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 "deinstitution-alization." 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 histor-ical 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 signifi-cant 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 con-viction 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 "Derivitive 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 euphe-
mistically 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 deinstitution-
alization 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

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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 chroni-
cally 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) develop-
ment of the philosophy that it is better to treat
mental patients in the community than in institu-
tions; 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 disasterous 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 in-
volved 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

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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 deinstitutionali-
zation." In his view, the diagnosis of "schizophre-
nia" 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 medi-
cations worked effectively as long as the patients
took them regularly under supervision and had suppor-
tive 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 "deinstitu-
tionalization" 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 re-
covery 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 adjust-
ment 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 depen-
dent 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 pre-
pared 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 trans-
ferred 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 Ammendments 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

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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 condo-miniums 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 govern-ment 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 psy-chiatric hospitals which discharged the patients.

THE RESULTS

If we examine outcome studies of deinstitution-alization 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 schizo-
phrenics, 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 de-
institutionalization 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 tran-
sients 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: "Alter-
native 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 programm-
ing for these patients is either insufficient, in-
appropriate 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 monitor-
ing of patient functioning, assertive intervention,

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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 tradi-
tion 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 visable 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 sponsor-
ing 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 re-
quirement 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 partici-
pated 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 treat-
ment 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 cooroborated
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 offi-
cials in the office of the Commissioner of Mental
Health in Connecticut. A great deal of the liter-
ature 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 scholar-
ships 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 facili-
ties 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 co-
ordinator and developing training manuals for addi-
tional case managers who will be hired by the Depart-
ment 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.

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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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