SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK

ROBERT CALLAHAN, et al., Plaintiffs, -against- HUGH L. CAREY, as Governor of the State of New York, et al., Defendants.	Index No.: 42582/79 IAS Part 10 Honorable Judith J. Gische
LOUISE F. ELDREDGE, et al., Plaintiffs, -against- EDWARD I. KOCH, as Mayor of the City of New York, et al., Defendants.	Index No.: 41494/82 IAS Part 10 Honorable Judith J. Gische

AFFIDAVIT OF DR. EZRA SUSSER

EZRA SUSSER, M.D., Dr. P.H., being duly sworn, deposes and says:

1. I am a Professor of Clinical Psychiatry and Clinical Public Health at the Columbia University College of Physicians and Surgeons. I am also Chair of the Division of Epidemiology at the Joseph L. Mailman School of Public Health at Columbia University and Head of the Epidemiology of Brain Disorders Department at the New York State Psychiatric Institute.

2. I make this affidavit in support of plaintiffs' Order to Show Cause requesting relief to enforce the Consent Decree in this litigation.

3. I received joint degrees in medicine and in public health from the Columbia University College of Physicians and Surgeons School of Public Health in 1982. I became a medical resident in the Department of Psychiatry at Albert Einstein College of Medicine in 1982.

4. In 1984, I was named a National Institute of Mental Health Fellow in Psychiatric Epidemiology at Columbia University's Psychiatric Epidemiology Training Program. I was certified by the American Board of Psychiatry and Neurology in 1989 and received my Dr. P.H. in Epidemiology from the Columbia University School of Public Health in 1992.

5. For more than two decades I have engaged in primary research on the mental status and treatment of the homeless population residing in New York City's municipal shelter system. I have taught courses in epidemiologic methods at the Columbia University School of Public Health and have been appointed to more than 24 positions with academic institutions, professional organizations, medical institutions and hospitals. I have received fellowship and grant support from numerous organizations, including the National Institute of Mental Health and the Center for Disease Control and Prevention. I have conducted major studies on the epidemiology of psychoses and the treatment of schizophrenia. Much of this research has involved homeless people. Additionally, I have published more than 75 articles in peer reviewed journals, written 25 chapters in books on various subjects including epidemiology, psychiatry and homelessness, and made more than 100 presentations in the areas of psychiatric disorder and homelessness. A copy of my curriculum vitae is annexed as Exhibit A to this Affidavit.

6. I am familiar with the August 26, 1981 Final Judgment by Consent entered into in this matter, which guarantees shelter to any man who meets the need standard for public assistance or who "by reason of physical, mental or social dysfunction is in need of temporary shelter" ("Consent Decree"). I am also familiar with the challenged City Defendants' announced policy, Procedure

Number 12–400 ("Eligibility Procedure"), which provides for the denial of shelter to homeless persons who fail to complete an assessment of their need for shelter and prove, by clear and convincing evidence, that they have no access to any other housing. I am also familiar with the Eligibility Procedure's policy for providing immediate, temporary shelter for applicants whose mental or physical impairment prevents them, in the opinion of City employees, from completing the assessment. This policy is set forth in Part IV.G of the Eligibility Procedure.

7. The limitation in Part IV.G will not protect vulnerable, mentally impaired homeless adults who lack proper diagnoses from denial of shelter. Nor will it protect even those mentally impaired adults who have diagnoses, if they lack the capacity to prove, as Eligibility Procedure requires, that their impairments are the cause of any noncompliance. Moreover, the complete failure of the Eligibility Procedure to account for socially dysfunctional persons will result in grievous harm to a population that is in need of emergency shelter and for which the Consent Decree specifically provided shelter.

Mental Impairment

8. The Eligibility Procedure will not permit proper assessments of shelter applicants' mental health. It asks applicants to "claim[] to have a mental ... impairment" in order to excuse their inability to comply with the City's new assessment procedure. Eligibility Procedure at 9. But mentally ill respondents not in treatment are often afraid to reveal information about symptoms and treatment history, and they are also often too disorganized to provide such information. Mentally dysfunctional individuals who have never been diagnosed will not be able to document their mental conditions, as the Eligibility Procedure demands that they do. Many mentally impaired individuals, even if they have received proper diagnoses, are unable or unwilling to describe their impairments.

9. For those mentally impaired applicants who fail to assert that they are impaired, the Eligibility Procedure relies on "eligibility specialist[s]" to detect their impairments and refer them to licensed social workers. The notions that an "eligibility specialist" can meaningfully "suspect[]" the

presence of a mental impairment, and even that a social worker in a shelter intake office or a shelter can reliably determine whether an applicant is mentally impaired, presuppose a level of certainty in the assessment of homeless individuals' mental status that is nearly impossible to attain in the overall shelter system, let alone in a shelter intake office at the entry point to that system.

10. Clinical diagnosis in shelters—or in shelter intake offices—is extremely difficult. The marginal nature of a shelter or shelter intake setting exacerbates distinct problems in diagnosis. Interviews are hard to conduct. Comfort and privacy are difficult to obtain. Records, when they exist, are far less complete than the records available in a formal treatment setting. The absence of records makes it impossible to rely on psychiatric history for guidance. As noted above, mentally impaired individuals are often reluctant or unable to provide information about their symptoms or treatment history. Without having a great deal of time—sometimes many months—a clinician sometimes cannot engage a homeless person sufficiently to piece together the person's medical history, observe his or her behavior, and consider complex diagnoses.

11. Further, because unusual behaviors may be adaptive for survival in the streets, in unstable and/or doubled-up housing situations, or in a shelter setting, it is often unclear whether certain behaviors are consequent to homelessness or to mental disorders.[1] To assess a patient accurately, a clinician must have significant diagnostic and clinical experience, must be familiar with the norms and necessities of street life or of an unstable and/or doubled-up housing situation and must have sufficient time to consider the complexity of diagnosis in this context. As a result, many homeless individuals who suffer from diagnosable mental disorders have never been properly diagnosed.

[1] Diagnosis of many personality disorders, for example, is problematic in a population unstable in social relationships, jobs and housing, features inherent in homelessness. The diagnosis of depression is equally difficult in a population under severe stress, deprived of sleep and hungry, other features common with homelessness.

12. Accordingly, by applying the Eligibility Procedure, the City will be labeling as uncooperative many mentally dysfunctional homeless people who clearly ought to be spared the Eligibility Procedure's harsh consequences.

13. Even if an assessment indicates a strong likelihood of mental disorder, the Eligibility Procedure will not provide a homeless individual even temporary, emergency shelter unless a licensed social worker determines that the disorder prevents the person from completing the new assessment procedure. This requirement, too, fails to square with the reality of assessing mental status among homeless people and the difficulty of proving that mental status.

14. When an individual resides on the street, in unstable and/or doubled-up housing, or in a shelter, his life is in disarray. The full impact of the trauma associated with homelessness is not immediately clear. Although the individual may be suffering from some early sign of mental disorder, such as post traumatic stress disorder, the disorder may not yet be evident or diagnosable. Meanwhile, the stress of homelessness can itself produce mental disorder in many ways. On one view, a homeless individual's psychological distress can be characterized as disorder when it leads to restrictions in functioning and alterations in social roles. This occurs, for example, when a distressed person neglects personal hygiene or shuns specific social interactions required to negotiate for housing. Even when such restrictions do not preclude a shelter applicant from cooperating with an assessment process, but they can contribute significantly to persisting homelessness.

15. Moreover, the difficulty of the Eligibility Procedure can itself impede a homeless individual's ability to cooperate in the assessment process. The Eligibility Procedure represents a steep barrier for even an unimpaired applicant; many applicants suffering from a mental disorder will be unable to complete the new process. The strenuous circumstances of homelessness, and the associated psychological distress, can make it difficult to collect documents and provide information. Faced with the demands of the Eligibility Procedure, many mentally impaired individuals may simply give up and stop seeking help.

16. In short, the Eligibility Procedure will lead the City to deny shelter to mentally impaired people who need and deserve help. The likelihood that such people will be harmed or will do harm to others will increase.

Social Dysfunction

17. Those with social dysfunctions constitute another category of homeless individuals to whom the Consent Decree promises shelter assistance. The Eligibility Procedure does not honor the Consent Decree's promise of safety-net shelter to people with social dysfunction. The Procedure makes no mention of social dysfunction; such dysfunction will evidently not excuse an applicant's inability to complete the new assessment protocol and will not constitute an independent ground justifying the provision of shelter.

18. Social dysfunction falls outside conventional definitions of mental disorder. While social dysfunction is among the criteria used to diagnose a DSM-IV mental disorder,[2] social dysfunction in itself does not constitute such disorder. "Normal" persons can become socially dysfunctional when exposed to stressors such as homelessness. In these cases, the dysfunction that results may be reversible once the stressor is removed. Homeless people who are socially dysfunctional may have trouble coping while in the homeless state, but may be able to manage once the stressor of homelessness is removed. Other socially dysfunctional homeless people, however, will not be able to manage even if housed.

19. Of great concern is that those who are under stress in seeking shelter or being placed in shelter, yet are not necessarily suffering from mental disorder, will ultimately suffer such disorder if not provided with assistance and support. Access to decent, safe emergency shelter is one of those necessary supports. Denying shelter to people with social dysfunctions raises the risk of doing great

[2] The Diagnostic and Statistical Manual of Mental Disorders, fourth edition, (DSM-IV) is the standard instrument for diagnosis and classification of mental disorders used by the psychiatric community. According to the DSM-IV, a mental disorder is considered a manifestation of behavioral, psychological or biological dysfunction.

harm—causing serious, long-term mental disorder with possibly life-threatening consequences—to socially dysfunctional homeless people. Post-traumatic stress disorder is just one disorder that a homeless person may suffer as a result of the homeless experience.

20. In 1989, I published a study of new entrants to shelter to assess psychiatric states in 223 homeless people at first entry to New York City's municipal shelters. The focus of this study was psychotic disorders, a very severe and narrow subset of mental disorder. My sample revealed that 17 percent of the men had a definite or probable history of psychosis and another 8 percent had a possible history of psychosis. A history of alcohol or other drug abuse was evident in 58 percent. One third of the men were in extreme distress, much of it apparently acute and associated with the transition to the shelter. Seven percent reported suicidal thoughts at the time of the interview.

21. Current research suggests continuing high prevalence of mental disorders among homeless people today. Of great significance here is the 8 percent—nearly one in ten of the homeless population—that is possibly, though not certainly, psychotic. These individuals are socially dysfunctional. They often slip through cracks in the health-care safety-net and certainly will do so if the Eligibility Procedure is implemented and they are left without a roof over their heads. These are exactly the people who will be turned away by operation of the Procedure. The consequences of denying shelter to people with social dysfunction is likely to be life-threatening to those people and dangerous to the community.