



March 1985

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## Recommended Citation

Conklin, John J. (1985) "Homelessness and De-Institutionalization," *The Journal of Sociology & Social Welfare*: Vol. 12 : Iss. 1 , Article 4.  
Available at: <https://scholarworks.wmich.edu/jssw/vol12/iss1/4>

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# HOMELESSNESS AND DE-INSTITUTIONALIZATION

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## ABSTRACT

The nation faces a social problem caused by the discharge of chronic mentally ill patients to the community through a process known as "deinstitutionalization." Frequently homeless, these individuals require many community supports and have aroused public sentiment. A review of current literature is used to validate these observations. The University of Connecticut has initiated a practicum training project to educate "case managers" in serving the homeless mentally ill. From an historical perspective, this study outlines the evolution of deinstitutionalization and the identification of treatment models applied to this process.

## INTRODUCTION

Recently, we have been exposed to the significant impact of the mass media in considering the ramifications of starvation in Ethiopia. Inherent in that concern is an appeal to human kindness for efforts to remedy mass starvation through financial donations. Closely related to that type of conviction but no less upsetting or costly is the plight faced by the mentally ill in our country for they, too, are homeless and starving. They are the victims of erroneous efforts over the past twenty years to "deinstitutionalize" them or release them from state hospitals to communities which frequently had few resources with which to assist them.

So dramatic are the results of an idea which was designed to empty the psychiatric hospitals of the "needlessly hospitalized" severely mentally ill that each night they are included in large numbers

among the more than 18,000 homeless of New York City.(1) Other estimates place that figure at 36,000(2) with only enough facilities to house 6,300 in what is described as the "largest publicly sponsored shelter system" by the Newsweek Magazine. (3)

A recent report entitled "Homelessness in America," released last June by the U.S. Conference of Mayors, corroborates a marked increase in the demand for emergency housing despite the decline in the national employment rate. The report concerns ten major cities throughout the nation: Atlanta, Columbus, Boston, Chicago, Denver, New York City, Philadelphia, Salt Lake City, San Francisco and Seattle.

Professional groups such as the American Psychiatric Association have commissioned various studies of the plight of the group we are considering. A three-year study by the A.P.A.'s "Ad Hoc Committee on the Chronic Mental Patient" illustrates this. The findings appear in a book entitled The Homeless Mentally Ill which reports the results of a special Task Force charged with studying the causes and effects of the phenomenon of homelessness and the mentally ill patient.

Inherent in the findings of that Task Force are fourteen suggestions with which we concur. Several of the specifics of the "Major Recommendation" and the "Derivative Recommendations" need to be implemented at once. To cite the overall scope, the A.P.A.'s recommendation is: "To address the problems of the homeless mentally ill in America, a comprehensive and integrated system of care for this vulnerable population of the mentally ill, with designated responsibility, with accountability, and with adequate fiscal resources, must be established." (5) Later recommendations regarding the provisions of basic needs for food, shelter and clothing are incontestable truths. In particular, we are interested in the recommendations for adequate psychiatric care, rehabilitative services,

outreach and the provision of an appropriate number of professionals and paraprofessionals to provide community care of the homeless mentally ill.

The failure of deinstitutionalization of the mentally ill has been well-documented in the literature.(6) (7) Some of the most impressive work has been done by Dr. John A. Talbott, Professor of Psychiatry at the Cornell University Medical College who indicates: "State mental hospitals in the United States reached their maximum census of 550,000 in 1955. Thereafter, the population steadily and dramatically declined to its current low of 180,000... The resultant change in the locus of treatment and care of society's most severely and chronically mentally ill from hospital to community settings, an unplanned but intentional movement has been euphemistically labeled deinstitutionalization."(8)

Others cited dramatic changes in the discharged population, since there were "more than" 550,000 in-patients in state mental hospitals in 1955 while "today the figure is roughly 125,000, a reduction of 75%"(9) "Newsweek" indicated that in 1955, 558,922 patients were in state hospitals and 27 years later, that number had been reduced to 125,200.(10)

In Connecticut today, there are estimated to be 2,000 to 4,000 homeless each night. Not all of these people are former patients but community statistics state that 50-70% of the residents have been previously hospitalized in mental health facilities. A complication arises from the fact that there is less room to hospitalize patients needing care. As another sequel of deinstitutionalization, many state hospital buildings were closed and staff vacancies "frozen" as patients were discharged.

In 1965, prior to the time that deinstitutionalization was as widespread, Connecticut provided care for 8,200 patients in its public mental health facilities. Twenty years later, there is room for just 2,300 patients in the state's institutions. Additional facilities in the community that have

close liaison with the Department of Mental Health have beds for 512 additional individuals.(11)

The Annual Statistics of the Department do not shed much light on what has happened to the chronically mentally ill in terms of treatment since their figures indicate that there are 22,092 admissions to community psychiatric clinics each year, of which only 1,874 or 8.5% are for "schizophrenia and related disorders" with an additional 239 patients or 1.1% having "other psychotic disorders." This is not to criticize the Department's statisticians for the community clinics are sending in reports which indicate that one quarter of all admissions to out-patient facilities were for "diagnosis unknown." In fact, the most frequently listed Diagnostic and Statistical Manual III diagnosis was "Social Adjustments" at 13.2% while "alcohol related" problems were only 6.3% and "drug related" diagnoses were 3.7%.(12) One has to raise the question of where the treatment for the chronically ill is being offered if the community clinics do not see many and the state psychiatric hospitals no longer house them.

#### CAUSES OF THE PHENOMENON

There are many interesting observations as to what has caused the homelessness of the mentally ill and still more interesting solutions. Many writers agree that we need more housing, staff, money and programs immediately. Also, when one discusses the needs of the homeless, many groups may be included in the simple definition of citizens who do not have a permanent domicile. A popular stereotype brands them as the "welfare chiselers." However, a careful study of homeless individuals reveals that many have no housing because they have no income due to government fiat. As a case in point, 400,000 people were ruled ineligible for Social Security Disability benefits or Supplemental Security Income through a 1981 Federal mandate.

A surprising number of the homeless are women, adolescents, minorities, the elderly and the single

heads of families who are not eligible for various types of categorical assistance. In fact, many who are admitted to shelters are still employed but are receiving such minimal wages that they cannot afford rentals or qualify for mortgages. There is frequent agreement between community coalitions, religiously-led groups of concerned citizens and professional groups like the A.P.A. that the problems of the homeless will not quickly resolve, no matter what is done in a dramatic way for the wheels of government turn slowly and community resistance to people perceived as "dead beats" is great. (13)

To focus on the specifics of the homeless mentally ill, Talbott observes that there were four major reasons that deinstitutionalization was practiced in such a widespread manner: "1) development of the philosophy that it is better to treat mental patients in the community than in institutions; 2) technological advances, especially the introduction of new pharmacological agents; 3) increasing emphasis on patient rights by legal, legislative and judicial forces; and 4) the shift in a substantial part of the economic responsibility for the several million chronically mentally ill patients from the states to the federal government (through SSI, Medicaid, and Medicare funding) as patients were discharged from state hospitals to nursing and board and care homes." (14)

The previously mentioned report from the Conference of Mayors gave several reasons for the phenomenon of homelessness which included the lack of affordable housing in the community, the high cost of living these days, the release of mental patients from institutions, the cutbacks in Federal assistance programs and tighter eligibility requirements for other programs. The report notes that all of the mayors called for additional funds and federal intervention.

Others such as Robert E. Jones, the President of the Philadelphia Committee for the Homeless, corroborated these observations in an article in the

"Journal of Hospital and Community Psychiatry" as reported in "Psychology Today": He blamed deinstitutionalization as the major cause, but he also mentioned, as significant contributors, economic recession, high unemployment rates and cutbacks in federal programs. In addition to blaming cutbacks in aid to individuals, he cited the cutbacks in programs for medical care, aging studies, alcoholism and drug abuse, families and children and employment training. He also cited urban renewal for severely cutting into the number of available low-cost housing units and for increasing the number of evictions. (15) Thus, we look at another social problem which can be viewed as having multiple causality and disastrous effects.

#### THE "BAD OLD DAYS" AND GOOD INTENTIONS

If one were to view the current results from the other end of the spectrum, that is, from the perspective of those who were critical of large institution "therapy," it may be seen that much has been obscured over the years. Not all who were involved in treating mental illness, particularly chronic schizophrenia, approved of what was derogated as "warehousing" of the severely ill patient. Critics of institutional treatment pointed to the effects of medication-linked diseases such as tardive dyskinesia while others such as Erving Goffman illustrated in the early 60's what went on in the "underlife" of a public institution in his book entitled Asylums. Alfred Deutsch wrote an earlier expose in 1948 concerning the shocking conditions in American psychiatric hospitals in The Shame of the States. More recent critics of the basic treatment offered to psychiatric patients include authors such as Thomas Szasz, well-known for his allegations about the "myth" of mental illness.

One of the currently popular authorities on schizophrenia, formerly a Special Assistant to the National Institute of Mental Health, is Dr. E. Fuller Torrey, who has written Surviving Schizophrenia, A Family Manual. In it, he offers a great deal of

information about the disease, options for treatment and the ethical-legal options for families of those diagnosed as having various forms of schizophrenia.

Torrey makes a number of critical observations about what he calls the "debacle of deinstitutionalization." In his view, the diagnosis of "schizophrenia" given to patients held in state institutions prior to the 60's was tantamount to a life sentence. When the psychotropic medications came into use, fully two-thirds of the patients treated received some positive benefit and were able to be released to their families. A key point is that the medications worked effectively as long as the patients took them regularly under supervision and had supportive people in the form of interested relatives with whom to reside.

Things went well for the first 200,000 patients who were released from state hospitals. Gradually the trend gained momentum and the term "deinstitutionalization" was coined. In the late 60's, the effort to discharge more and more patients became an issue of concern to civil libertarians along with other causes of the day and the "rights" of many groups.

Today, there is a tendency to disparage the good intentions of the time. It has long since been forgotten that the clinicians of the 60's, including the author, were optimistic about the seeming recovery made by many patients through the use of the new medications. Not everyone was happy with the idea that chronically ill patients had to be locked into wards in old buildings. Many spent their days pacing on screened in porches or idly staring at a television set. With the very best of intentions, those who had families and made a reasonable adjustment with the aid of medication were discharged to community facilities. Out of this enthusiasm for a seeming solution came the creation of a much larger problem.

As Torrey states it, "whereas the first group had consisted of those who were relatively prepared



for return to community living, the second group was woefully unprepared. They included those who responded poorly (or not at all) to the anti-psychotic drugs, those who had become highly dependent on the state hospital, and those who had no family and nowhere to go. Many of them wanted to stay in the hospital. This group had not been prepared to leave and the community was not prepared to receive them." (16)

Some readers will recall that hospitals were totally locked in those days because of necessity. Patients were held in secure facilities, then transferred to open wards and discharged to the community. We participated in the "discharge planning" of the day, both in this country and in England where the "open door policy" was in vogue at the time.

Initially, discharges were made to community facilities and to families, frequently with the promise that if "anything happened," a hospital employee would make a visit to insure that the patient's transition went smoothly. As time went on, the focus of discharge shifted to an administrative mandate based on the "number of beds needed" to "empty out a ward" or "close a building." As Torrey said, both patients and relatives often asked that patients be left "where they were happy" but this was not possible. Even in the middle 60's we began to experience a shortage of community facilities for the chronically ill and aged.

In 1963, historic legislation was passed during the Kennedy administration which initiated community mental health centers. A new treatment modality was established which promised to offer a number of services to all mentally ill people. Almost 800 community mental health centers were funded by the federal government at a cost of more than \$3,000,000,000. Newsweek's estimate of the situation is: "A 1963 goal of starting 2000 community mental health centers throughout the nation by 1980 is still 1283 short. Fewer than a quarter of the patients discharged from state mental institutions remain in any mental health program at all." (17) This statement

may be related to the statistics reported earlier regarding out-patient follow-up care as reported by the Connecticut Department of Mental Health. Unfortunately for the chronically ill population, the promise of the early 60's was not fulfilled for as Torrey notes: "CMHC's have never been interested in patients with schizophrenia." (18)

While mandates were issued that mental health centers were to offer aftercare services to discharged state hospital patients according to the Community Mental Health Centers Amendments of 1975, this simply reiterated the intent of national legislation ten years before. Following the new legislation, the National Institute of Mental Health initiated an approach known as the "Community Support Program," designed to fund states and local communities which would develop "comprehensive" support programs and "network" existing services which were presumed to be in the community. To date, this program known as "CSP," is still being implemented some eight years later with many states at all different levels of progress. Ironically, some of the wealthiest in terms of per capita income are the farthest behind in development.

## HOUSING

Moving closer to some of the more pragmatic community problems which complicated the fate of the deinstitutionalization process, one of the most difficult involves the provision of shelter for the discharged patients. There is no question that all needed what Charlotte Towle, a well-known social work educator once termed "common human needs" or, food, shelter, medical care, emotional sustenance, an income and provision for a spiritual life. However, because of some interesting societal changes over the past two decades, many of the previous "community resources" have ceased to exist. Hotels are now condominiums, inexpensive housing has been torn down and the site turned into a parking lot, civic center or sports colliseum. Local athletic clubs had to close residence halls to provide space

for the construction of indoor jogging tracks.  
"Nationwide, more than one million rooms in flop-houses and in residential hotels called single-room occupancies ("SRO's") were lost between 1970 and 1980 when SRO's were either converted into condominiums and co-ops or destroyed."(19)

The quality of what remains varies greatly. "On the one end of the spectrum are small foster homes where each patient has a room, the food is adequate, and the foster home sponsors watch over and worry about their charges as if they were their own children. A larger version of this may be a renovated hotel where the manager hires staff which organizes social activities for the ex-patients, checks to be sure they are taking their medicine, reminds them of dentist appointments and helps them fill out applications for food stamps.

But, at the other extreme are foster homes with sponsors who provide insufficient heat, blankets and food, steal their patients' meager funds, use them as cheap labor and sometimes even rape them or pimp them. The larger versions of these homes are old hotels that provide no services other than a rundown room and perform similar kinds of exploitations."(20)

Housing shortages will be with us for a long time unless more incentives are offered by government to construct low-cost shelter. Currently, there are no federal funds available for the construction of single room occupancies. In the meantime, the answers may lie in community coalition sponsored approaches, some of which go right back to the psychiatric hospitals which discharged the patients.

## THE RESULTS

If we examine outcome studies of deinstitutionalization based on shortages of community facilities and the housing losses, we move toward designing some current interventions. Dr. John Talbott draws upon the results of a three-year study done by the American Psychiatric Association's "Ad Hoc Committee on the Chronic Mental Patient" when making estimates

about the effects of deinstitutionalization. Contained therein are indications as to why the problems of the homeless are so massive. For instance, in answer to the question of how many chronically ill patients there are in the United States, Talbott says, "there are 1,100,000 schizophrenics, 180,000 of whom are in hospitals and almost a million in the community." (21) Also, there are one million elderly people in institutions, mostly psychiatric hospitals and nursing homes and three quarters of them have psychiatric diagnoses. There are an additional one million psychotic elderly people living in the community, 1.1 million people severely disabled enough to qualify for SSI benefits in institutions while another 3.1 million are in the community. Talbott's conclusion is "Thus, there are between one and four million chronically mentally ill patients in this country." (22)

More recent complications surrounding deinstitutionalization indicate that public sentiment is a factor often aroused in a horrendous manner. Recent newspaper articles attest to the fact that many communities are attempting to rid themselves of those called "bums," "deadbeats," "vagrants," "trolls," "tree people" or "street people." A recent news release indicates that in Santa Cruz, California, three youths were hunting street people with a homemade bazooka. In Fort Lauderdale, Florida, local officials have launched a "bum busting" campaign involving mass jailings of transients and former mental patients. Ordinances have been promulgated which make it illegal for anyone to rummage through refuse, sleep in public parks or camp under bridges. (23)

Political campaigns now contain promises to "get the transients the hell out of town" as in the case of the recent mayoral election in Tucson, Arizona. In Santa Barbara, California, a vagrant was murdered and a warning was issued to others that they faced a similar fate. (24)

Mitchell Ginsberg, former New York City Welfare Commissioner, currently a Professor of Social Work at Columbia University recently summed up his observations in these words: "I am getting an increasing sense of something ugly spreading through our land. It is a mean-spirited attitude toward poor people, and it is essentially based on the belief that they are responsible for their plight--and that if they were only willing to pull themselves up by their own bootstraps--whatever that means--they could. When top officials of the U.S. Government, including President Reagan himself, say these people really prefer to live in the streets and to eat in soup kitchens, it lends an air of legitimacy to those feelings." (25)

Some of the most extensive community research studies have been done by Mary Ann Test, Leonard Stein and Burton Weisbrod in several articles which appeared in the "Archives of General Psychiatry." They wrote a three-part article entitled: "Alternative to Mental Hospital Treatment." In it, they presented their assessment of a treatment model they initiated. Their study was done according to a clinical evaluation, "social cost" and a cost benefit analysis focus.

Several of their conclusions are relevant to our concern. They observed: "traditional programming for these patients is either insufficient, inappropriate or both. The second is that when community programming is inadequate, the hospital is forced to serve as the primary focus of treatment for the patient rather than being used for the more appropriate specialized role it is capable of performing. Third, the results suggest that for a large number of patients, treatment must be ongoing rather than a time-limited endeavor. Our study suggests to us that this ongoing treatment program must be organized so that it can provide a flexible system of delivery that gives the patient only what he needs and where he needs it. This involves a careful assessment of patient needs, close monitoring of patient functioning, assertive intervention,

and working closely with and providing support to community members as well as patients." (26)

With this design in mind, Test and her colleagues went on to establish a community treatment service for the chronically mentally ill which was effective in preventing the readmission of patients as long as active treatment was offered. An interesting observation about the cost of community care, however, indicates that it is more expensive than in-hospital care. An older presumption of those who measure treatment in terms of cost benefit analysis was that it was "cheaper" to treat patients in the community as a reason for wishing to close large state hospitals. In fact, "the hospital-based program is about 10% cheaper per patient" according to Test and her colleagues. (27)

A number of models of community treatment have been developed over the past few years, and national authorities such as Dr. Leona Bachrach of the University of Maryland have produced designs on how to assess the models. In an excellent article entitled: "Overview: Model Programs for Chronic Mental Patients," she suggested a number of approaches in making community treatment models "generalizable" to the national situation. Like Test, she suggested individually tailored treatment and cultural relevance as being important variables but also she recommended linkage with other resources, hospital liaison and specially trained staff, all of which seemed quite relevant to the project we ultimately developed.

As a further exploration of the studies done about community treatment and housing for the chronic mentally ill, we contacted some authorities who have been struggling with a growing problem for years. A Northeastern city which has a state hospital located within the metropolitan area has received discharged patients since deinstitutionalization began. Because of its central location, a number of ex-patients take up residence following release from the hospital. Over the years, a number

of effective housing arrangements were made through close collaboration with community agencies such as the YMCA, Salvation Army, Red Cross and similar resources. In the recent past, due to a shortage of housing, a community coalition was founded.

Part of the Coalition's "Statement of Purpose" illustrates this: "Today, most people assume that government and private agencies continue the tradition of meeting the needs of the homeless. That this is not true came as a shock when, in December, 1981, an emergency meeting was called (by a local soup kitchen which had been organized) to rally support for a temporary shelter in the city. Those attending spoke of persons living--and freezing--on the streets and under bridges. Included were former patients at mental institutions who had been "de-institutionalized," and who helped make visible a much larger group of abandoned and often broken people who, by necessity or choice, had been there all along. Abruptly, a whole segment of our community had come painfully into view." (28)

That Coalition, despite a significant amount of community resistance, went on to establish three shelters in its city. That process has been repeated in other parts of Connecticut. Currently, there are 33 shelters which can accommodate a maximum of about one thousand people per night. (29)

Statistical data collected by two of the sponsoring agencies within the Coalition over a four month period reveal some interesting facts about two of the shelters. The largest group of residents is young; they are in the age range of 16-29 years of age. A total of 1745 beds were used during the period of time the survey was conducted. The greatest number of the 208 individuals served requested shelter for one to two weeks but then often had to be housed again. Comparing the two shelters, there are some differences in the population served. In one case, 72% of the residents were former state hospital patients while the other shelter had no residents from the state facility. As a result, 53% of the 208 residents from

both facilities were formerly at the hospital. The succinct statement in the statistical report is that "a majority of the homeless population sheltered are deinstitutionalized state hospital patients."(30)

An interesting comment made in a conversation we had with an authority from the Coalition is that "money is not the problem, shelter is." Several years ago, the state law had to be changed so that towns and cities in Connecticut would be required to assume financial responsibility for their own residents. A large number of discharged patients were becoming public charges in the cities closest to the state hospitals.

Another interesting solution developed by the Coalition involves the establishment of a third shelter on the grounds of the same state hospital which discharged the patient. As hospitals which formerly housed about three thousand patients shrunk in size to a bed capacity of only several hundred, there was also a diminution in the size of staff. This shelter is located in what once was staff quarters for psychiatric aides, physicians and other institution workers. Thus, it does not have the appearance of a psychiatric ward.

It may be that this is one of the "stop-gap" moves necessary to house people, the former patients as well as people faced with economic necessity, until other housing can be constructed for low-income people on a national basis. Housing of this sort may be available in several types of state facilities since treatment services for the mentally retarded and those with chronic diseases have also experienced the same changes in the need for large institution treatment. In the case we are citing, it is interesting to note that the vacant staff building is next door to another state hospital residence that once was used effectively as a half-way house in the days when funding was more available for such community facilities.



## A PARTIAL SOLUTION

At the national level, these issues have not escaped the concern of legislators. "Rep. Stewart McKinney, R-Conn., has introduced legislation aimed at correcting the defects of deinstitutionalization. The McKinney bill, offered as an amendment to the Public Health Services Act, would replace the requirement for 'least restrictive setting' in the standard care for a mental patient to one of 'optimum therapeutic setting.' The bill is specific in stating that a hospital or other form of institution may be optimum for some patients, while community living is most desirable for others. The bill also puts responsibility on the states for insuring that the chronically mentally ill receive appropriate care, tying that responsibility to eligibility for federal block-grant funds." (31)

While these legislative considerations are taking place, there is still a pressing need for some solutions at the present. One of the strategies which grew out of our study concerns a new program at the University of Connecticut School of Social Work.

Historically, the graduate school has participated for many years in the training of social workers for entry into the mental health field. Much of the education was sponsored through training grants from the National Institute of Mental Health. Recently, we began to explore other avenues through our own national educational organization, the Council on Social Work Education, which has a special project on the Chronically Mentally Ill. Part of the focus of this project is to encourage the development of new courses and interest in the community treatment of the mentally ill. As an example of their efforts, two day workshops were held in New York led by Dr. Mary Ann Test which included visits to Fountain House, a prototypical residential community facility. The Fountain House staff corroborated Dr. Test's finding--community treatment is indeed more expensive than hospital care.

Simultaneously, contact was made with other

national authorities such as Dr. Bachrach of Maryland and Dr. Paul Carling of the University of Vermont. Discussions were held with various officials in the office of the Commissioner of Mental Health in Connecticut. A great deal of the literature was surveyed.

What emerged was a plan, developed with the assistance of a state legislator, Representative Paul Gionfriddo, to request an appropriation from the General Assembly. This would provide scholarships to our graduate students who would serve as "case managers." In the first year of the project they would be placed in one of the regional facilities of the Department of Mental Health. The Regional Director and the Director of Psychiatric Social Service at Cedarcrest Hospital gave us a great deal of technical assistance.

The appropriation was approved by the General Assembly and two graduate students were assigned to a field practicum at Cedarcrest to act as "case managers." Their duties would include linking patients more closely to community facilities, finding tangible resources such as housing for them and taking responsibility for general supervision on a case by case basis. In addition, they are also working in conjunction with the Community Support Program coordinator and developing training manuals for additional case managers who will be hired by the Department later in the Spring.

The second stage of this plan is now being developed. Discussions have taken place with members of the Community Coalition previously mentioned. There is a great need for additional staff to work in the residential programs mentioned and graduate students would be welcomed to carry out a variety of duties such as home-finding, counseling, working with groups of residents, planning and implementation of programming. The School of Social Work already has students placed at agencies such as the Massachusetts Coalition for the Homeless in Boston so we have some experience with the process. Also, many of our

students have served in various capacities as "case managers" prior to the time of admission to graduate school.

One of the "generalizable" tenets to the above concerns the fact that many educational institutions at both the undergraduate and graduate level require some form of field experience or practicum assignment in community settings. A recent edition of the Sunday New York Times "Higher Education" section attests to the fact that more colleges nationally are promoting the idea of service to the public through programs at Stanford, Harvard's Lamont Public Service Fellowships, Connecticut College, Dwight Hall at Yale and the Madison House at the University of Virginia, to name just a few.

In addition to the above, there are several hundred Bachelor of Social Work programs and over eighty M.S.W. programs in the country, all of whom require a practicum assignment as part of the degree requirements. There is a pool of potential case managers and "community interns" who might be assigned to the growing numbers of community coalitions for the homeless.

The above would require considerable discussion on the part of the many schools which might be involved since it is not pedagogically sound simply to assign students to a community program and expect that they would receive a positive educational experience from it. In our case, this took a great deal of discussion in the Department where the plan originated and many conferences were held with Mental Health authorities. Also, as problems arose, conferences were held with the students involved and a Faculty Consultant was assigned to a student unit. A graduate level course was developed regarding the community treatment of the chronically mentally ill which is currently being taught at two of the School's campuses. What remains is a great deal of work with the Coalition to develop plans for the future and to explore further funding opportunities.

Throughout our discussions with a variety of community leaders, an overriding concern expressed was that eventually new legislation will be passed and money will be budgeted to cover the needs of homeless citizens who are in the community. Bills such as that introduced by Congressman McKinney will be approved or the Community Support Program, after several years, will become active in all states. The question which lingers is that if the public is being aggravated by the "trolls," "street people" or "bag ladies," will the new programs arrive in time?

#### SUMMARY

A number of the positive and negative reasons for a current social phenomenon, homelessness of the "deinstitutionalized" mentally are surveyed. In this format, an initial group of 200,000 patients were systematically and successfully moved from hospital to home where they took up useful lives. As the enthusiasm developed, however, a second large group of patients were discharged to community facilities which already were strained to the limit. This group, which steadily increases in size, has complicated the fact that many others in the community are also homeless due to additional economic and health complications, to say nothing about the needs of the elderly. The result is a shortage of housing in an era when there is a vastly increasing demand.

A partial solution is offered in the form of linking unused staff housing on the grounds of state facilities with the assignment of student interns from various graduate and undergraduate schools on a national basis. A design was offered which has resulted in the development of scholarships to fund such student training opportunities.

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