degrees of freedom. Significance = 0.93670

Cramer's V = 0.21206

Contingency coefficient = 0.27793

Lambdas lambda) = 0.02222 with 8705 dependent = 0.02222 with 84 dependent.

Uncertainty coefficient (lambda) = 0.04725 with 8704 dependent = 0.04566 with 84 dependent.

Kendall's Tau b = 0.37562, Significance = 0.0040

Kendall's Tau c = 0.21129, Significance = 0.0040

Omea = 0.37399

Cramer's D (taumetric) = -0.22222 with 8706 dependent = -0.22294 with 84 dependent.

Spearman's D (taumetric) = -0.22222 with 8706 dependent = -0.22294 with 84 dependent.

Pearson's R = 0.36423 Significance = 0.0046

Number of missing observations = 4
In summary, Chi-Square Test findings suggest that the relationship between both client's admission status and employment status are not significant to his/her level of functioning as assessed by staff.

The findings suggested that the relationship between client's educational level is also not significant to his/her level of functioning as assessed by the staff.

The findings also indicated that with the exception of psychiatric problems, other problems such as housing and placement problems, legal problems, medical problems, financial problems, job related problems or the lack of knowledge about services available, did not have significant relationship to the client's level of functioning.

We should note that the validity of the $X^2$ test results may be restricted to the population under study. Sample size and its selection procedure are but two factors behind this observation. Another equally important factor is the fact that the findings are based on the assumption that staff assessments of clients' level of functioning are valid and that their judgment of what they considered psychiatric problems was acceptable. Non acceptance of these latter assumptions could minimize the validity of the findings and their interpretations.

With the above caution in mind we offered some interpretations of the findings with the understanding that such interpretation, if unable to stand the validity test, could still be useful in developing new hypotheses and examining some popular notions concerning
psychiatric admission to state hospitals.

There was no significant relationship between the client's level of function and his/her admission status. This finding suggests that clients seeking readmission to the state hospital were not different with reference to their level of functioning than those who sought admission for the first time. This interpretation holds only where admission status is used as a sole criterion for comparison. State psychiatric facilities in New York are currently using level of functioning as a criterion for admitting and discharging their patients. It was also reported that prior admission is the factor "most predictive of admission to the New York State mental hospitals." It could be suggested on the basis of the findings of this study that patients with prior psychiatric admission should not be considered low functioning individuals and granted readmission on the basis of past history of psychiatric hospitalizations.

The study also suggested that the client's level of function is not related to the client's being employed or unemployed.

This finding was further confirmed in the second part of the analysis which related client's level of functioning to his/her problems.

Housing, financial, unemployment and medical (non-psychiatric) problems were not significantly related to the client's level of functioning as assessed by staff. On the other hand, psychiatric problems, according to the study data, were significantly related to the client's level of functioning. One interpretation to these
findings could be that unless the client does have psychiatric problems we may be unable to predict his level of functioning on the basis of having or not having other social problem(s).

A conclusion could also be drawn from the above findings with regard to voluntary admission to state psychiatric hospitals. Judgments concerning the level of functioning of clients who seek voluntary admission to state psychiatric facilities (on their own or through other agents) should be based on whether they are having psychiatric rather than social problems. It follows that if the client's level of functioning is one of the criteria for admission to the psychiatric facility, determinations concerning this criterion could be more accurate when based on psychiatric rather than social factors.
CHAPTER VIII

SERVICE DELIVERY: OPTIONS AND OBSTACLES
STAFF ASSESSMENT - PART II

In addition to the individual assessment of the client's needs, staff opinions were sought on issues which have an impact on clients as a group. Line as well as management staff of the Emergency Housing Program (EHP) responded to this part of the questionnaire. As such, this part of the study data represent the thinking of the EHP practitioners, administrators and consultants.

The staff wrote their opinions regarding service delivery, EHP as a service option, and causes for readmission to psychiatric facilities in general.

Also, a number of the state mental hospital officials offered their opinions on the problem during personal interviews with the investigator.

1. Service Delivery at the Community Level:

The staff were asked to write their personal opinions about the reasons, if any, that the client sample are unable to obtain services through community agencies. Staff opinions on this issue could be grouped under two main categories, (A) the client's individual problems and (B) the system pitfalls.

According to the staff, many clients were kept away from existing resources due to some personal problems, problems such as lack of motivation and an "I do not care" attitude. This attitude
is manifested through a high degree of dependency not caused by any health causes and the expectation that others should take full care of them. Behavior problems also included untidy appearance, unwillingness to pay rent despite receiving rent allowance through SSI and public assistance, not keeping their home environment clean and livable, and non-compliance with clinical treatment such as taking medication and attending therapy sessions at the clinics. These problems, according to staff, resulted in housing eviction and service termination affecting many of these clients.

It is interesting to note that the staff's general assessment presents the clients as a more dependent and low-functioning group. This behavioral profile is in contrast to the earlier profile which was drawn from the staff assessment of each individual client (Chapter VII). The earlier assessment indicated that a majority of clients are able and willing to live independently. It also indicates that the majority of clients function at an acceptable level.

It appears that the staff opinion about EHP clients as a group is a reflection of public attitude about the chronic state of dependency of these clients; such opinions were not fully supported by staff's individual assessment of clients.

The above observation applies especially to opinions presented by staff who were functioning as consultants to the program. As an example, one consultant's view suggested that "Clients in Emergency Housing are not what they were supposed to be: They have various degrees of psychopathology which make it extremely difficult for
them to enter the usual social and community routine. In essence, it is hard to draw the line between an inpatient in the ward and a client in the housing program." Another consultant also wrote "... clients have chronic problems in interpersonal relationships. They are not able to manage jobs. Many of them abuse drugs and alcohol on top of their problems which makes things worse." The consultant further suggested that "staying in Emergency Housing delayed patients from getting proper treatment in many cases." It is interesting to note that such an observation was made despite the fact that the Emergency Housing Program was not accepting clients with drug or alcohol problems. The number of clients who mentioned having problems with drugs or alcohol did not exceed 8 percent of the sample population.

According to the majority of EHP staff, many of the difficulties surrounding service delivery could be traced to pitfalls and gaps in the system. Many staff reported that, being former mental patients, most clients are the subject of discrimination in housing as well as other services due to community attitudes against them. As a result of community resistance, these clients are unable to locate housing. A mental health therapy aide suggested that "... It is difficult for the community to accept clients for housing because they feel that clients do not belong in the community but should remain in the hospital."

Another therapy aide wrote, "clients have difficulty because people in the community do not understand or have not got enough
information about clients, so most people are afraid to rent apartments to them. . . " The psychologist wrote, "...without interested family or relatives, the client difficulties would be no different than any other patient leaving the inpatient facility."

Views relating to the pitfalls of the services delivery system were shared by most of the staff. These views suggested that clients have difficulties in obtaining community services largely because of lack of such services as appropriate housing and the financial means that could pay for such housing when available. It was suggested that some clients who have been hospitalized for long periods of time discover once they are released that the economy has drastically changed. They find it much harder to budget their meager incomes from SSI and/or public assistance.

Another pitfall which was mentioned frequently is that the service system is not designed with the clients' situation in mind. The example which is frequently mentioned by staff concerns the approval for level of care by the City Department of Social Services (form 418). Processing this form is a subject of confusion, delay, and 'catch 22' for clients trying to get financial pieces in place. In order to get emergency funds, clients need an address (housing). Meanwhile, they can't get an address because they have no funds.

Two of the staff also elaborated on how clients got lost negotiating with various agencies and wandering in the bureaucratic maze. It was suggested that when clients go to the Department of
Social Services alone, they encounter a hard time. "...Many do not have the patience to wait in long lines at the department, and that there is too much bureaucracy in obtaining assistance." The client is not familiar with exactly what the agencies have to offer and how to receive assistance.

Staff were also asked to assess community services with reference to their adequacy in meeting the EHP clients’ needs. Eighty-eight percent of staff described services available in the community as inadequate in meeting the needs of EHP clientele. The staff also suggested that the following services should be made available and accessible to the clients:

- supervised housing and housing alternatives in general
- liaison persons such as case managers who can help clients get through the system and act as advocates
- follow-up services
- job opportunities programs
- educational and rehabilitative programs geared toward self-care especially for those clients who are discharged from the hospital

2. Emergency Housing Programs as a Service Option:

In order to elicit staff opinions regarding the Emergency Housing Program as a service option we posed the following question to them:

If you had to classify clients who were serviced by emergency housing into two groups, those who benefitted from the service most and those who benefitted least, how would you characterize these two groups and the problems they presented?
Ninety-five percent of staff suggested that, as a group, clients who benefitted the most from the Emergency Housing Program were those who are highly motivated, assertive, cooperative, functioning at a high level, and are not drug or alcohol abusers. Some staff members also thought that clients who benefitted most were those who had some outside support such as family or friends who are supportive and those who can function in a community setting with little or no supervision. A social worker summarized it this way: "...those who benefit the most are those who really did not need the service at all and were independent enough to manage their affairs with a minimum of support..."

It was also noted that while two of the staff thought that among those who benefit the most are clients who take their medication; another two staff members thought that those who were taking their medication did not benefit because such medication made them very passive and dependent. It is interesting to note that both views were expressed by staff from the same discipline.

Clients who were seen as the least likely to benefit from the program by the staff were those who did not meet the program requirements mentioned earlier. Meanwhile, a program consultant felt that some clients were put at a disadvantage by being placed in the "nontreatment" emergency housing program at a time when they were in need of psychiatric treatment. The consultant went a step further to suggest, "...I think hardly anybody really benefitted because I see the same patients coming back and forth. Ten days
are not enough to work out adequate housing. The only benefit is for the patients who need temporary housing (not permanent)."

Other staff suggested that "...the least benefitter is the recidivistic client who never engages in aftercare, who has exhausted every agency in New York City and whose 'act' is to mess up any plan made for him/her by mental health workers..." 

3. **Reasons for Seeking Readmission to the State Hospital by Clients who are Referred to the EHP:**

One of the troublesome questions in the field of mental health is the fact that many clients seek readmission to state mental hospitals. Seventy-one percent of our client sample sought readmission to Creedmoor and consequently they were referred to the EHP. The study sought an explanation for this phenomenon. The following question was posed to the EHP staff:

"As a group, what are the main reasons that clients who sought readmission to Creedmoor and were referred to the EHP, were not able to sustain in community living?"

Some responses to this question were not consistent with the individual assessment of client's level of functioning. Five staff suggested that clients seek readmission because they cannot function in the community setting, "they are more comfortable in a closed setting and cannot cope with current stresses of basic everyday living." Other reasons which were listed by staff included:

- Inability to obtain financial assistance in time to pay their rent (in four responses)
Failure to follow through with previous arrangements made for them by staff such as attending clinics, taking their medication, paying their rent, etc. (in three responses)

Premature discharge from the program due to the mandated 10-15 day stay. Such hasty discharge did not permit staff to make proper discharge planning for the client to sustain him/herself in the community. (in two responses)

Those who were sent to their family were coming back for readmission because their family did not want them in view of their behavioral problems. (in five responses)

Many of the clients are former mental patients and this label hindered them in the community and brought them back to seek readmission. (in five responses)

It is important to remind the reader that the above responses were reported in part II of the staff questionnaire. Part II of the staff questionnaire was designed to elicit staff opinion on clients and issues affecting them as a group. Consequently, staff responses listed in this section represent staff opinions on the sample clientele at the EHP and not on the individual clients.

4. State Hospital Officials View the Problem:

After the survey of clients and staff opinions we interviewed some officials at the state hospital. Officials interviewed were Yousef Havelawala, M.D., a psychiatrist, and the director of Creedmoor Hospital, Leon Goldberg, Ph.D., a psychologist and the hospital director for Community Services, and Angela Maggio, an occupational therapist and the Chief of the Community Linkage Unit which administers the Emergency Housing Program (EHP) at Creedmoor.

The main purpose of the interviews was to elicit the opinions of those officials on the boundaries of psychiatric services and the role
that the state hospital plays in providing nonpsychiatric services such as housing.

There was a consensus of opinion among hospital officials that housing as such is not a mental health problem. For persons who are either homeless or have a problem locating housing within their own means, the hospital in their view should not be expected to serve as a last resort. As a matter of policy, Havelawala indicated, for example, that "...it is not the responsibility of the Office of Mental Health to provide housing for anyone." In his view, providing housing is the responsibility of the local governments. Creedmoo's role as a State Hospital is to provide mental health care to those who need it and not all of the homeless are mentally ill." Goldberg agrees with that view and adds that the State Department of Social Services is mandated by the law to provide appropriate living arrangements only for discharged mental patients, especially for those who lack a supportive network such as families or relatives. Maggio, meanwhile suggests that for those who were found in need of psychiatric follow-up a joint effort should be made between the hospital and the City Department of Social Services to provide supervised housing accommodations that suits these patients' needs.

Hospital officials' opinions regarding that issue could be considered a reflection of the State policy which they are mandated to implement at the institution level.
As we mentioned earlier the issue of who should provide housing to the homeless and former mental patient is currently a subject of intense public debate in New York City. City officials charge that as a result of the massive discharge of patients from State hospitals and tightening of admission criteria while failing to provide adequate community services, the State has flooded the city streets with thousands of homeless individuals wandering aimlessly. State officials meanwhile accused the city of attempting to make the homeless synonymous with the mentally ill and, thereby, lay the blame and the cost for their support solely with the State. In so doing, however, it has obscured the real facts and issues and held the mentally ill hostage from needed services in their communities.

Recently, New York State decided to participate in financing local projects that help house homeless persons. According to published reports, the State allocated about $8.5 million to non-profit groups to renovate single-room occupancy hotels and residences for the homeless.

According to Creedmoor officials, the hospital's responsibility does and should insure that clients who are discharged from the hospital and receiving after care are living in a humane and safe condition.


This view is again in line with the State policy, its laws and regulations. In Queens, the county which is served by Creedmoor hospital, there were reported abuses to discharged patients living in unlicensed boarding homes. The State Senate Mental Hygiene and Addiction Control Committee conducted public hearings on Creedmoor grounds to investigate the issue in August 1979. During that hearing, Havelawala testified that "...we have not done enough in the last 25 years to see that appropriate care, both in terms of housing and programs, is available in the community." He also added "...I do not feel that patients should be released to live in dingy, unsupervised settings in the community, like some of our unlicensed boarding homes and single room occupancy hotels. Such settings in the community are no better than the back wards of the hospital. Neither does the solution lie in bringing these patients, or keeping those who can be released, for continuing stay in the hospital. All evidence indicates that it is more humane and appropriate to take care of the patient within his/her own community in a setting where he or she maintains community ties and continues to play a constructive role. At the same time it is the responsibility of the State to see that they are not abandoned after discharge from the hospital."1

1Y. Havelawala. Toward a Responsive and Responsible Mental Health Delivery System. Testimony given at a Public Hearing on Community Living Arrangement for the Mentally Disabled, held at Creedmoor Psychiatric Center, Queens Village, N.Y., August 28, 1979.
Havelawala also proposed that all mental health programs which provide residential as well as treatment programs in the community be mandated to work with an active community advisory board for that program. Such a board, in his view, should be comprised of members from the local community including neighbors, concerned relatives of patients, members from the block association, etc., so that the community at large does not feel as a passive recipient of State policy but active participant in formulating it.  

Goldberg testified at the hearing and stated:

Unfortunately no program works perfectly even given optimal conditions of funding, staffing, and community acceptance. Some patients placed in the community will wind up in unsatisfactory living arrangements where they may be exploited by landlords who hold them as virtual prisoners in their apartments or they may congregate in demeaning 'single room occupancies' where their behavior gradually deteriorates and they become a problem to the community.

As always, the best remedy is prevention and I would urge that the Legislature give all possible support to the Office of Mental Health's efforts to develop the extensive network of community programs and alternative housing arrangements that are necessary to make deinstitutionalization work. To deal with the inevitable but hopefully small percentage of placement failures I would suggest support for case management and community outreach services. These programs by providing in the first case for continuous follow-up of all patients discharged from the hospital and in the other for the ability to respond

\[\text{\textsuperscript{1}}\text{Ibid.}\]
immediately in the person's natural environment to the developing crises, would enable us to detect problem situations early enough to take preventive action.\textsuperscript{1}

The Senate Committee also heard testimony from the State Commissioner of Mental Health\textsuperscript{2} who indicated that many patient abuses are likely to occur in unlicensed boarding homes due to the fact that the hospital staff is denied access to patients residing in these homes. As a remedy to the situation, the State requested the New York City Health Department to investigate these homes to assure the health and safety of the residents. He also mentioned the Office of Mental Health is considering possible legislative action that would extend the provisions of Chapter 804 to prevent municipal and voluntary hospitals from discharging patients to inappropriate or inadequate community placements.\textsuperscript{3}

The State Commissioner of Social Services, meanwhile, testified at the same hearing and suggested "...The population living in single room (SRO's) - and perhaps to a lesser degree those living in unlicensed boarding homes - end up in these places because we have not recognized that planning for adequate and appropriate housing must have highest priority in any discharge plan, at a time of shrinking

\textsuperscript{1}L. Goldberg. "Problems in Community Placement." Testimony given at a State Senate Public Hearing, \textit{op. cit.}

\textsuperscript{2}Statement of Morris Cohen, Associate Commissioner, O.M.H. before the Senate Mental Hygiene Committee public hearing, \textit{op. cit.}

\textsuperscript{3}Ibid.
housing stock, the most difficult to place individuals will be pushed into the most undesirable housing — or as we are already beginning to observe, into the streets and the subways. The development of a housing policy for all dependent people, including the ever-growing number of single individuals, whether they are old or young, mentally or socially disabled, must become a Prime Public Policy concern at the federal, state and local levels of government.¹

Officials interviewed offered different predictions about the future role of Creedmoor as a State Psychiatric Facility; despite differences of opinion, officials all agreed that Creedmoor as a State hospital will remain as a viable psychiatric service provider in the County of Queens. Predictions differed, however, with reference to the scope and focus of services which will be provided.

Maggio's view is that Creedmoor will not be the main provider of public psychiatric treatment in the county but will share this responsibility equally with the city municipal and publicly supported private hospitals. Creedmoor as well as municipal and private hospitals will provide all services needed to persons with mental health problems including screening, inpatient treatment, follow-up and aftercare services. The county will be divided along the lines of the health planning map and each hospital will be responsible for serving a given area.

¹Testimony given by Karen Friksen Perez, Deputy Commissioner, New York State Department of Social Services at a Senate Public Hearing, op. cit.
Havelawala meanwhile predicted that Creedmoor will function as a Community Mental Health Center for the county. It will give more emphasis to servicing patients in their own communities rather than in the hospital grounds. An expansion of aftercare and community clinics, in his view, will facilitate this new trend.

Goldberg suggested that during the coming years Creedmoor will provide a number of specific services for a relatively small group of patients, namely those who are in need of long term care. The reason, in Goldberg's view, is that these patients are unable to sustain themselves in community settings due to severe mental disability. Another specific group that Goldberg referred to is the criminally mentally ill individuals; Creedmoor in his view will be used as an alternative to sending these patients to the custodial and overcrowded State prisons and correction facilities. Subsequent to Goldberg's interview, the state began to utilize some mental hospitals not only for criminally insane individuals but also for regular criminals as well. Starting with Pilgrim State Hospital, the State transferred more than a thousand inmates from regular prisons to Pilgrim Psychiatric Hospital grounds. This move had taken place on July 1982 despite an intense appeal and community pressure to stop the action in Suffolk County.¹

There are indications that Creedmoor is also being considered for the prison wards option.²


It is interesting to note that literature on the changing role, function, and utilization of state mental hospitals offers many options. However, changing psychiatric wards to prison wards was not perceived as a viable alternative.\(^1\) Some suggested that the hospital be used as a tertiary care facility,\(^2\) a domiciliary care facility,\(^3\) or a Community Mental Health Center.\(^4\)

On the issue of the boundaries between psychiatric services and social services, the three officials interviewed are of the opinion of clear distinction between the domains of the two sets of services. However, the opinions of hospital officials in one state institution may not necessarily represent a consensus among other officials in state psychiatric facilities.

\(^1\)At the time of this writing the newly elected Governor of New York has postponed this prison option and no other alternative was proposed.


\(^3\)Richard Filer and Jack Ewalt, "State Hospitals as Domiciliary Care Facilities," Ibid., p. 172.

\(^4\)Francis Tyce, "State Hospitals as Community Mental Health Centers", Ibid., p. 181.
CHAPTER IX
IMPLICATIONS AND RECOMMENDATIONS

This study has identified clients who sought admission to state psychiatric facilities to satisfy non-psychiatric needs. The study data suggested that even outpatient psychiatric treatment was not the most needed service for many of the above group of clients.

The data also supported earlier reports by Kamerman and Kahn.¹ These reports indicated that according to officials of a state psychiatric center in a northeastern community in the United States, "some 30 percent of the cases in their services system were there not primarily out of psychiatric need but because of "social deficits or problems," (emphases provided) – housing needs, financial problems, difficulties in access to health services and the like."²

Some would argue that clients should have sought direct help from providers of such services in their local community. This

²Ibid.
argument is based on the assumption that services are available and accessible to these clients on a universal or at least on a means test basis. However, the majority of clients interviewed did not know of any community agency that could help them with their problems. Staff working with those clients suggested that without being enrolled as SSI recipients many clients could not meet their housing and financial needs. A psychiatric certificate of mental disability is required for those clients to qualify for SSI benefits.

It could also be argued that clients' unrealistic expectations from the state hospital is an indication of a thought disorder which may warrant admission for psychiatric observation. However, though such an argument has some validity, it cannot be used to refute the data of this study. As a prerequisite we accepted the psychiatric evaluations which were conducted on each client in the study sample. The psychiatric evaluations suggested that these clients did not need to be admitted to the hospital for psychiatric treatment. Rather, there was evidence that the clients needed temporary or permanent living arrangements at the time they sought admission or readmission to the hospital.

One of the clients' expectations of staff at the mental hospital was that the staff supply them with information and act as referral agents to other services in the community. Such expectations were consistent with the fact that the majority of clients did not know about services available outside the hospital. The staff, however, did not consider lack of information and
referral services as a highly significant obstacle that contributed to clients' problems. Staff opinions are consistent with the current view in the field. This view suggests that clients such as the subjects of this study can gain access to services only after they are identified as mental patients. It follows, that information and referral services were considered of no value since needed services require a certificate of mental disability as a basic requirement for access.

Analysis of the data implied that evaluating clients for admission to psychiatric treatment should not give undue emphasis to the clients' prior hospitalizations and their current housing, financial, legal and medical (non-psychiatric) problems. These variables did not have a significant relationship to the client's level of functioning. However, the data suggested that psychiatric problems and client's level of function were significantly related. Consequently, based on the study data, psychiatric admission decisions would be more accurate if they were made not on the basis of the existence of non-psychiatric problems but rather on the basis of whether the client has psychiatric problems.

We should point out that the above findings do not refute or support the assumption that it is hard to separate the medical and social components of mental disease. The study did not deal with the cause(s) of psychiatric problems but whether the client did or did not have psychiatric problems that warrant hospitalization upon seeking admission to the state psychiatric facility.
The data presented seem to support the argument that social problems alone may not constitute a rationale for psychiatric admission unless the client also has psychiatric problems. Such findings support the argument for state hospital service boundaries that cannot be easily crossed by persons with no need for psychiatric treatment.

State mental hospitals can make use of these findings to counteract community pressures, which imply that clients with social problems should also be "treated" by these hospitals.

Restricting state hospital admission to clients who needed hospitalization should follow the initiation of service alternatives for clients with non-psychiatric problems. The failure to initiate such services could further aggrevate the lives of clients with urgent non psychiatric problems such as the need for shelter and food. Lack of services also will place undue burdens on relatives of these clients.

Many of the state and federal mental health plans that we reviewed seem to accept as a fact the assumption that families are best able to care for their members who have social and/or emotional problems. The findings of this study question the validity of such an assumption. There were indications that many families were unable and/or unwilling to provide their members with such needed support. There were also indications that many clients preferred to live on their own rather than living with their families or friends.
Much evidence was presented in Chapter II to support the argument that the first admission of mental patients could have been in error. It follows that many clients who seek readmission, are not necessarily "chronically mentally ill."

The majority of the clients in this study were seeking readmission after one prior admission. This factor alone may not be sufficient to classify these clients as chronically mentally ill.¹

A closer look at the study data reveals that a sizable number of the client sample had functional problems in one or more areas. The majority of clients were also out of the labor force at the time they sought admission. However, clients with such problems could be served in less restrictive settings outside the state hospital. Community agencies could also be utilized to attend to the psycho-social needs of these clients. Categorizing these clients as "chronically mentally ill" increases the chances of admitting them to the mental hospital rather than meeting their needs in community settings.

¹A chronic mental patient is defined as "a person who needs psychiatric services indefinitely to attain and preserve the maximum possible independence from a substantially disabling mental illness." See: The Positive Aspects of Long Term Hospitalization in the Public Sector for Chronic Psychiatric Patients. (New York, Group for Advancement of Psychiatry, MHMC, 1982) p. 6.
Recent findings of a New York State Psychiatric Institute study could be used in support of the above discussion. The study which was conducted on chronic schizophrenic patients in New York City suggested that patients living with parents or in rundown single room occupancy hotels (SRO's) tend to have the highest mean number of rehospitalizations. The study further suggested that while patients who lived in parental and nuclear family groups have good support, they experienced a high level of stress. Meanwhile, patients who lived in SRO's were found to have poorer supports and low levels of stress.

With these facts in mind it is reasonable to suggest that state and federal planners and policy makers ought to take into account whether the "natural support system" is able and willing to live up to the expectations of providing needed care and emotional support to its members.

The study data and case reviews implied that housing resources which are available to persons with low income and those who are dependent on public assistance and SSI disability funds are very limited. Almost all the clients who participated in this study were among this group and housing was the most important issue that affected their lives. Thus the findings underscore the

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2Ibid., pp. 20-21.

3Ibid., p. 23.
need for what is called supportive housing. Supportive housing consists of apartments or small single-family dwellings that are shared by two to five clients or former mental patients. The housing is leased by a supervising agency such as departments of social services or by the residents themselves. These housing accommodations allow for more independence for the clients and also are less costly than supervised arrangements such as foster care, halfway houses or family care programs.

Based on the current investigation we see a great need for a clear distinction between social services and psychiatric services. The identification of each service domain or boundary is a prerequisite for an effective and efficient delivery system. Data presented in this study suggest that clients' problems are further complicated when access to social services become part of the psychiatric services domain. The following are specific recommendations for implementation at the organizational, local, state and federal levels.

At the hospital level, screening for admission to psychiatric facilities should be conducted by highly qualified psychiatric teams. Each team should consist of a psychiatrist, a social worker, a psychologist and a nurse. Members of the team should be familiar with services available to clients in the community. The team's

decision not to admit a client should be accompanied by a referral to a community agency that can help the client with his/her non-psychiatric needs.

Referrals to psychiatric clinics also should not be applied indiscriminately to all clients who seek admission or readmission to the state hospital. Clients who were found not in need of psychiatric treatment should not be given mental diagnosis or referred to psychiatric clinics. These organizational changes could be implemented using the current resources at state facilities. In order to achieve the desired outcome, teams should be given clear mandates in decision making regarding admission with no interference from the hospital or community agents.

At the local level, based on the findings that the majority of clients lack knowledge about services available in the community, an informal referral service should be instituted. The new service could follow the British "Citizen Advisory Bureau" model,\(^1\) the Neighborhood Information Center model,\(^2\) or have a unique model of its own. This new information and referral service will help


relieve the hospital screening teams of initiating many referrals, a secondary assignment which is costly in time and money to the hospital.

There also seems to be a great need for family counselling agencies in the community. This observation is based on the fact that the majority of clients were living with families and friends before seeking admission or readmission to the hospital. Such family agencies can offer counselling assistance and conflict resolution to many of these clients. It is likely that clients and their families tend to use the mental hospital as a temporary respite, instead of working on their problems. Professional help through family agencies could be instrumental in that regard. Social workers in these agencies could help a family member to relocate without having to seek psychiatric admission.

The state hospital could also initiate liaison teams to work with the current community facilities which accept discharged patients. The team’s main function would be to assist community agencies in dealing with clients’ problems which do not necessarily require readmission to the hospital. Creedmoor Psychiatric Center has taken a similar initiative and formed crisis intervention mobile teams for Queens County with reported positive outcome.

The state hospital should also establish a system to monitor its referrals to other community agencies. Such a system will help reduce the number of clients seeking readmission for non-psychiatric reasons. Recent studies have shown high return rates for clients
who did not comply with their referral.  

The above recommendations could be instrumental in reducing first admissions to the hospital. Problems of clients who frequently seek readmission for non psychiatric reasons may require another set of actions at the state level, such as the conversion of some of the mental hospital's buildings to health related facilities, skilled nursing facilities, domiciliary care facilities and emergency housing. This arrangement will help ease the shortage of such services in the community and minimize the number of re-admissions which result from such shortage.

As a matter of policy the state should insure that the discharged mental patients are not denied access to geriatric, health, education, employment and social services because of their history of psychiatric illness. It is important that former mental patients gain access to services which are available to the general public. The current practice is that such clients have access to categorically segregated mental health services which enforce their isolation from the rest of the society.

Meanwhile, many clients with no psychiatric problems attempt to fit under the psychiatric banner to qualify for needed services. Such practice locks those clients into a career as mental patients with insecure identity and erosion of self esteem. It seems that

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the current service delivery demand for the individual to give up— to use Maslow's hierarchy of human needs— his/her highest needs of self-actualization and esteem as a price to fulfill the need for security and physical survival.

Based on the facts presented in the study, it is important that clients' access to certain social utilities or services such as temporary housing, financial aid and medical care should be based on the client's need regardless of his/her psychiatric condition. This latter issue involves many changes in the local, state and federal laws, statutes, rules and regulations which set eligibility criteria for such services.

Changes in the current service delivery scene should aim at facilitating access. Kahn argues that "...many more people would make use of social programs if they knew about them or, if knowing, they could gain entry." "Gaining entry" is what clients seem to need. The issue is not whether needs are met, rather, how these needs could be met without having to convert these clients to mental patients. The conversion process involves changing the status of the client from an ordinary citizen faced with problems of unemployment, housing shortage, and escalating high cost of living to a case of a mentally ill, disabled, unemployable individual

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who needs to reside in supervised housing under a psychiatric label for a prolonged period of time.

As we mentioned earlier, the tightening up of mental hospital admissions and stressing the need for information and referral services may help maintain the mental hospital as an organization but it does not address the problems of clients in situations similar to our study sample. Most services which are needed by these clients are offered as mental health services or case services rather than universal social utilities. As a result, referral by screening teams to a specialized agency for non-psychiatric clients could amount to wishful thinking when there is no room in the categorical system for these clients. Further, assessment of the neighborhood service centers of the 1960s suggested that these centers tend to act "as a shelter for service providers rather than as a single coherent delivery system."¹

News stories and press reports provide us with examples of the issue at hand. Recently one such story focused on the housing shortage in New York City. A single working woman, who struggled with the problem for months was quoted in the story as saying, "I am tempted to pose as a mental patient and... when they release me they would put me out on SSI, and they would have to find me housing."²

¹Alfred J. Kahn, Service Delivery at the Neighborhood Level, op. cit.

In another news story, it was reported that improved conditions at
New York City's public shelters attracted hundreds of people who
might otherwise remain in other housing alternatives and that
"instead of continuing to live with friends and relatives who do
not want them, many young able-bodied men and women, particularly
those who have just lost jobs, are seeking public shelter." 1 We
noted that the shelters' new clients are similar in characteristics
and problems to clients in our study sample in many respects.
As mentioned earlier, the majority of the study sample were young,
unemployed, living with relatives or friends and were unable to
secure housing accommodations within their limited resources. We
also noted that none of the clients of the study sample indicated
that they actually sought admission because they wanted to remain
in the hospital. (Table 20).

Based on these facts, it is reasonable to suggest that
temporary housing programs or clean and safe shelters available
at all times on a sliding scale fee would be preferable to many
who seek admission to the state hospital for lodging. Such a
stigma free alternative allows clients to pursue their daily lives
without seeking conversion into a mental patients status. Supportive
apartment programs which we referred to earlier could also be
instrumental in dealing with the problem.

1"Better Shelters in City Drawing Young and Able," New York
Times, April 26, 1982, p. 131.
A long term solution to the problem at hand, however, calls on psychiatric facilities to operate within their boundary limits (treatment of mental patients) while clients receive non-psychiatric services through community agencies. This goal could be facilitated through the initiation of community based service delivery centers in each locality. These centers could be used as an entry point to other community services including psychiatric services. The centers could also be used as the exit point for psychiatric patients after being discharged from the hospital. Being the entry point, these centers will insure that psychiatric services as well as other services receive only those persons who belong within each service’s domain. Being the exit point of the hospital’s discharged patients, will also waive the mental hospital from its obligation as a custodian of the discharged patients in the community. This will allow the hospital to devote its expertise and funds to better treatment of new patients and ease the concerns of some mental health officials who argue that "...until we can make sure that other people are providing these resources we have to take an active role." Relinquishing this active role by mental health officials will also discourage clients from using the mental hospital as a vehicle to gain access to services upon discharge. Access to such services will be facilitated through the new centers without the need for psychiatric admission.

In practice, this option will benefit individuals who need psychiatric treatment as well as clients with other pressing social service needs. Persons in need of psychiatric treatment would be guaranteed exclusive access to such services. According to Gate's formula for measuring service access effectiveness, by excluding twenty to thirty percent of the users of psychiatric services (those with no psychiatric problems) the service access for those who need psychiatric treatment will reach 100 percent.

Planners of the proposed centers could use the personnel social services system (PSSS) as a model of service delivery at the local level. PSSS has been introduced by Kahn and Kamerman as a viable option after a thorough assessment of the national and international service delivery structures. Based on the findings


of this study and the review of current options, it is our judgment
that the PSSS has a great potential for success in dealing with
current problems in service delivery. PSSS centers could be a key
alternative in dealing with problems of mental institutionalization
and deinstitutionalization. This assumption is based on the premise
that the new centers will:

- Direct clients to appropriate community housing and
  services through its screening, information and
  referral system. A single entry door will insure
  accountability.

- Handle clients who have problems in living and thus
  limit their chances of being admitted to a mental
  hospital.

- Provide a system of accountability and monitoring
  of services provided to discharged mental patients
  through a well organized case management system,
  management information system or an adopted system
  which serves this function.

- Help to destigmatize services to ex-mental patients
  in the community. This will occur due to the fact
  that the center provides services to all community
  residents on a universal basis and not to a categorical
  group.

The above four functions of the proposed new centers are most
relevant to clients in situations similar to our study group.

The centers are also expected to serve additional functions,
which are helpful to the above group of clients; these functions
were outlined by Kahn and Kamerman and include:

- Contributing to socialization and development.

- Disseminating information about, and facilitating
  access to services and entitlements anywhere in the
  social sector.

Alfred J. Kahn and Sheila B. Kamerman, "From Social Welfare to
Personal Social Services," paper prepared for presentation to the
Expert Group on Global Trends in Social Welfare Policies, Vienna,
Social Services in the United States, op. cit.
- Providing help, counseling, and guidance which will assist individuals and families facing problems, crises or pathology to reestablish functional capacity and overcome their difficulties.

- Supporting mutual aid, self-help, and activities aimed at prevention, overcoming problems in community living, advocating changes in policies and programs, and service planning.

- Integrating the variety of appropriate programs or services as they impact upon individuals and families to assure co-ordination for maximum effect.¹

The development of the proposed centers could take different forms and could be publicly or privately administered. However all centers should adhere to the following basic principles:²

- Universal access to services regardless of ability to pay.

- A generalist practitioner as a starting point in providing services to insure accountability and follow-up.

- Social work as the central profession in providing services. This distinction is made on the assumption that social workers are expected to be most knowledgeable about community resources and how to utilize them to meet clients' needs. Other professionals are called upon as consultants and experts in their specific fields.

- An integrated free standing system with its own functions and funding mandates.

Thus, the proposed PSS centers' main goal is to integrate service delivery at the local level with no need for a categorical banner. The center's mandates and funding mechanisms should also

¹Kahn and Kamerman, The Course of Personal Social Services, op. cit., p. 16.

²These principles are adopted from Kahn and Kamerman's writings on PSS. See, Alfred J. Kahn and Sheila B. Kamerman, The Course of Social Services, op. cit.
allow them to initiate new services to meet clients' needs rather than to satisfy the requirements of the funding sources.

Planning, programming and implementing the proposed centers will require a thorough review of the existing federal, state and local legislations, statutes, and regulations which govern the current categorical programs.

Implementation: Problems and Prospects

Implementation of the proposed system could be perceived as a loss of the political gains of the 1960's especially in the field of community mental health. The 1960's gains are exemplified by the enactment of the Community Mental Health Centers Act (CMHCA). The CMHCA committed the federal government for the first time to share the cost of mental health services at the local and state levels.

Some would also argue that a general social service system such as PSS would not be a popular idea among taxpayers who prefer to allocate tax revenue to programs for those who are physically or mentally ill and not to those who are unable to support themselves. According to this view, gaining access to services under any banner could be a more humane alternative than receiving no services. For this reason it has been argued that a strict boundary distinction between mental health and social services could create more suffering for clients who are not ill enough to require hospitalization but who do need social services that help sustain them in their communities. This view is supported by the fact that there is no agreement about
what constitutes mental illness and mental health and the difficulty in drawing the line between psychiatric, non-psychiatric, mental health or social services.

A second issue is that a holistic, well integrated service delivery system is likely to be labeled by its opponents as a planning venture that threatens the American pluralistic, diverse and free system. It was also suggested that a change from the current categorical programs to a systems approach is not only dangerous but could be disastrous. Austin in presenting this view indicates that "... to develop a comprehensive and integrated structure which cuts across traditional categorical identifications and funding patterns is like walking at midnight through a trigger wired mine field in which one mis-step in any direction is likely to produce explosions on all sides... "¹ Austin also suggested that the costs of developing a new system are highly visible and the benefits are uncertain.²

A third problem in implementing the proposed PSSS is the lack of needed political support similar to that enjoyed by many categorical programs for the past two decades.

The above problems represent a real challenge not only to the proposed PSSS but to any new innovation that calls for a change in the current categorical services scene.

¹David Austin, "Historical Precedents and the State of Knowledge on the 'Comprehensive, Coherent Organization of Social Services'" Paper presented at the Cleveland Foundation/APWA on Redesigning Local Social Service Delivery (May 1978, p. 8).

²Ibid., p. 9.
Meanwhile, the case for PSSS as a new service delivery system rests on the fact that providing non-psychiatric service under a mental health banner is a costly alternative to clients and society in general. For clients, such practice tends to stigmatize the user of the service for a prolonged period of time and makes patienthood a prerequisite for receiving needed social services. For society, the cost of providing psychiatric treatment is high when compared to the cost of social service programs. As an example, the current cost of treating one patient in a New York State Mental Hospital is $323 per day.¹ The cost is even higher when the patient is treated in a New York City general hospital ($525.00 per day).²

In addition to the high cost of unwarranted hospitalization, providing social services under a psychiatric banner is not a viable option even for those who need psychiatric treatment. As Kahn suggests "... it can be extremely harmful to those in need of case services to have the presence of a specific handicap deemed the critical basis of assignment of service responsibilities in all realms of a persons life."³

A second argument to support the need for PSSS is that fragmentation

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²Personal communication with Queens General Medical Center in New York City and New York City Bellevue Hospital.

and duplication of services makes it difficult for the client to receive needed services and leaves many gaps in service provisions. In proposing the PSSS option Kahn and Kamerman referred to the pitfalls of the current arrangement and suggested that "The society cannot afford parallel systems for all favored groups covering all major life contingencies. The categorical pathway is ultimately one which consigns us to inadequate service provisions and continuously pits one group in need against another."¹

In addition to the stigma, the cost, and service gaps, there are other risks in tying the provision of social services to psychiatric and mental health treatment. These risks stem from the fact that psychiatry changes its intervention strategies with the change in the sociopolitical scene. As a case in point, it has been noted that in the 1980's conservative political climate psychiatry is moving away from "treating the environment" through community psychiatry and preventive strategies to treating mentally ill patients in institutional settings."² A recent report by the Group for the Advancement of Psychiatry (GAP) acknowledges the above fact. The report also questions the validity of the assumptions, premises and accomplishments of community psychiatry and community mental health of

¹Alfred J. Kahn and Sheilah Kamerman, "The Course of Personal Social Services," op. cit., p. 41.
²Community Psychiatry: A reappraisal, Committee on Psychiatry and the Community, Group for the Advancement of Psychiatry (New York, Mental Health Materials, 1983) p. 43.
the liberal era of the 1960's. The report is critical of the many psychiatrists such as Duhl, Caplan and Zusman who "jumped on the CMHC bandwagon."1

The GAP report meanwhile, supported Borus's view that during the 1960's era psychiatrists:

... deceived themselves into trying to fulfill the public illusion that psychiatry could solve societal problems ... Public disillusionment with CMH followed shortly thereafter when the impossible could not be delivered.2

The risk here is that social services which are funded under community psychiatry and community mental health auspices are likely to be abolished whenever psychiatry decides that community care is not a viable treatment modality.

A second risk is that states and localities tend to drop the non-revenue producing activities (those which are not reimbursable through Medicaid and Medicare) from the CMHC services once these centers exhaust their eight year federal funding support. Many services such as consultation, education and preventive services are classified as non-revenue producing activities and, consequently, lose their funding.3

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1Ibid.
2Ibid, p. 46.
The above risks may not be totally eliminated through the implementation of the proposed PSSS. However, as indicated earlier, the new system will ensure that policy decisions affecting the delivery of social services are based on clients' needs rather than on the changing priorities of psychiatry and sources of funds.

Finally, it is suggested that PSSS will offer a unique and permanent domain for social work as a helping profession. Such a domain is as important to social work as medicine to the medical profession and law to the legal profession.

In conclusion, the problems outlined in this study as stated by clients and assessed by staff reflected the many gaps in the current fragmented non-system of services. There is a great need for a coherent, accessible service delivery system to deal effectively and efficiently with these problems.
A. Books:


A. Books (continued):


A. Books (continued):


B. Articles and Conference Papers:


E. Articles and Conference Papers (continued):


B. Articles and Conference Papers (continued):


B. Articles and Conference Papers (continued):


B. Articles and Conference Papers (continued):


C. Government Documents and Official Papers:

Appropriate Community Placement and Support, Phase One:
Five Year Mental Health Plan, New York State Department of Mental Hygiene, Division of Mental Health, 1978,


"Entering the New Decade with a New Plan" a Creedmoor publication, 1980.


Five Year Comprehensive Plan for Mental Health Services; New York State Office of Mental Health 1983,

Five Year Comprehensive Plan for Services to Mentally Ill Persons in New York State 1979, New York State Office of Mental Health, Vol. I - Nov. 1978,

Memorandum 80-6 from William Morris, New York State Office of Mental Health, Deputy Commissioner on the subject of Crisis Residence Program dated March 11, 1980 to the Office of Mental Health Regional Directors.

C. Government Documents and Official Papers:

New York State Mental Hygiene Law, a reproduced copy issued by the New York State Department of Mental Hygiene, 1974.

New York State Department of Mental Hygiene, 1974 Annual Report, June 1975.

Preliminary Report to the President from the President's Commission on Mental Health, a White House memorandum dated Sept. 1, 1977 from Thomas E. Bryant Chairman of the President's Commission on Mental Health to the President.


APPENDIX 1

INFORMED CONSENT FORM

Note: Clients are told that their participation in the study is entirely voluntary and that refusal to participate will not jeopardize their relationship with Creedmoor Psychiatric Center or the Emergency Housing Program. When the client is interviewed by the investigator or his associates, she/he is asked to sign the following consent:

I agree to participate in the study being conducted at Creedmoor Psychiatric Center and to the review of my chart. I understand that the purpose of the study is to learn more about clients who sought admission or readmission to the Center and were referred to the Emergency Housing Program. As part of the study, I am being asked some questions about aspects of my life such as living arrangements, income, problems encountered, etc. I understand that this research project does not directly benefit me; its goal is to improve service delivery options to clients seen at this facility. Any questions I have will be answered by the investigator or his associates and all my responses will be treated as confidential. I am free to withdraw from the study at any time.

NAME______________________________

DATE______________________________

SIGNATURE______________________________

CODE #______________________________
**Client Questionnaire**

1. **Client's code #**

2. **Staff code #**

3. Client sought:
   1. new admission ( )
   2. readmission ( )

4. Number of readmissions to CPC or other psychiatric hospitals within the past year:
   
   0 1 2 3 4 5 6 7 8 or more

**Referral Information**

5. Who referred you to Creedmoor Psychiatric Center?
   1. self ( )
   2. family ( )
   3. friend ( )
   4. school ( )
   5. police ( )
   6. private psychiatrist ( )
   7. mental health center ( )
   8. mental hospital ( )
   9. general hospital ( )
   10. nursing home ( )
   11. adult home ( )
   12. voluntary agency ( )
   13. other (specify) ( )

**For Coders Only**

CARD I

<table>
<thead>
<tr>
<th>1 - 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 - 5</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td>7</td>
</tr>
<tr>
<td>8 - 9</td>
</tr>
</tbody>
</table>
Demographic Information

6. How old are you?
   1. under 20 ( )
   2. 20 - 30 ( )
   3. 30 - 40 ( )
   4. 40 - 50 ( )
   5. 50 - 60 ( )
   6. 60 - 70 ( )
   7. over 70 ( )

7. sex:
   1. male ( )
   2. female ( )

8. Do you identify yourself with an ethnic group? If so, what is it?
   1. White ( )
   2. Black ( )
   3. Hispanic ( )
   4. American Indian ( )
   5. Asian or Pacific Islands
   6. Other ( ) specify
   7. Do not know ( )

9. What is your religion: 1. Roman Catholic ( )
   2. Protestant ( )
   3. Jewish ( )
   4. Other specify

10. At present are you:
    1. married ( )
    2. never married ( )
    3. divorced ( )
    4. separated ( )
    5. common law/living together ( )
    6. widowed ( )
    7. don't know
11. What is the highest grade you completed in school?

<table>
<thead>
<tr>
<th># of years</th>
<th>1) elementary school</th>
<th>0 1 2 3 4 5 6 7 8 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2) high school</td>
<td>0 1 2 3 4 5 6 7 8 or more</td>
</tr>
<tr>
<td></td>
<td>3) college</td>
<td>0 1 2 3 4 5 6 7 8 or more</td>
</tr>
<tr>
<td></td>
<td>4) graduate school</td>
<td>0 1 2 3 4 5 6 7 8 or more</td>
</tr>
<tr>
<td></td>
<td>5) business, technical, vocational school</td>
<td>0 1 2 3 4 5 6 7 8 or more</td>
</tr>
<tr>
<td></td>
<td>6) other (specify)</td>
<td>0 1 2 3 4 5 6 7 8 or more</td>
</tr>
<tr>
<td></td>
<td>7) do not know</td>
<td>0</td>
</tr>
</tbody>
</table>

12. Did you graduate from:

1) High School ( )
2) High School, and College ( )
3) High School, College and Graduate School ( )
4) none of the above ( )

13. Currently are you: 1) not in the labor force ( )
2) employed ( )
3) unemployed ( )

14. If not in the labor force, why?

01) illness, physical ( )
02) homemaker ( )
03) student ( )
04) retired ( )
05) unemployable ( )
06) mentally disabled ( )
07) other ( )
08) do not know ( )
09) N/A
15. If you are employed, are you employed:
   01. full time ( )
   02. part time ( )
   03. N/A

16. If you are unemployed, are you:
   01. on lay-off ( )
   02. looking for work ( )
   03. on rehab workshop ( )
   04. N/A

Income
17. How much money do you receive each month:
   1. none to less than $50 ( )
   2. $50 to less than $150 ( )
   3. $150 to less than $250 ( )
   4. $250 to less than $350 ( )
   5. $350 to less than $450 ( )
   6. $450 to less than $550 ( )
   7. $550 to less than $650 ( )
   8. $650 or more ( )
   9. do not know

18. What is the main source of your income:
   1. work ( )
   2. relatives ( )
   3. retirement( )
   4. SS or SSI ( )
   5. own assets( )
   6. public assistance ( )
   7. public assistance and SSI ( )
   8. no source of income ( )
   9. do not know
19. At present are you receiving:
   1. medicare benefits ( )
   2. medicaid benefits ( )
   3. both medicare and medicaid benefits ( )
   4. no medicare or medicaid benefits ( )

20. If you are not receiving medicare and/or medicaid benefits, what is the reason you are not receiving such benefits?
   1. do not know ( )
   2. I am not eligible ( )
   3. did not apply for it ( )
   4. N/A (receives benefits)( )
   5. other (specify)

21. I will read you a list of services. You tell me which services you expect from Creedmoor:
   1. counselling  1) yes ( )  2) no ( )
   2. to be given information and referral
      1) yes ( )  2) no ( )
   3. help in finding a place to stay
      1) yes ( )  2) no ( )
   4. allow me to stay temporarily until
      I find a place to live
      1) yes ( )  2) no ( )
   5. make paper work so I can obtain financial disability benefits
      1) yes ( )  2) no ( )
   6. give me medication
      1) yes ( )  2) no ( )
   7. other (specify)
      1) yes ( )  2) no ( )
Living Arrangement:

22. What was your living arrangement prior to admission to the emergency housing program?

- 01. own home or apartment
- 02. home of relative or friend
- 03. boarding house
- 04. hotel, motel, rooming house
- 05. community residence
- 06. supervised living in psychiatric center
- 07. family care home
- 08. foster care
- 09. arranged group living
- 10. private proprietary home for adults
- 11. other domiciliary care facility
- 12. state psychiatric center
- 13. certified psychiatric center
- 14. general hospital (psychiatric unit)
- 15. general hospital (other unit)
- 16. skilled nursing facility
- 17. health related facility
- 18. homeless

23. I understand that you were placed in emergency housing because you did not have a temporary or permanent place to stay at the present time. The following could be some reasons for this situation. Which reason or reasons apply in your case?

1. Do not have money
   - 1. Yes ( ) 2. No ( ) 3. N/A ( )
2. Don't want to live with parents, children, or spouse
   - 1. Yes ( ) 2. No ( ) 3. N/A ( )
3. Parents, children or spouse do not want me to live with them
   - 1. Yes ( ) 2. No ( ) 3. N/A ( )
4. Both relatives and I do not want to live together
   - 1. Yes ( ) 2. No ( ) 3. N/A ( )
5. Can't find a room or apartment
   - 1. Yes ( ) 2. No ( ) 3. N/A ( )
6. Landlord does not want me to stay because of my condition
   - 1. Yes ( ) 2. No ( ) 3. N/A ( )
7. I prefer to stay in the hospital
   1. Yes ( )   2. No ( )   3. N/A ( )

8. I would rather be on my own in the street
   1. Yes ( )   2. No ( )   3. N/A ( )

9. do not know
   1. Yes ( )   2. No ( )   3. N/A ( )

10. other (specify)

24. Prior to admission, did you live

   1. alone ( )
   2. with parents ( )
   3. with spouse ( )
   4. with other family members ( )
   5. with unrelated room or housemates ( )
   6. do not know ( )

25. Do you have family living nearby (within one hour travel time)?

   1. Yes ( )
   2. No ( )
   3. Don't know ( )

26. What housing accommodations do you prefer when you leave emergency housing?

   01. own home or apartment ( )
   02. home of relative or friend ( )
   03. boarding house ( )
   04. hotel, motel, rooming house ( )
   05. community residence ( )
   06. supervised living in psychiatric center ( )
   07. family care home ( )
   08. foster care ( )
   09. arranged group living ( )
   10. private proprietary home for adults ( )
   11. other domiciliary care facility ( )
   12. state psychiatric center ( )
   13. certified psychiatric center ( )
   14. has no preference ( )
   15. skilled nursing facility ( )
   16. health related facility ( )
   17. homeless ( )
   18. other (specify) ( )
### Functional Abilities

27. To what extent are you able to:

<table>
<thead>
<tr>
<th></th>
<th>Independent</th>
<th>Need Minimum</th>
<th>Need Moderate Assistance</th>
<th>Totally Dependent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Walk</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Bathe</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Dress</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Feed yourself</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Toilet</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Groom yourself</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Problems Presented

28. I will read you a list of problems. Tell me if this is an ongoing problem for you.

1. emotional problem  yes () no ()
2. housing problem    yes () no ()
3. family problem     yes () no ()
4. problem in the    yes () no ()
5. work related problem yes () no ()
6. drug or alcohol    yes () no ()
7. medical problem    yes () no ()
8. financial problem  yes () no ()
9. other problem      yes () no ()

specify
29. Do you expect people at Creedmoor to help you with the following problem(s)?

<table>
<thead>
<tr>
<th>Problem Type</th>
<th>Yes ( )</th>
<th>No ( )</th>
<th>N/A ( )</th>
</tr>
</thead>
<tbody>
<tr>
<td>emotional problem</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>housing problem</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>family problem</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>problem in resident home</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>work related problem</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>drug or alcohol problem</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>medical problem</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>financial problem</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>other problem specify</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

30. Do you know of any other agencies that can help with these problems other than Creedmoor?

<table>
<thead>
<tr>
<th>Yes ( )</th>
<th>No ( )</th>
</tr>
</thead>
</table>

31. If the answer to 30 is yes, what are these agencies?

32. If the answer to 30 is yes, have you attempted to contact these agencies?

<table>
<thead>
<tr>
<th>Yes ( )</th>
<th>No ( )</th>
<th>N/A ( )</th>
</tr>
</thead>
</table>

33. If the answer to 30 is yes, what happened when you contacted these agencies?

34. If the answer to 32 is yes, why haven't you contacted these agencies?
Dear Colleague,

Our day to day activities in helping clients and patients with their problems are enhanced through better understanding of such problems and an objective assessment of their needs. For this reason your help is being sought in a study designed to achieve the above goal. The following questionnaire is one part of the study's tools. The questionnaire is designed to be filled only by the staff who are currently working with clients in the Emergency Housing program. The questions in Part I of the questionnaire will be filled out on each client you worked with during the period of the study. The questions in Part II of the questionnaire will be filled only once during the period of the study.

This study is done under the auspices of Columbia University School of Social Work. The conducting of the study was approved by the Chief of Service of the Community Linkage Unit, the Creedmoor Institution Review Board, the Creedmoor Deputy Director for Community Services and the Creedmoor Director.

The information you have given will naturally be held confidential and will be analyzed only in general terms. To insure confidentiality, you will be given a code number that will be used instead of your name on the questionnaire. Please do not sign your name on any of the questionnaires.

Thank you very much for your help in filling out the questionnaire. After completing each questionnaire, please return it to me.

Sincerely,
Staff Questionnaire

Part I

1. Re: Client Code #_____________________

2. Staff Code #_____________________

Assessment of Client's Level of Function:

3. Having worked with the client at EHP for the past few days, how would you assess the ability of the client to communicate his thoughts and needs to others:

   The client has:
   1. no difficulty ( )
   2. mild limitation ( )
   3. moderate limitation ( )
   4. severe limitation ( )
   5. no communication ( )
   6. do not know ( )

4. In your opinion, upon discharge from emergency housing, do you think the client could function at:

   1. high level ( )
   2. moderate level ( )
   3. low level ( )
   4. cannot function in a community setting ( )
   5. I cannot predict at the present time ( )
   6. do not know ( )
5. Using available information, check the box for each item which best reflects the client's current usual manner of performing the following:

<table>
<thead>
<tr>
<th></th>
<th>Independently</th>
<th>With difficulty</th>
<th>Unable or need of assistance</th>
<th>Does not apply</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1) Uses public transportation on familiar routes</td>
<td></td>
<td></td>
<td></td>
<td>18</td>
</tr>
<tr>
<td>2</td>
<td>2) Uses public transportation on unfamiliar routes</td>
<td></td>
<td></td>
<td></td>
<td>19</td>
</tr>
<tr>
<td>3</td>
<td>3) Manages available money</td>
<td></td>
<td></td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>4</td>
<td>4) Maintains prescribed medication program</td>
<td></td>
<td></td>
<td></td>
<td>21</td>
</tr>
<tr>
<td>5</td>
<td>5) Bathes and grooms himself</td>
<td></td>
<td></td>
<td></td>
<td>22</td>
</tr>
<tr>
<td>6</td>
<td>6) Dresses self appropriately</td>
<td></td>
<td></td>
<td></td>
<td>23</td>
</tr>
<tr>
<td>7</td>
<td>7) Performs household chores (e.g. cleans, makes bed, does laundry)</td>
<td></td>
<td></td>
<td></td>
<td>24</td>
</tr>
<tr>
<td>8</td>
<td>8) Can or does prepare or obtain own meals</td>
<td></td>
<td></td>
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<tr>
<td>9</td>
<td>9) Can or does maintain adequate diet</td>
<td></td>
<td></td>
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<td>26</td>
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<tr>
<td>10</td>
<td>10) Engages in leisure time activities</td>
<td></td>
<td></td>
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<td>27</td>
</tr>
<tr>
<td>11</td>
<td>11) Shops outside the residence</td>
<td></td>
<td></td>
<td></td>
<td>28</td>
</tr>
<tr>
<td>12</td>
<td>12) Socializes with others</td>
<td></td>
<td></td>
<td></td>
<td>29</td>
</tr>
<tr>
<td>13</td>
<td>13) Takes initiative or seeks assistance with problems</td>
<td></td>
<td></td>
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</table>
Behavior problems:

6. Within the last month has the client:

<table>
<thead>
<tr>
<th></th>
<th>Yes, mild problem</th>
<th>Yes, severe problem</th>
<th>Not applicable</th>
<th>Don't know</th>
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<td>1</td>
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<tr>
<td>9</td>
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</tr>
</tbody>
</table>

-1-
Client's social and health problems:

7. The following are causes of admission to emergency housing. Please rank them according to their degree of significance for client.

   1. Most significant
   2. High significance
   3. Moderate significance
   4. Low significance
   5. No significance

<table>
<thead>
<tr>
<th>Cause</th>
<th>Rank 1</th>
<th>Rank 2</th>
<th>Rank 3</th>
<th>Rank 4</th>
<th>Rank 5</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Housing and placement problems</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>45</td>
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<tr>
<td>2) Legal problems</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>46</td>
</tr>
<tr>
<td>3) Medical problems</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>47</td>
</tr>
<tr>
<td>4) Psychiatric problems</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>48</td>
</tr>
<tr>
<td>5) Financial problems</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>49</td>
</tr>
<tr>
<td>6) Lack of knowledge about services available</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>50</td>
</tr>
<tr>
<td>7) Job related problems</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
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<td>51</td>
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<tr>
<td>8) Lack of support in the community such as homemakers and nursing assistance</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
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<td></td>
<td>52</td>
</tr>
<tr>
<td>9) Lack of support in the home environment such as family and friends</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>53</td>
</tr>
<tr>
<td>10) Other problems</td>
<td>1 2 3 4 5</td>
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<td></td>
<td></td>
<td></td>
<td>54</td>
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</tbody>
</table>
8. Rank the following services according to your assessment of the client's needs:

1. most needed service
2. highly needed service
3. moderately needed service
4. least needed service
5. not a needed service

<table>
<thead>
<tr>
<th>Service</th>
<th>1 2 3 4 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>legal services</td>
<td></td>
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<tr>
<td>education</td>
<td></td>
</tr>
<tr>
<td>employment</td>
<td></td>
</tr>
<tr>
<td>day care for children</td>
<td></td>
</tr>
<tr>
<td>nursing aid</td>
<td></td>
</tr>
<tr>
<td>financial aid</td>
<td></td>
</tr>
<tr>
<td>recreation</td>
<td></td>
</tr>
<tr>
<td>readmission to C.F.C.</td>
<td></td>
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<tr>
<td>housing</td>
<td></td>
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<tr>
<td>psychiatric outpatient services</td>
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<tr>
<td>health services</td>
<td></td>
</tr>
<tr>
<td>homemakers</td>
<td></td>
</tr>
<tr>
<td>counselling</td>
<td></td>
</tr>
<tr>
<td>meals on wheels</td>
<td></td>
</tr>
<tr>
<td>rehabilitation services</td>
<td></td>
</tr>
<tr>
<td>other</td>
<td></td>
</tr>
</tbody>
</table>
9. If housing is a needed service to the client, according to your assessment what is the most appropriate placement for the client upon discharge from emergency housing. (mark only one option)

1) Transitional group home (halfway or quarterway house)  
2) Supervised group home (generally long term)  
3) Skilled nursing facility  
4) Health related or intermediate care facility  
5) Family care or foster care  
6) Cooperative apartment, supervised  
7) Cooperative apartment, supportive  
8) Board and home care (PFNA, adult homes)  
9) Boarding house (includes meals)  
10) Rooming house or hotel (including SRO-no meals)  
11) Private home or apartment  
12) Other, specify
10. Many factors are considered obstacles in providing services to clients. With reference to this client, please rank each of these factors from 1 to 5 according to the following scale:

1. Greatest obstacle
2. Highly significant obstacle
3. Moderate obstacle
4. Manageable obstacle
5. Not considered an obstacle

client lacks motivation: 1 2 3 4 5
uncooperative attitude of family: 1 2 3 4 5
lack of housing arrangement that is appropriate for the client: 1 2 3 4 5
lack of homemaker service that can sustain the client in his/her home: 1 2 3 4 5
the client's lack of knowledge about available services: 1 2 3 4 5
insufficient family counselling agencies that can help the client with marital and family problems: 1 2 3 4 5
confusion as to who is responsible for providing and monitoring services needed for the client: 1 2 3 4 5
admission criteria of most placements are very selective and as a result the client may wind up in the hospital as a last resort: 1 2 3 4 5
client has limited financial means and is unable to live within these limits: 1 2 3 4 5
client's relatives are not willing to have him back because they are afraid of what he might do: 1 2 3 4 5
client is unable to live on his own for a prolonged period of time
client is not able to function in a community living arrangement
client does not want to stay with his family despite the family's willingness to have him with them
the client's continuing resistance to any suitable placement in the community
other; please specify
Part II

11. In your opinion what seem to be the main reasons that clients at emergency housing have difficulty in obtaining community services such as housing, financial assistance, transportation and the like?

12. According to your experience, would you assess services for clients in the community as adequate? If not, which services should be made available to this group of clients?
13. If you had to classify clients who were serviced by emergency housing into two groups, those who benefited from the service most and those who benefited least, how would you characterize these two groups and the problems they presented?

14. What were the main reasons that clients who sought readmission to emergency housing, were not able to be sustained in community living arrangements?
Personal Data

15. Staff code # ________________

16. Sex  1. male ()  2. female ()

17. Staff member's occupation:
   1. case manager ()
   2. psychiatrist ()
   3. nurse ()
   4. occupational therapist ()
   5. social worker ()
   6. psychologist ()
   7. rehabilitation counselor ()
   8. mental health therapy aide ()
   9. other ()

18. Number of years of schooling of staff member
   1. high school
   2. some college
   3. college graduate
   4. post graduate
   5. masters degree
   6. advanced studies
   7. Ph.D., M.D.

19. Years of experience in mental health or related fields -
   up to 1 year  2  3  4  5  6  7  8  9 or more
APPENDIX 4

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
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<tbody>
<tr>
<td>1.</td>
<td>181st service</td>
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<td>2.</td>
<td>FACILITY ISSUE</td>
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<td>3.</td>
<td>FULL CODE</td>
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<td>4.</td>
<td>SOCIAL SECURITY NUMBER</td>
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<td>5.</td>
<td>PHONE</td>
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<tr>
<td>6.</td>
<td>PATIENT/RECIPIENT NAME</td>
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<td>7.</td>
<td>STREET</td>
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<td>8.</td>
<td>CITY</td>
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<td>9.</td>
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<td>ZIP</td>
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<td>PERSONAL IDENTIFICATION NUMBER</td>
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<td>BIRTH DATE</td>
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<td>13.</td>
<td>ETHNICITY/GENDER</td>
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<td>14.</td>
<td>RELATIONSHIP</td>
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<td>15.</td>
<td>INTERVIEWER</td>
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<td>16.</td>
<td>DATE OF BIRTH</td>
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<tr>
<td>17.</td>
<td>ETHNICITY/GENDER</td>
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<td>18.</td>
<td>LANGUAGE</td>
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<td>19.</td>
<td>EDUCATION STATUS</td>
</tr>
</tbody>
</table>
APPENDIX 5

Queens
COMMUNITY DISTRICTS

Source: THE NEW YORK DEPARTMENT OF CITY PLANNING
Queens Health Planning Districts

A = Health Planning District

Source:
The New York Department of City Planning
APPENDIX 6
COMMUNITY MENTAL HEALTH RESIDENCES

TERMINOLOGY

Care Setting

Community
Located in community - not requiring continuous psychiatric care.

I.T.P.C.
Intensive Psychiatric Treatment Center

R.P.E.
Rehabilitative Psychiatric Environment

Care Level

SNF or SNU
Skilled Nursing, 24 hour care and supervision for chronic and/or acute somatic illness and need for skilled nursing related to impaired self care ability.

ERF, ICU or ICF
Health Related Facility or Intermediate Care Unit for patients requiring intermittent nursing service of a supportive restorative and preventive nature (assistance with bathing, dressing, feeding, etc.). Beyond room and board but less than SNF.

Supervised Living:
Supervised Living or Supervised Care Unit (FPHA) for patient requiring limited assistance and supervision in self care activities for whom skilled nursing and medical attention for somatic problems is unnecessary.

Congregate Housing
Independent living is a possibility for some patients leaving the hospital either immediately upon discharge or with intermediate steps leading to this independence as a goal.

For the patient who is ready to share and make adjustments, participation in an apartment program has many advantages. By pooling resources, two or more persons are able to afford the cost of rent, utilities and food. Equally important is the alleviation of loneliness and feelings of isolation, which many former patients experience when returning to the community.
Congregate Housing
(continued)
In the Fountain House model, the organization rents
the apartment and makes them available through sub-
leases to 2 or more members. They may live in an
apartment for as long as they wish and they have the
option to take over the lease whenever they feel ready
to do so. Another important factor in this program
is the possibility of having a hospitalized patient
spend a night or two in the apartment, so as to ex-
terience being away from the hospital; also the avail-
ability of temporary housing for a patient just dis-
charged from the hospital.

Skilled Nursing
Facilities (SNF's)
The skilled nursing facility (SNF) affords the patient
relatively complete assistance in activities of daily
living, as well as necessary skilled nursing care;
rehabilitative services, and medical supervision.
Often following hospital discharge, the SNF patient
needs care which cannot be provided at home or at a
lower level of institutional care. In addition, SNF's
provide care to patients with long term chronic ill-
nesses. Patients who are not improving or are slowly
deteriorating can be permanently placed in a SNF;
these patients require periodic review of their med-
ical status by physicians and medical consultants.

More specifically, dimensions of SNF care include:
24 hour nursing care and/or supervision as well as
physical, occupational, speech and hearing therapy;
social services; dental, dietary, pharmacy and pod-
iatric services; activity programs and electrocard-
iology. In addition, clinical laboratory and radio-
logy services must be available on the premises or by
satisfactory arrangement; this stipulation also covers
other consultative services including psychiatry. A
system for medical records is also required.

Domiliary Care
Facilities (DCF's)
Domiliary Care Facilities (DCF's) are those facili-
ties which provide services to persons who because
of physical, mental or social need require supervised
residential and boarding care, laundry and house-
keeping service, as well as minimal assistance with
or supervision of some of the activities of daily liv-
ing. Persons in this level of care must be mentally
and physically able to be responsible for the admin-
istration of their own medications and must not re-
quire any skilled nursing service other than that
which may be provided by a public health nurse. DCF's
are considered "social care" rather than "health care"
institutions and as such are licensed through the
New York State Dept. of Social Services. Types of
DCF's include the following:
Domiciliary Care Facility for Adults (D Home) - one which provides limited health care for residents who have essentially stabilized chronic disorders or disabilities, who are not bedfast and who do not require on a continuing basis: medical or nursing care; skilled observation of symptoms and reactions or accurate recording of facts for purposes of reporting to the resident physician.*

Domiciliary Care Facilities for Adults, Type "D" Homes, are most frequently referred to as Private Proprietary Homes for Adults (PPHA's) and have five (5) or more beds.

Health Related Facilities (HRF's) provide services to persons requiring health care services in addition to board and lodging but not to the extent provided in a SNF. People in an HRF may be mildly confused, incontinent (on an infrequent basis) and needing occasional - but not regular skilled nursing care, (eg; the changing of a dressing after a temporary injury). Persons requiring care in an HRF generally meet the following criteria:

- they are ambulatory (alone or with mechanical aids)
- they need more than minimal assistance with one or two activities of daily living - eg; bathing, dressing, feeding, toileting - but not complete assistance, and/or
- they need assistance in taking medications.

Pre-admission and periodic medical appraisal is required for all HRF residents as well as periodic evaluation of individual nursing needs by a registered professional nurse in order to determine whether individual care needs are being met at the appropriate level. In addition, the following services must be available on the premises or by suitable arrangement: activity programs, social work, dental care as well as pharmaceutical and other supporting services, (eg; clinical, laboratory and x-ray services)

* New York State Board of Social Welfare, Article 16