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# The Needs of Hartford's Homeless Mentally Ill

*Steven Kessler, M.D.*

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*A state budget deficit in Connecticut threatens the closing of state mental hospitals and holds the potential of displacing chronically mentally ill patients into homelessness. This article explores the historical association between deinstitutionalization of patients from mental hospitals and subsequent homelessness. One third to two thirds of homeless individuals are mentally ill and require intensive, specific, and targeted responses by the community to end their homelessness. Trends in the care of the chronically mentally ill and the conditions of those who are homeless in Connecticut are explored. Model treatment programs are discussed to suggest possible actions, and recommendations that would help ensure treatment and humane care for the homeless mentally ill in the Hartford region are offered.*

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In 1990, Connecticut hired consultants Deloitte and Touche to make recommendations on how the state could save money to deal with its deficit. Their report, also known as the Thomas Commission Report, was published on July 26, 1990. In part, the report declared "opportunities for savings and revenue increases," including a savings of \$31 million by closing two of Connecticut's four mental hospitals, along with vague plans to "increase the flow of federal funds" to support the community-based services needed to allow such a shift of patients out of hospital settings.

It is imperative, in my view, that we be certain we do not engage in an action which effectively balances the state budget on the backs of the chronically mentally ill, who because of their disability are unable to fight for their right to decent and humane care. It is all too clear that the past deinstitutionalization of mentally ill patients has resulted in the rise in homelessness among these persons. Hospital care may not have been very good, but at least it provided a minimal level of care. The streets offer none. Indeed, one of the members of the Thomas Commission opposed the hospital closing recommendation because of his concern that this would result in more mentally ill persons "wandering the streets."<sup>1</sup>

*Steven Kessler, a fourth-year resident in psychiatry at the University of Connecticut Health Center, has begun a volunteer program providing on-site psychiatric service at a Hartford shelter.*

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## **Deinstitutionalization**

Between 1950 and 1980, there was a decrease in state mental hospital population from about 560,000 to fewer than 140,000 persons as the result of the policy of deinstitutionalization. This policy implied the care of these patients in the community, but such care has been slow in coming and has failed in many ways. There have been many criticisms of the attempts thus far made to treat the mentally ill in the community. The Robert Wood Johnson Foundation program for chronic mental illness is among those attempting to correct these problems. They have attributed the lack of success of these community programs to "the multiple agencies required to the job, fragmentation of funding and administration among different levels of government and between public and private sectors; professional turf battles or disinterest; and lack of administrative sophistication within mental health professions," as well as the difficulties that accompany the arbitrary boundaries of catchment areas."<sup>22</sup> This fragmentation makes it difficult for services to follow clients, or for services to be coordinated in a reasonably workable way.

In his review of the economic barriers to implementation of model programs for the mentally ill, E. Fuller Torrey ascribes the difficulties to "attempts by various government components to shift the fiscal burden of those services away from themselves," finding a tendency for care to be given based on "what services are fundable and not what services are needed or appropriate."<sup>23</sup> He cites evidence supporting his contention that deinstitutionalization is an attempt by states to get patients out of programs that are not federally funded by Medicaid into programs that are. He states that "these actions have been publicly rationalized as promoting community living and a less restrictive environment for patients, but such rationalizations are but a thin veneer covering an underlying economic imperative," concluding that "until the economic aspects of deinstitutionalization are addressed, those services for the seriously mentally ill are not likely to improve significantly."

In their comprehensive review on the subject, Richard Lamb and Leona Bachrach begin their analysis by realistically defining the nature of the population as follows:

Chronic mental patients generally constitute a marginal population with wide ranging service requirements. Most have relatively low levels of psychosocial functioning even when they are receiving highly focused care in the community. When improvements do occur they are generally the result of direct and intensive interventions in specific activities of daily living and tend to be sustained only for the length of treatment. Unfortunately most services set up for the mentally ill were based on acute care models and fail to meet the needs of chronic patients.

This acute care model, although unrealistic, is based on society's desire, based on the American dictum of individualism and independence, not to see these persons as chronically dependent. By fulfilling this desire we fail to meet patients' true needs and improve the quality of their lives. One way this desire has been enacted is by the movement to limit commitment of mentally ill persons, ostensibly to help preserve patients' civil rights. Dr. Bachrach and Dr. Lamb argue that instead, these laws simply limit our ability to help those who need our assistance. Finally, they emphasize that the provision of good community services is not cheap: "Humane concern for the fates of these patients must prepare society to anticipate increased per capita treatment costs."<sup>24</sup>

These and other difficulties of community treatment were well demonstrated by the experience of "second generation deinstitutionalization" at Northampton State Hospital in Massachusetts. There, as the result of a class-action lawsuit, the court mandated an 86 percent reduction in census and the creation of a large number of community residential placements and nonresidential services. Since 1976, with large expenditures of state funds, the hospital has achieved a 49 percent census reduction and a 40 percent decrease in monthly admission rates, but at a higher per capita cost than in the rest of the state. The successes were mostly in placement of geriatric and mentally retarded patients. Younger patients, especially those with a history of repeated hospitalizations, did not seem to benefit. The authors of a review article on the program conclude that "the belief . . . that the requirements for newly admitted patients with acute psychopathology and repeat admission patients with chronic mental illness could be fulfilled by residential environments, nonresidential community services and general hospitals was simply not borne out". They point out that the "underpinnings of the . . . decree were perhaps undermined by a misperception of the nature of serious mental illness itself."<sup>5,6</sup>

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### **The Chronically Mentally Ill Become Homeless**

The psychiatric community has long argued for comprehensive services for the chronically mentally ill. In its 1978 position paper, the American Psychiatric Association attempted to address "the striking inadequacy of care, treatment and rehabilitation of this group, estimated to be one million persons."<sup>7</sup> A more recent editorial revealed little progress in the intervening decade, stating,

The chronically mentally ill are abandoned, rejected and neglected — in other words they are jailed, warehoused in snake pits, or homeless. Somehow our society is not prepared to commit adequate resources, and it lacks the inner moral authority to ensure that those who are psychologically impaired will be given more than a modicum of food and clothing. There appears to be a denial of the suffering experienced by these patients, and a tacit wish to perceive the homeless schizophrenic individual as exercising a right to be different.<sup>8</sup>

The phenomenon of the homeless mentally ill is the biggest indictment of our failure to care, our choice as a society to let these persons suffer. There are few good estimates of the number of homeless persons. A 1984 estimate ranged from 250,000 to 2.2 million. The Department of Health and Human Services estimated that 33 percent to 66 percent of the homeless in shelters are characterized principally by mental illness, and 25 percent to 35 percent are former patients of mental hospitals.<sup>9</sup>

To better characterize the population, an in-depth study of fifty-three homeless persons admitted to a residential program in Los Angeles for acute and subacute treatment was conducted.<sup>10</sup> Of these, 87 percent had diagnosable psychiatric illnesses: 66 percent schizophrenia, 9 percent schizoaffective disorder, 23 percent major affective disorders, 66 percent substance abuse. Of these, only two had case managers, and none were in outpatient treatment during the time of their homelessness, ranging from one week to nine years. Seventy-nine percent had a history of psychiatric hospitalization. The researchers found that "in every case, severe mental illness appeared to have contributed to the subjects becoming and remaining homeless . . . Present clinically were disorganization and poor problem solving abilities resulting from the illness,

severe paranoia that interfered with or prevented subjects from accepting help, and the depression that immobilized many patients.” Unable to get themselves out of their homeless situation, half of this sample were involuntarily committed to this program. Most had had some treatment, but had been considered “treatment resistant”: not taking prescribed medications, impulsively leaving supervised living settings, and becoming lost from the system. However, many of those committed to this program were later able to enter a community treatment program voluntarily. This led the authors to conclude that “this group cries out to us to set aside our preconceived ideologies, to come face to face with clinical reality, and do what is necessary to provide them with support, protection, and rehabilitation,” including such methods as outpatient commitment, conservatorship, and residential and hospital treatments.

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### **Needs of Homeless Chronically Mentally Ill Persons**

A survey targeting homeless users of psychiatric services was conducted in San Francisco to find out what they perceived their needs to be.<sup>11</sup> They described their use of emergency rooms or jail as an alternative when they could find no other place to stay. Most of those who were seen by psychiatrists and given recommendations for follow-up, did not act on them. They “tried it once and didn’t like it” or were bothered by specific aspects of treatment, such as lack of anonymity. When asked what kinds of resources they needed to get by in the community, they indicated affordable housing (86%), financial entitlements (74%), employment (40%), free-time activities and social contacts (32%), food (19%), alcohol cessation (18%), supportive counseling (14%), money management (9%), interpersonal skills (7%), and storage space (5%). The authors found a mismatch between the kinds of services offered and those desired. In addition, many respondents complained of barriers to getting resources they needed most. The authors concluded that only when the basic survival needs of these persons are met could they realistically engage in psychiatric treatment.

A number of recommendations have been made over the past decade about the kinds of services that should be provided for this population.<sup>12,13</sup> They have declared a need for a comprehensive and integrated system of care with designated responsibility, accountability, and adequate financial resources to comprise: housing, including a range of supportive living environments; treatment and rehabilitation services, offered assertively through outreach programs; crisis services; specialized case management by those knowledgeable about the system, these illnesses, homelessness, and able to coordinate care; targeted outreach services; as well as general medical care, family assistance, general social services, legal and administrative procedures such as easier conservatorship status, involuntary inpatient and outpatient commitment, confined long-term settings, training, and research. There was emphasis placed on greater coordination between providers of services, development of programs specifically for the homeless, and the extension of services to prevent the falling through the cracks of those with dual diagnoses.

As Dr. Lamb noted, with a few welcome exceptions “little has been done to implement these recommendations since they were originally published,” that generally “when anything has been done it has too often relied primarily on shelters. Although they are a necessary emergency resource, shelters address the symptom and do not get at the root of the problem; they are only temporary solutions from night to night.”<sup>14</sup>

This position has been echoed locally by the Connecticut Coalition for the Homeless, which recently adopted a Vision Statement, setting forth its goal that "we will eliminate the need for emergency shelters by the year 2000 by developing housing and support services to meet each person's needs." They add that "in Connecticut, emergency shelters have grown from three in 1983 to a network of forty-five that provide more than 1,600 beds for shelter each night." They explain how they, "as shelter providers and concerned individuals who have worked to assure that emergency shelter is available to those that need it, we are shocked and saddened by this development." They declare that "we reject and we urge everyone to reject emergency shelters as an acceptable response to homelessness . . . To do otherwise is to give tacit approval to the operative position of our society that it is enough to try to see that no one freezes to death in the winter, and families with children are not on the street."<sup>15</sup> They recognize that this is an inadequate response, but have filled in because no one else has been willing to do so. They have been left to care for our most severely disturbed mentally ill without the resources, training, or ability to do so adequately. The evidence is clear, and we are found morally wanting as a society. We can no longer deny this reality.

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### **The Homeless Mentally Ill in Hartford**

Estimates of the number of chronically mentally ill in the Hartford area range from 1,700 to 3,500, although no solid data exist.<sup>16</sup> Although this state has the highest per capita income in the nation, Hartford ranks fourth among all U.S. cities with populations greater than 100,000 in percentage of residents with poverty-level income, and among the top ten cities for child poverty rates.

The capital region has ten shelters for the homeless. In the entire state, from October 1988 to September 1989, 18,449 different people used homeless shelters. Of these 21 percent were women, 44 percent black, 37 percent Caucasian, 18 percent Hispanic. In age distribution, 19 percent were seventeen or younger, 37 percent eighteen to thirty, 42 percent thirty-one to fifty-nine, and 2 percent sixty and over. For income, 17 percent were employed, 18 percent received general assistance, 8 percent Social Security, 8 percent AFDC, 1 percent veteran's benefits, and 28 percent had no income source at all. The most common reasons cited for their homelessness were: family/friend eviction (23%), legal or other eviction (17%), new to the area (13%), substance abuse (12%), loss of income (7%), family abuse (4%), disaster victim (2%), and "other" (22%) (statistics gathered by the Connecticut Coalition for the Homeless). These figures do not reflect persons housed in hotels and temporary apartments (at that time numbering about a thousand), and may reflect a different population that would be found owing to the recession and other changes in the state. In a review of medications taken by 115 shelter users at the South Park Inn Shelter in Hartford, approximately 10 percent were taking psychiatric medications.<sup>17</sup> This is clearly an underestimate of the true prevalence of psychiatric disease among this population, but it does give a sense of the use of the psychiatric system by these patients. Prior efforts to define the psychiatric service needs of the homeless include two surveys of shelter providers in Hartford, in July and November 1988, respectively. In the first study,<sup>18</sup> shelter staff felt that a total of forty-two to forty-seven adults in their facilities (of a total population of two hundred) in a one-week period were thought to have emerging or chronic psychiatric needs. This made for an over-

all rate of 21 percent to 23 percent of clients. Of these persons, more than 50 percent were felt to have a coexisting alcohol or drug problem. Many of them were described as repeaters or regulars at the shelters, and thus account for an inordinate number of shelter bed nights. The November study asked shelter directors to estimate the psychiatrically related needs of their clients over the prior year.<sup>19</sup> The estimated need for services ranged from 5 percent to 50 percent, depending on the shelter. Such estimates, as in the prior study, are based on the ability of shelter personnel to assess psychiatric illness. The figures probably reflect only the most severely ill clients who cause disruptions of some sort. The kinds of services they felt were needed included client assessment, outpatient treatment, case management, and crisis services each for more than 50 percent of these clients. Of the men thought to need psychiatric services only 17 percent were receiving any treatment. Of the women so identified, 33.3 percent were receiving some form of treatment. The most useful services were felt to be those which were on site, rapid, and provided good communication and a sense of cooperation with shelter staff.

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### **Prior Accomplishments and Current Efforts**

The extent of homelessness in our capital city is shameful, occurring as it does under the shadow of the governor's mansion and state legislature. As the state begins another round of deinstitutionalization, it must come to grips with its prior failure to provide for the basic dignity and comfort of these persons. The Hartford area has many resources that could, in this time of transition, be used as the building blocks for a comprehensive program for treatment. These resources include public and private hospitals, community mental health centers, a university training program in psychiatry, and a highly trained professional community.

The state of Connecticut has come a long way in the last decade in improving its services for the chronically mentally ill. These include an increased proportion of Department of Mental Health budget going to community services, from 10 percent to 32 percent between 1981 and 1988; community-based residential positions up from 274 to 1,013; case management clients up from 100 to 3,000; 7,000 clients served in crisis intervention; 2,600 clients in Fountain House model programs; and 415 in work services programs.<sup>20</sup> However, in its 1989 report, the North Central Regional Mental Health Board cited several remaining difficulties in the Hartford area, including hospital emergency rooms turning would-be patients onto the streets for lack of beds, the inability of state hospitals to discharge patients because of inadequate housing or community services to support them, a case management system serving only 10 to 20 percent of the need, and the lack of a single coordinating agency with resources and authority to implement a managed mental health system.<sup>21</sup>

The state's current actions on homelessness date back to 1982, when the Governor's Blue Ribbon Task Force on Mental Health Policy cited the large need for housing assistance for the chronically mentally ill. An interagency Task Force on Homelessness was established in 1984 involving the Department of Mental Health (DMH). In response, DMH began in the past couple of years to provide funds to fund shelter outreach services from five community mental health centers around the state, including one in Hartford, to provide assessment, referral, linkage to treatment, and support services. In 1990, 207 shelter guests were seen in this program, on which \$207,619 was spent. An equivalent amount was spent on case management

services, and about \$60,000 on drop-in centers, which were to provide some rehabilitation programs. Other funds were used to provide training to those from mental health agencies who work with homeless and mentally ill persons.<sup>22</sup>

In the assessment made by the North Central Regional Health Board in 1987, it was felt that some effort had been made to expand services in Hartford, but that “no overall plan exists,” and that the steps taken lack “an overall strategy and [are] without specific numerical targets.”<sup>23</sup> They go on to note that “no formal effort is under way by the City of Hartford to seek action on behalf of the homeless mentally ill from either the state, the towns, or the private sector.” Their position paper outlined a number of recommendations for each of the involved sectors, including: the city: to pursue a legislative program giving the highest priority to the needs of the homeless, to develop a registry of homeless persons to enable tracking, seek appropriate residencies and residential services; regionally: pursuit of a regional approach to the housing crisis involving all surrounding thirty-eight towns; DMH: to pursue accurate and current statistics on the population, to monitor its own discharge policy, to work with other city agencies to review how fully the homeless mentally ill are able to take advantage of their entitlements, and to explore the ongoing need for institutional care for that percentage of the population that will continue to require it; private sector: use of private agencies to provide supervised housing and support housing efforts. Such an overall and comprehensive approach has not been implemented since these recommendations were made. The suggestions, if enacted, would form a solid and systematic basis to enable effective interventions to be made. Such interventions can and should be based on models that have proved to be effective elsewhere as the basis for action here.

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### **Model Programs for the Homeless Mentally Ill**

To get a sense of what can be done to meet the special treatment needs of this population, one can look at some particular types of programs that seem to work. I review three types of programs: one that aggressively commits patients, two that use professional volunteer services, and the last being a comprehensive three-phase model.

1. *Getting New York's homeless mentally ill off the streets: Project Help.* This program, begun in 1987, resulted from a program instituted by New York's mayor requiring “the removal from the streets to a public mental hospital those homeless mentally ill persons who were clearly neglecting their essential needs for food, clothing, shelter, and medical care, and who by reason of their mental illness are at risk of physical harm.” It utilizes a mobile unit staffed by psychiatrists, nurses, and social workers empowered to order the police to transport these patients to the Bellevue Hospital emergency room for a second evaluation and determination of a psychiatric disposition. The team is notified of most potential patients by a “help line” set up for people to call in referrals. A specialized eighteen-bed, short-term inpatient unit at Bellevue is used for patient evaluation and stabilization, and the system has access to a longer-term state facility, a thirty-bed rehabilitation transitional living facility, and other community residences and support services (case management, computerized tracking system, interagency cooperation). Of 298 individuals evaluated since the program's inception, 84 percent were brought in involuntarily, and half were later transferred to a state facility for extended care. Diagnostically, 80 percent were schizophrenic and 30 percent had a secondary substance-abuse problem. At the end of two years, of the 298 persons, 83



were living in community settings, 80 were in hospital settings, 100 were back on the streets or lost to follow-up, and 2 were known to be dead.<sup>24</sup> The authors reviewing the program conclude that it “illustrates how mental health professionals can work with policy makers to develop programs that are responsive to this often neglected, multiply disabled population.” Although the outcomes were less than ideal, more persons received care than otherwise would have. One would expect far better results in a smaller city like Hartford, should such a program be implemented here.

2. *Volunteer, pro bono programs.* Critics have charged that a good part of the blame for the deterioration in care for the chronically mentally ill lies with professionals who have abandoned them for more lucrative opportunities. Actually, the American Psychiatric Association (APA) has recommended to its membership since 1988 that they donate 5 percent of their time to pro bono work with underserved populations. The following two programs illustrate the success of such efforts.

*The Project for Psychiatric Outreach to the Homeless, Inc.* This project began in 1986 as the work of a task force of the American Psychiatric Association New York County Branch. It places about thirty private-practice psychiatrists who volunteer one to four hours a week into one of four community agencies in Manhattan that assist homeless mentally ill persons (shelters, outreach programs, hotels and residences, and a drop-in center). These psychiatrists provide diagnostic assessments, treatment planning, medication prescriptions, individual and group psychotherapy, and follow-up services. The project also provides in-service training to social service teams at the agencies. Since its inception, the project psychiatrists have treated over fourteen hundred homeless clients (more than four hundred in 1990 alone), with a total donation of over \$800,000 in in-kind services to the program. The project was awarded the 1991 Hospital and Community Psychiatry Achievement Award. The program’s director, Dr. Katherine Falk, has stated, “Our work has demonstrated that volunteer psychiatrists can make a significant difference in the lives of mentally ill homeless persons,” although warning that it is unrealistic to expect that volunteers alone can meet the increasing need for psychiatric services.<sup>25</sup>

*Colorado Pro Bono Mental Health Project.* This program, begun in 1986, organizes and coordinates the placement of more than thirty psychiatrists, psychologists, social workers, and psychiatric nurses in the Denver area at any of five sites that serve the homeless, for an average of six hours per month. A nonprofit, independent citizen action group organizes this interdisciplinary effort. The program volunteers have seen more than a thousand homeless individuals per year. Later, a separate pro bono program specifically for high-risk children was developed. This has been a very successful program, a winner of an APA Significant Achievement Award despite its low budget. It has given a rare opportunity for various professionals to work together and be seen as contributing to the care of the most needy.<sup>26</sup>

3. *A Phased Intervention Approach. The Los Angeles Skid Row Project.* This program, also a winner of APA awards, approaches care at three clinically relevant points: Phase 1: addresses emergency first aid, using a “battalion aid station” model, to attempt to form the first link in a bridge out of homelessness. It includes outreach, drop-in centers to provide temporary safe haven and a focal point for intervention, early identification, liaison with the police, training for shelter personnel, establishment of self-help groups, and the “patching in” of mental health programs into existing structures.

Phase 2 attempts the goal of stabilization, utilizing a “stabilization center” — a five- to seven-day treatment center where patients are cleaned up, rested, given medical

care, psychiatric observation, and evaluation. There they also begin to be linked with appropriate aftercare services, including Social Security benefits, vocational rehabilitation, and counseling; families are contacted and helped to reintegrate the patient. Phase 3 attempts to help patients establish and work through long range solutions, focusing on appropriate housing, benefits, psychiatric care, and case management.<sup>27</sup>

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## Recommendations

Our challenge, as described by Dr. Lamb is to "take action without waiting for the ideal to happen."<sup>28</sup> Reviewing the cited programs, we in Hartford can begin to take action. The recommendations should build on those made by the North Central Regional Mental Health Board in its 1987 report, previously cited. The following types of programs should be considered.

1. Integration of current providers of service to the homeless under an umbrella organization so that case coordination and integration of services can be accomplished.
2. Coordination of this organization with the Department of Mental Health and the University of Connecticut to pursue accurate epidemiologic and diagnostic data about this population to better target and assess interventions.
3. A coordinated volunteer professional service, preferably an interdisciplinary one, perhaps under the auspices of the United Way or another independent party, to provide on-site services. An effort should be made to involve as many professional groups as possible, to provide services (psychiatric, social services, and so on), and other representative services (such as legal services to help homeless persons fight for rights and entitlements).
4. Targeted outreach programs based on the Project Help model, with mobile teams that can evaluate and bring persons into an emergency setting. Other outreach programs should be established to include drop-in centers, self-help groups, and the like.
5. Creation of an inpatient program designed for the observation, evaluation, and stabilization of homeless patients as in Phase 2 of the Los Angeles program. This program may be able to take advantage of underutilized existing private hospital space. The benefits of such a program have been documented,<sup>29</sup> and the need, as I have learned through my experience, is very clear.
6. Creation and augmentation of outpatient services, especially case management services, so that all chronically mentally ill persons are on the caseload of a mental health agency that will follow them, have sufficient staff to work intensively with them, take full responsibility for individualized treatment planning, link patients to needed services, and monitor them. We should be working toward easing barriers to financial entitlements, easing commitment laws, including outpatient commitment and conservatorship, and providing a payee to patients to help hold and manage their money.
7. A real effort by the city, state, and private sector to ensure adequate housing, because without housing and other basic necessities it is impossible to treat the mental and other illnesses from which these persons suffer. A variety of housing alternatives must be developed, with a range of greater to lesser supervision, or the ability to move from supervised living to independence. Both the client's psychiatric needs, and his or her own preferences need to be taken into account in designing and implementing these options.

Again, as Dr. Lamb reminds us, "What needs to be done is abundantly clear. We need to be bold and strong of will. We must be prepared to mount a large-scale

operation that will give relief to all of the homeless mentally ill. The fate of these persons with such great needs and at such great risk cannot be left in the hands of the faint-hearted."<sup>30</sup>

In the past, the care of the chronically mentally ill has suffered from naiveté, excessive optimism, and unrealistic expectations about the clinical course of these diseases. The result has been an epidemic of homelessness within this population. Let us rise to the challenge here in Hartford. Before we embark on another round of deinstitutionalization, let us take care to close the gaps in the system that allow homelessness to occur and do justice to those who rely on us to see that they do not have to go hungry and homeless because they are mentally ill. ❧

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## Notes

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