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Historically, people with chronic mental illnesses have been particularly at risk for homelessness. In 1984, the Connecticut Department of Mental Health (DMH) articulated policy to insure housing for mentally ill persons. One facet of that policy is to increase mental health services to homeless people. The Greater Bridgeport Community Mental Health Center has addressed this need through the formation of the Homeless Outreach Team (HOT). This article describes the development, organization, clinical work, and future of HOT. The team is run jointly by the Mental Health Center (funded through DMH) and Family Service–Woodfield, a United Way–funded agency that provides case management services. Members of the team identify homeless mentally ill persons at local soup kitchens, homeless shelters, and through a network of community contacts. HOT functions by taking clinical services into the community, offering supportive interventions as accepted by its clients. Its success is reflected in numbers of persons housed, psychiatrically stabilized, and participating in rehabilitative services either at the Mental Health Center or through other providers in the community. Several clinical vignettes illustrate HOT's work.

Homelessness is a serious social problem, particularly acute for people with mental illness. Many have insufficient resources to meet the high cost of decent housing. In addition, people with mental illness face considerable prejudice from landlords and neighbors in finding a place to live. Some individuals with serious mental illness lose their housing when they are admitted to a hospital.

The situation was exacerbated during the 1980s, when the federal government abandoned its commitment to the development of affordable housing. At the same time, the purchasing power of persons with serious mental illness, who rely on federal entitlements or state welfare for income, was diminished. Responding to these

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trends, in the early 1980s the state of Connecticut initiated activities that led to the development of services for those at risk of homelessness.

In 1982, the Governor's Blue Ribbon Task Force on Mental Health Policy in Connecticut estimated 70 percent of all discharges from state hospitals would be in need of some form of housing assistance.[1] The dramatic expansion of community mental health services since 1982 by the Department of Mental Health (DMH) has incorporated the recognition that the single most pressing need of individuals who experience prolonged and severe mental illness is housing of acceptable quality. Through the services the department now offers in the community, particularly residential services, a high number of individuals are served who in the absence of such services would probably be homeless.

In 1984, a Governor's Task Force on Homelessness was established in which the DMH has been an active participant. In a 1985 report, this task force concluded that the increased number of homeless persons in Connecticut was due primarily to a lack of low-cost housing and the reduction in federal housing assistance. Responding to stereotypes about homelessness and mental illness, the task force report pointed out that while not all homeless people are chronically mentally ill, a significant proportion do experience some form of psychiatric disability.[2]

The task force quoted an American Psychiatric Association report on homeless persons with mental illness.[3] It concluded that homelessness among the mentally ill was not the result of deinstitutionalization per se, but rather of the way deinstitutionalization was implemented: specifically, inadequate services had been provided in the community for people discharged from the hospitals. The report further stated that although caring for severely mentally ill persons in community programs is clinically sound and economically feasible, a vast expansion of community housing and services was needed. Also cited was the need to revamp the mental health delivery system to meet the needs of people with severe mental illness.

Among the observations made was that outreach work is a key factor in providing services and integrating homeless persons into the mental health system. The task force recommended that development of a comprehensive system of care for psychiatrically disabled homeless persons should include outreach advocate workers in each mental health region who would provide both initial service contact at the shelter and referral and limited follow-up services.

DMH's response to the needs identified was twofold. First, residential services were developed as a major priority of extensive community support and psychiatric service system development. Second, and concurrently, there was growing recognition in the mental health field that the housing needs of most individuals with long-term mental illness can be met by accessing the same type of community housing alternatives as are available to the general public. Typically, however, people with severe mental illness have fewer resources and face greater barriers. DMH has therefore increasingly emphasized individualized support services to enable people with mental illness to utilize available housing resources.

The department has also incorporated into its discharge policy the requirement that each patient treated in a state mental health facility have a discharge plan that includes appropriate housing arrangements. Emergency shelters are not considered appropriate housing, and patients are not to be directly discharged by the state hospital to an emergency shelter.

At the same time as efforts have been made to prevent homelessness among people with mental illness by developing residential and other community services, DMH has also focused on establishing and accessing mental health services for people who are homeless and in need of mental health care. First, in 1986, DMH began to utilize a portion of its federal Alcohol, Drug Abuse, and Mental Health Services Block Grant funds to develop a network of new mental health outreach services, targeted to residents of homeless emergency shelters in Connecticut. The thrust of this initiative has been to respond to the immediate needs of emergency shelter residents for mental health services. Integration of residents into the established network of community mental health services is also a major goal where possible. Second, since 1986, state grants have been appropriated each year for case management services to people who are homeless and in need of public mental health services. The core of this program is ready access to mental health and other appropriate support services. Finally, since fiscal year 1987, the Connecticut DMH has been awarded a grant from the Mental Health Services for the Homeless (McKinney) Block Grant.[4] It allows DMH to participate in the federal program for states to establish, maintain, and evaluate projects for the development and expansion of mental health services to persons who are homeless or at risk of becoming homeless. These services include outreach, as well as community mental health services such as crisis intervention, case management, and supportive residential services.

When McKinney Block Grant funding became available in late 1987, a grant to the southwest region of the state was used to reconfigure services for homeless people with mental illness into one unit, with a focus on mobile outreach services.

In January 1988, the Greater Bridgeport Community Mental Health Center (GBCMHC), a facility of the Connecticut State Department of Mental Health, started a Homeless Outreach Team (HOT). This article focuses on HOT's clinical services, outlining development, staffing, target population, diagnostic issues, and networking. The final section outlines directions for the team in the future.

GBCMHC provides services to the Greater Bridgeport area, which consists of the city of Bridgeport and five surrounding towns. The population of the catchment area is 300,000, while the population of Bridgeport proper is 150,000. Bridgeport has been ravaged by the decline of the industrial Northeast and is one of the state's poorest cities, largely minority, with widespread drug abuse, alarming levels of violence, and shortages of resources typical for inner cities of the Northeast. Bridgeport is in Fairfield County, one of the wealthiest counties in the country.

Homelessness in the GBCMHC Catchment Area

The United Way of Eastern Fairfield County has compiled statistics on homelessness, which indicate that 1,835 individuals stayed in shelters in Bridgeport during the fiscal year 1989. Of these, 872 were adults and their children, 710 single men and women. Fifteen percent who stayed at adult single shelters had become homeless through loss of income, but 19 percent were either fully or part-time employed when they entered the shelter. Sixty-six percent were receiving General Assistance (welfare) when they came to the shelters, 11 percent were receiving Social Security income (SSI, SSD, or retirement payments), and only 5 percent had no source of income. As noted on the fact sheet, these data do not include statistics on persons who lived in the street, in abandoned buildings or cars, or were at imminent risk of loss of their housing.[5]

Structure of the Homeless Outreach Team

HOT offers assertive outreach to clients with severe and prolonged mental illness who are homeless or at risk of becoming homeless. It is a multidisciplinary team that consists of a psychiatrist, a psychologist, a nurse clinician, two social workers, a mental health worker, and three case managers. It is a collaborative effort between a private-sector agency, Family Services–Woodfield (FS-W), and a public-sector agency, GBCMHC. Positions sponsored by Family Services–Woodfield are funded through a federal Stewart McKinney Fund Grant. Positions from the Mental Health Center are funded by state DMH moneys, through matching salary-to-grant dollars.

HOT Intervention and Treatment Programs

GBCMHC and FS-W share responsibility for the HOT caseload. FS-W provides case management services, including case identification, locating housing, obtaining entitlements, budgeting, training in activities of daily living, and transportation. GBCMHC provides clinical services: assessment, diagnosis, counseling, and medications.

Those clients identified by the team who readily accept psychiatric interventions are treated through the usual procedure at GBCMHC — that is, requesting services through the crisis team and evaluation by the Intake program. They are referred either to GBCMHC's Outpatient Services Division (OSD) or to appropriate community agencies. However, other clients seen by HOT are considered to have a major mental illness, but refuse psychiatric services. Such individuals are followed in the community by the GBCMHC HOT clinicians. For these clients, an attempt is made to establish a trusting relationship and provide supportive counseling; case management services, when desired, are provided through FS-W. It is our hope that eventually, as an outcome of our relationship building, some of these clients will accept medications as indicated.

HOT clinicians, to the extent possible, also gather psychosocial data on clients, for several purposes. First, it gives some basis for making a diagnostic evaluation and thus developing a formulation of treatment needs. In addition, it helps sensitize us to the salient interpersonal issues for our clients, especially important because histories of loss are so pervasive among this population: besides losing their homes, many have lost contact with families of origin, spouses, and children. Wherever possible, HOT works to reestablish these supportive networks.

Clinical Services

All clinical services are provided for the HOT clientele by GBCMHC. These include: case identification, psychiatric assessment, triage, medication monitoring, crisis intervention, ongoing medical assessment, and linkage to outpatient, inpatient, and respite services.

There is a significant amount of overlap in the services provided by GBCMHC and FS-W, and this seems to have been useful to the coordinated functioning of the team. Since its creation, GBCMHC clinicians and FS-W case managers have worked side by side in the community. Aware of each other's areas of expertise, they have come to depend and rely on each other, and the team's strength and effectiveness have evolved as its cohesiveness has emerged.

The Need for Role Flexibility

Membership in HOT thus requires significant role flexibility. Clinicians need to be able to function independently, making quick decisions in times of crisis. They must also be patient and adaptable. Assessments can be tedious and difficult with this client population, which is often ambivalent about accepting services. Developing clients' trust can take months. Our effectiveness has emerged through our willingness to do whatever is necessary to engage clients. This has meant diapering babies, finding homes for pets, and establishing bartering relationships with church groups and shelters to obtain needed furniture and clothing for clients. HOT staff are people with high energy and a commitment to the target population.

Interestingly, we have not found it necessary to have a team from the local area, from similar ethnic and cultural backgrounds as the clients, or who have a wealth of experience on the streets. A staff that is sincerely committed to the work communicates this. Clients, in turn, teach staff things they need to know about survival on the streets. However, case managers do need intimate knowledge of entitlement systems in the area and how to negotiate them, as well as patience and flexibility.

While it has always been our goal to have a psychiatrist regularly join the team for rounds in the community, staffing shortages have made this impossible. The team has had to share psychiatrist time with other programs, largely limiting the psychiatrists' participation to consultation by phone from the community, unless clients have been willing to come to the center.

Establishing a Community Presence

We have established ourselves in the community, with both homeless persons and providers through our predictability, constancy, and availability. We make regularly scheduled rounds at the soup kitchens, church suppers, and shelters — both during the day and in the evening. We also make rounds in the downtown area, checking doorways, parks, dumpsters, alleys, and the bus depot. We accept referrals from anywhere. We can mobilize quickly and go wherever we need to in order to serve our target population. We have seen clients in parking lots, condemned buildings, and vacant lots. Rarely do our clients come to the Mental Health Center. We go to them.

Networking

Survival and development of a homeless outreach program relies on community networking, which consists of at least three activities: providing referrals, sharing resources, and pooling knowledge. There is a reciprocal relationship between our referral sources and our resources. Many of our referrals come from other providers, including soup kitchens and shelter staff, local police, jails, the businessmen's council, entitlement programs, and legal aid services. These sources also supply us with a network of resources to assist us in assisting our clients.

Since its inception, the HOT codirectors have sat on the Regional Council for the Homeless, a coalition sponsored by the local United Way. The regional council includes representatives from such diverse groups as the various individual and family shelters, the Department of Income Maintenance, local state representatives, representatives of other local governments, and Legal Services. In addition, HOT collaborates with other health care providers in the Health Care for the Homeless Coalition, which the HOT codirectors currently chair. We have also established relationships with the

Downtown Bridgeport Businessmen's Council, which has provided the team with office space, walkie-talkies, and referrals.

Finally, a critical part of our network is the people of the streets, who are an unending source of information. Street people alert us to others they are concerned about and provide information concerning their behavior and mental status. In addition, familiarity with people on the street enhances the team's safety. Through regular contacts, the street people come to know and respect our work. They are alert to dangers, and some seem to assume a protective posture toward team members and clients. These people are better equipped than we are to teach HOT clients survival skills for the streets. Street people teach one another where to sleep, what public rest rooms are safe to use, and where to get free food and health care.

The Population Served by the HOT

It is important to point out that persons are accepted as clients of the HOT team only if they have refused more conventional psychiatric referral. As mentioned above, a mentally ill person identified at a shelter or soup kitchen who is agreeable to receiving service is directed by HOT to appropriate service providers. They are not followed by HOT if they are willing to pursue services themselves. Thus HOT clients are self-selected by their unwillingness to enter the mental health system by more conventional routes — which might involve walking into the center and requesting that they be seen.

Second, HOT patients may in fact be psychotic, but again by definition they must be functioning sufficiently that on first contact they do not qualify for involuntary hospitalization. When homeless persons are gravely disabled they are hospitalized through some combination of the HOT team and GBCMHC's Mobile Crisis Team, both of which are part of the Community Services Division (CSD) of the Center.

HOT clients typically are minimally compensated: they may be chronically delusional, hypomanic, have significantly impaired hygiene, socially isolative, or experiencing hallucinations, but nonetheless they are minimally functional. They have survived on the street or found minimal shelter. Some HOT clients are marginally employed. None, on first contact, have been found to be receiving psychotropic medications.

Table 1 gives a demographic description of the 61 patients followed by the HOT team since January 1989. (Note: patients are not registered as active with GBCMHC-HOT until after three contacts, when it seems likely that ongoing clinical contact will be maintained. For this reason, our number of active cases has been significantly lower than our actual number of community contacts.)

Two factors surprised us as we reviewed these data. The first is the high proportion of white to African-American clients followed for clinical services by HOT. The majority of homeless persons in Bridgeport appear to be African-American and Hispanic-American. Poverty alone may be a frequent cause of homelessness among the minority population in Bridgeport. In contrast, the white population of this area is largely upper middle class, and includes many extremely wealthy families. The white homeless population may disproportionately include persons whose homelessness is due to poverty, which is a consequence of their chronic mental illness. Nonwhites, in contrast, are disproportionately represented among the homeless due to other socioeconomic factors.

Table 1

Demographics of the Population Served by the GBCMHC Homeless Outreach Team, January 1989–December 1991 (N = 61)

	Category	Number	Percent
Sex			
Male	36	59	
Female	25	41	
Ethnicity			
White	41	67.2	
African-American	16	26.2	
Other	4	6.5	
Age			
20–29	6	9.8	
30–39	23	37.7	
40–49	13	21.3	
50–59	7	11.4	
60–69	6	9.8	
70–79	6	9.8	

Sex x Ethnicity		Percent Sex	Percent Ethnicity	Percent N
Male				
White	24	66.6	58.5	39.3
African-American	10	27.7	62.5	16.3
Other	2	5.5	50.0	3.2
Female				
White	17	68.0	41.5	27.8
African-American	6	24.0	37.5	9.8
Other	2	8.0	50.0	3.2

We were also surprised at the age range of our clients, especially the number of older persons. Perhaps this speaks to the obstacles encountered by older, chronically mentally ill persons to obtaining housing entitlements. It may also speak to their becoming "invisible" to service providers. Finally, many of our older female clients face poverty common to their age/sex cohort, as the survivors of a working spouse who lose pension supports with the spouse's death, or as women who have no income following divorce.

Table 2 describes the range of diagnoses of the HOT patient population. We note that as the team is mandated to follow only those clients whose primary diagnoses represent major mental illnesses, persons whose primary diagnoses were found to be mental retardation or substance abuse were referred to other facilities for treatment.

The extent of substance abuse among our client population (totaling 29%) is expected. Indeed, the team is frequently asked to assess persons who appear to be transiently psychotic as the result of substance abuse. We take pains not to include these persons in our ongoing caseload, as their treatment needs can be quite different from those of our target population. The six clients with primary diagnoses of substance abuse who were followed transiently by HOT were referred to other treaters once their primary substance-abuse diagnosis was made.

The most significant source of referrals to HOT has been the Thomas Merton House soup kitchen. It attracts much of the same population as are seen at the shelters, and in addition serves persons who are either entirely homeless, or living in

marginal circumstances and at risk of becoming homeless. The team has established a most important relationship with the soup kitchen staff, who are extremely helpful in identifying persons who may be in need of our services. In turn, the team collects canned goods and clothing, which it offers to the soup kitchen staff to distribute to all clients, regardless of their mental status.

Other clients at the soup kitchen are also sources of referral and information concerning persons the team is already following. It is our practice to hang around in public spaces at the soup kitchen, to assist in serving when needed, to chat casually with people as they eat. In this way we have become familiar to people who depend on the soup kitchen for their nutritional needs. They see us as offering a useful service either to themselves or others.

Table 2

Distribution of Diagnoses of HOT Clients Treated at GBCMHC

Primary Diagnosis	Secondary Diagnosis			
	N	%	N	%
DSM IIIR Axis I				
Schizophrenia (chronic, undifferentiated)	13	21.3		
Schizophrenia (paranoid)	12	19.6		
Bipolar (manic)	8	13.1		
Psychotic disorder (not otherwise specified)	7	11.4		
Posttraumatic stress disorder	5	8.1		
Major depression	4	6.5		
Schizoid/schizotypal personality disorder	4	6.5		
Delusional disorder (paranoid type)	3	4.9		
Organic personality disorder	2	3.2		
Polysubstance dependence	5	8.1	5	8.1
Alcohol dependence	1	1.6	7	11.4
Mental retardation	1	1.6	2	3.2
Pathological gambling	1	1.6		
Dementia			2	3.2

Note: Total diagnoses are greater than 61 because some clients received more than one primary diagnosis.

The soup kitchen also provides space to a medical clinic sponsored by one of the local voluntary hospitals. The medical and mental health providers share information and referrals of clients and have collaboratively assessed several people who have both medical and psychiatric concerns.

Our second most frequent source of referrals is the adult homeless shelters. It is the job of one of the FS-W case managers to identify homeless mentally ill persons at the adult shelters. (Many of the persons identified at Merton House are also seen at the adult shelters.) We have also established working relationships and referral protocols to provide smooth access between the shelters and HOT.

Table 3 indicates the sources that have identified clients to the team.

In spite of our identity as a homeless outreach team, we were struck that so many of our clients were indeed living literally on the street at the time of our first contact. Referral to a shelter was immediately made for those who would accept it; however, as will be illustrated by the case vignettes that follow, not all our clients readily accept offers of housing.

Table 3

Source of Referrals (N = 61)

Source	Number	Percent
Soup kitchen	26	42.6
Shelters (single adult)	17	27.8
Other treaters	7	11.4
Street	6	9.8
Church suppers	2	3.2
Adult protective services	2	3.2
City Hall	1	1.6

Although we have a continuing relationship with the local family shelters, it is notable that none of our caseload has come from them. All but one of our referrals from the family shelters were women with children, many of whom were fleeing an abusive situation (domestic violence and/or sexual abuse), and had symptoms of posttraumatic stress disorder, depression, or both. Those who functioned well enough not to need immediate hospitalization accepted direct referral for evaluation for outpatient services at the Mental Health Center.

In the spring of 1990, we began to offer weekly support groups at each of the emergency family shelters in Bridgeport. As most of the clients in the shelters are women and their children, we made parenting skills and support our initial focus. However, the needs expressed by the clients have had a much wider range, including questions concerning legal and housing assistance and broader issues of problematic relationships and abuse. The group has also functioned for crisis intervention and prevention.

Table 4 indicates our clients' status at the time of their referral to HOT.

Table 4

Housing Status at the Time of Referral to HOT (N = 60)

Status	Number	Percent
Street	21	35.0
Individual shelter	20	33.3
Housed but at risk	11	18.3
Transient hotel	7	11.6
Hospital*	1	1.6

*This client refused all housing referrals at discharge.

Clinical Vignettes

Three vignettes describe the processes of engagement and the results of HOT's interventions with several of our clients.

E.W., a white female, was referred to the team by Thomas Merton House. At the time of the referral little was known about her. She appeared to be in her mid-sixties, was paranoid, thought disordered, hostile, threatening, and verbally abusive. E.W. was rarely seen without her brother, who was protective and apologetic for her behavior. The two of them lived on the street, spending nights in doorways of a downtown shopping arcade.

We remained in touch with E.W. and her brother over a period of approximately three months. During this period, visits varied in length depending on E.W.'s ability to tolerate them. Slowly both she and her brother began to accept us. To our knowledge, neither of these two elderly homeless people was ever married, and both were childless. They became protective of members of the team, as if we were their children. Eventually it became apparent that E.W.'s brother, J.W., was mentally ill as well. He began sharing with us paranoid delusions, which he was adept at concealing owing to the reclusive habits he and his sister had developed. About six months into our relationship with this unusual couple, and about the time they began to consider allowing us to pursue housing for them, J.W. disappeared. The grapevine on the streets told us he had become romantically involved with a woman and gone to New York.

We became concerned about E.W. and her ability to survive, since she had always been cared for by her brother. E.W. now dropped out of sight, and was rarely seen at the soup kitchen. When we did accidentally encounter her, she had become paranoid and verbally abusive again, delusional that a female member of the team was having an affair with her brother and had caused his disappearance. We continued to monitor her mental status in the community. A high-functioning, resourceful street woman (who was also mentally ill) taught E.W. how to survive on the street. She showed her where to sleep safely, where to get free meals without harassment, and what bathroom facilities she could use. E.W.'s condition deteriorated, however, and eventually she was hospitalized involuntarily.

Once hospitalized, E.W. accepted and responded to psychotropic medications. During her hospitalization, HOT referred E.W. to an aggressive case management program at the Mental Health Center. This program was able to arrange for a coordinated program of supervised housing, daily medication monitoring, socialization, and strong supports for psychiatric rehabilitation. E.W. has become an active participant in the newsletter printed by the outpatient psychiatric rehabilitation program at GBCMHC. Poems she writes have appeared in several monthly issues. E.W. has been psychiatrically stable for the past thirty-six months. An active client in treatment with an intensive case management program, she is housed in a family-care home, where she has been for most of this period.

C.B. is a thirty-seven-year-old divorced white male. He was referred to the team in February 1989, also by the staff of Thomas Merton House Soup Kitchen. At the time, C.B. was living in an abandoned car outside his parents' home. His family had refused him entry into the house because of past episodes of violence directed at his mother. During our initial evaluation of C.B., he was dirty, disheveled, smelling of urine, thought disordered, exhibiting loosened associations, ruminations, and tangentiality. It was quite difficult for him to follow a conversation, or for us to make much sense of his. C.B. was unwilling to accept any services from us. However, from time to time he would approach us "to talk" at the soup kitchen, where he was a regular. During these contacts he indicated that he also had a significant alcohol problem.

A few months after we established regular contact with C.B., he was arrested on charges of criminal trespass. Following failure to appear at a court date, he was incarcerated. The team visited him regularly in jail, and during this period C.B. became more open to case management services. We arranged housing for him in a single-room-occupancy house and have continued to see him there frequently. At

this writing, C.B. has been psychiatrically stable for over twenty months, without medications, although old records to which he more recently permitted us access indicate a past history of "revolving door" hospitalizations. While he refuses medications, C.B. has accepted assistance with obtaining entitlements and budgeting, and he uses team members as informal counselors. He has also reestablished contact with his family.

S.R. is a thirty-four-year-old, single woman of mixed ethnic background (African-American, Native American, and white). She was referred to the team by a suburban homeless shelter for men. That shelter had tried to offer services to her, as she had been living in the woods in winter and was grossly psychotic. She expressed paranoid delusions, was extremely avoidant of close contact, and exhibited various compulsive behaviors. S.R. seemed so severely mistrustful that the team decided to approach her with extreme gentleness, but consistent regularity. Three team members individually visited her three days a week, titrating the length of the visit to S.R.'s tolerance. Initially some visits lasted only a few seconds. Over the course of several months, S.R. gradually accepted longer contacts. She continued to be extraordinarily guarded, permitting staff to talk with her from across the room. The thought content she expressed was extremely disturbed, focusing on issues of sexual and child abuse. Although these were described in the third person, we assumed that S.R. was describing in some measure her own experiences of abuse. There were also some reports that S.R. was abusing cocaine.

S.R.'s mental state deteriorated. She was increasingly threatening to others, which culminated in an assault. This resulted in an arrest, and S.R. was sent to the State's only women's prison, some fifty miles from our catchment area. The team visited her at the jail and contacted the jail clinic to request that S.R. be psychiatrically evaluated for treatment purposes and to assess her competency to stand trial. This evaluation resulted in S.R.'s hospitalization for three months. She was medicated, and her cognitive processes significantly cleared. S.R. was discharged to a group home, where she continues to live. She attends the GBCMHC-MICA program (mentally ill/chemical abuse) and has successfully completed three semesters at a local community college.

Outcomes

Complex as their problems are, the disposition of HOT clients is also a complex matrix. As of December 1991, we have lost contact with ten of our sixty-one once-registered clients. We have placed two in nursing homes: both are elderly women who required psychiatric hospitalization but were found to have significant medical problems as well. Seven clients live in single-room-occupancy housing; two continue to live in transient hotels. Six live in supervised housing for the chronically mentally ill. Eight are followed in outpatient programs at the Mental Health Center. Two clients were able to identify resources for private treatment and live privately as well. We are aware of three who remain on the street, two who are in jail, and two who are living with their families. Two were referred for alcohol treatment services and two moved out of state. One client has returned to services in the Veterans Administration system. One client was referred to the Department of Mental Retardation for housing and other services. One is deceased.

Directions for the Future

HOT's future directions, as with all other publicly funded programs, will be limited by the resource limitations imposed on the public sector. Our goals focus, nonetheless, on the expansion of both the nature and extent of our services. HOT has seen a need for a variety of groups that could be offered both in the shelters and the soup kitchens. These groups would be largely psychoeducational, using a model in which gaining information and skills at efficacy will enhance the independence and empowerment of the groups' participants. A parenting education group ran for several months at the family shelter, with some success. Its primary goal was to share information about how to access resources. A client empowerment group, which focused on assisting clients to gain skills to become more effective in meeting their basic needs, ran at the soup kitchen.

HOT plans to collaborate with the Mobile Crisis Unit, particularly expanding HOT availability to include some weekend hours. This will enable HOT clinicians to see clients at the homeless shelters during weekends, when the shelters frequently contact the crisis team about concerns that are actually of a noncrisis nature and should be addressed to HOT.

The addition of a psychiatrist to the team in September 1990 reinvigorated the plan to bring the psychiatrist into the community. Currently, the psychiatrist makes regularly scheduled rounds, seeing clients who may refuse to come to the mental health center, but are willing to be seen and accept medications in the community.

In September 1991, the team was awarded additional money through a grant from the Stewart McKinney Foundation, which has allowed us to create two new positions. One is for a person to teach activities of daily living skills. This person will work primarily in the soup kitchen, providing specialized focus on areas such as hygiene, budgeting, shopping, and stress management. The second position is for an additional nurse clinician with expertise in treating the dually diagnosed (persons with major mental illnesses and substance-abuse problems), an especially frequent problem encountered among the homeless.

The Homeless Outreach Team has functioned since January 1988. Initially it was staffed by persons "on loan" from other programs; the first permanent staff were hired in December 1988. Initially the team was directed by the director of the Intake Program, whose role has evolved increasingly into clinical consultation. The nurse clinician who spearheaded direct services in the community has progressively taken over administrative responsibilities, and became program director in January 1991.

Our experience has been that this close overlap of service provision and administration/policymaking has been vital to maintain the responsiveness of HOT. We have found it advantageous to have the administrative director intimately familiar with the community service providers, shelter staffs, and clients. This maximizes the team's ability to respond to the evolving needs of the clients and the evolving services provided in the community.

In sum, we cite the following factors as critical in the success of the Homeless Outreach Team: intimate involvement with community providers, flexibility in treatment approaches, and innovative treatment planning.

Finally, of course, we simply hope to hold our own in the face of recession, budget deficits, and cutbacks. We expect to see an increased demand for shelter beds as

the result of the poor economic forecast and the predictable losses of jobs, medical coverage, and housing that the poorest of the populations are likely to suffer. The Mental Health Center as a whole anticipates intensified need; HOT will see its manifestation among those who have the least resources to cope. ❧

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Notes

1. Governor's Blue Ribbon Task Force on Mental Health Policy, *Interim Report* (State of Connecticut, April 1983).
2. Governor's Task Force on the Homeless, *Final Report* (State of Connecticut, 1985).
3. "American Psychiatric Association Task Force on the Homeless Mentally Ill," a report cited in H. R. Lamb, ed., *The Homeless Mentally Ill* (Washington, D.C.: American Psychiatric Association, 1984).
4. Stewart B. McKinney Homeless Assistance Act, Original P.L. 100-77, Revised P.O. 100–628
5. United Way of Eastern Fairfield County, *Fact Sheet on Homeless Single Adults, #4, Homelessness in Eastern Fairfield County,* Spring 1990.