

In Defense of Deinstitutionalization

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THE TERM “DEINSTITUTIONALIZATION” IS A WORD, A THEORY, and a practice that has provoked more than its fair share of commentary and political bloodletting over the past two decades. Scarcely ten years ago, deinstitutionalization was an honorable word and practice among reformers of all stripes. Reducing the populations of large, overcrowded mental hospitals was viewed in the same light as minority civil rights issues—few “right-thinking” persons could oppose it. As a result, a political movement imbued with almost religious fervor swept many state capitols and hundreds of thousands of hospitalized mental patients were “deinstitutionalized.”

Deinstitutionalization today carries few of these overtones. Rose (1979) and many others assess the practice as, at best, merely another ill-advised liberal political movement of the 1960s. Alternatively, more sinister motives are ascribed to the movement, ranging from fiscal conservatism to profiteering and outright disregard for the needs of the mentally disabled.

In a public policy sense at least, deinstitutionalization has indeed fallen on hard times. Emboldened by the failures of deinstitutionalization, state hospital advocates have called for a revitalization of institutions once considered “bankrupt beyond remedy” (Robitscher, 1975: 146). The American Federation of State, County and Municipal Employees, a militant union of the AFL-CIO, has launched all-out attacks on state plans to close hospitals (Santiestevan, 1975). Congress has assailed state

governments for using federal funds to transfer patients from state hospitals to nursing homes (Pepper, 1978). And such papers as *The New York Times*, the *Village Voice*, and *The Washington Post* continue to devote most of their mental health investigative reporting to the problems of deinstitutionalization.¹ (Ironically, similar reporting about the problems of state hospitals earned for Mike Gorman, in 1948, the Albert Lasker Award given by the National Committee Against Mental Illness.)

Despite the range of connotations associated with the word "deinstitutionalization," the term itself is merely an awkward neologism meaning "moving patients out of hospitals." It is not, as some infer, a synonym for "community care." In fact, mental health reformers and recent government documents now go to great lengths to distinguish the two terms. While continuing to advocate reducing the populations of state hospitals, they tend to use phrases such as "alternative living facilities" and "community care," presumably because they imply something more than simple removal from the hospital.

Whatever the words used for it, deinstitutionalization as a phenomenon has been more accurately described than explained. Bachrach (1976), the Comptroller General (1977), Rose, and many others have described the great decline in the number of hospital inpatients that has taken place in two and a half decades. Psychotropic drugs, community mental health centers, Medicaid, World War II, scandalous conditions in state hospitals, fiscal penny-pinching, lack of regard for patient needs, and more—all have been cited as causes of the precipitous decline. Bennett (1979) raises yet another interesting and perhaps overlooked reason—the way society views the state hospital. Could it be that the public at large, influenced by the writings of Deutsch (1948), Goffman (1961), and Gorman (1948, 1956), and films such as *The Snake Pit* and *Titticut Follies*, had lost faith in the effectiveness of state mental hospitals? When combined with rising economic and educational standards, and increasing health insurance coverage, this change in societal perceptions might well have a place in the litany of explanations for reductions in state hospital populations.

¹See, for example, Sheppard (1979); Trotter and Kuttner (1974); and Stevens (1979).

The Course of Deinstitutionalization

As shown in Figure 1, deinstitutionalization has gone through at least two phases, and appears to be entering a third. The first period, from 1955 to 1964, is marked by a slow but steady decline in the number of patients living in state mental hospitals, a decrease averaging about 8,300 per year nationwide. In the second period, from 1965 to 1975, the decline averaged 27,200 per year nationwide—a rate more than three times that of the previous decade. This second period also witnessed most of the significant changes in public policy affecting deinstitutionalization. Today, if present statistics are any indication, we are entering a third period marked by far slower rates of decline in inpatient populations.

Rose (1979) reviews in considerable detail the various explanations offered for deinstitutionalization, and finds most of them inadequate. He maintains that neither development of the psychotropic drugs nor development of community mental health centers, two of the most frequently cited explanations, have been major factors in emptying state hospitals. Instead, he argues, deinstitutionalization is best understood as a series of political and economic measures designed primarily to sustain near-bankrupt state governments and to establish a basis for transferring public service moneys to the private sector.

More specifically, Rose speculates that because deinstitutionalization is seen (whether consciously or unconsciously) as a problem defined in medical and individualistic, rather than political and economic, terms, analysts fail to comprehend the real origins of the policies, whose ends they serve, and where they are leading us. Using mostly economic data, he interprets deinstitutionalization as the result of political decisions at the state level to 1) save money for state governments; 2) build a social structure wherein professionals and private industry can profit at the expense of both the mentally disabled and the public at large; and 3) rid state governments of the responsibility to provide for some of their most disabled citizens.

I think this cynical—and limited—view of the deinstitutionalization movement is wrong. To be sure, policy decisions of state governments have been at the very core of deinstitutionalization programs. But to describe complex decisions almost solely in terms of attempts to forestall the “bankruptcy” of state governments is hardly accurate, either in terms of motives or finances. Nor

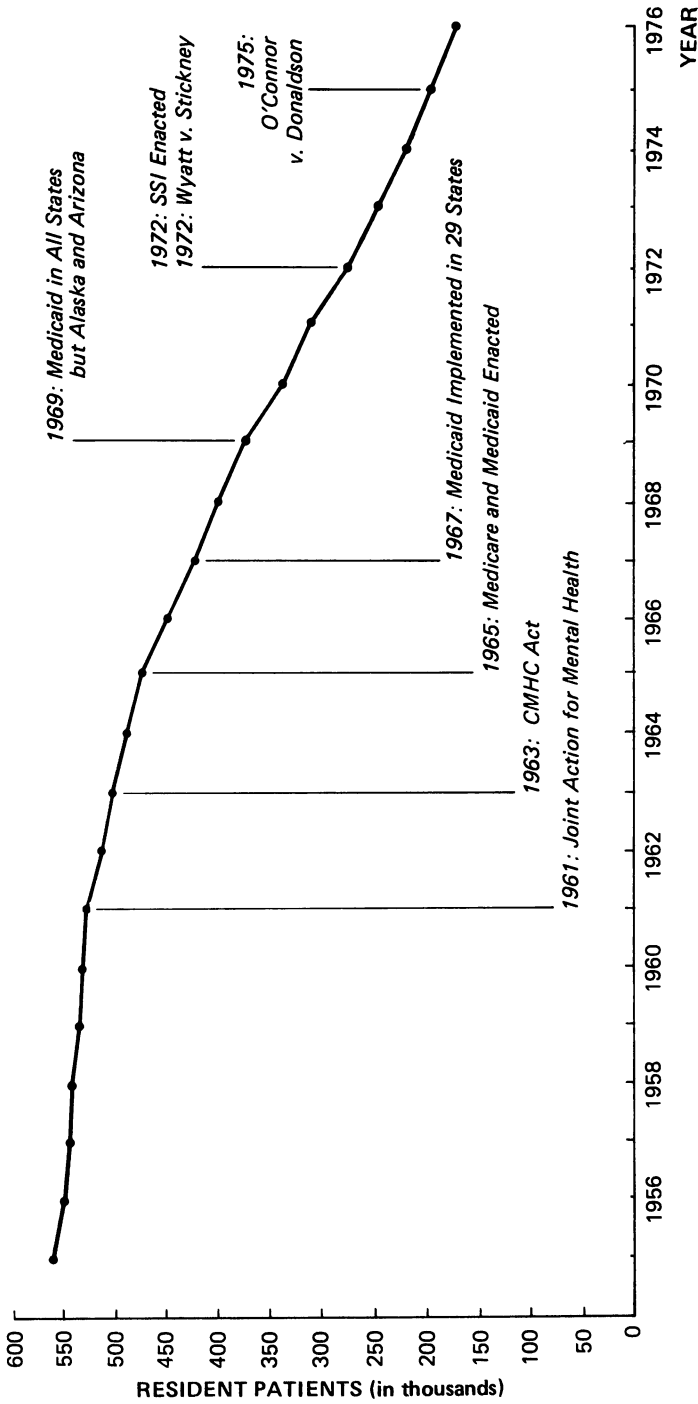


FIG. 1. Number of Resident Patients in State and County Mental Hospitals, 1955-1976. Source: Division of Biometry, National Institute of Mental Health, DHEW, 1979. (Various published and unpublished reports.) Note: Only selected legislative and judicial actions are cited. No attempt has been made to account for the introduction or use of specific medical or pharmacologic agents.

is it entirely accurate to view the various policy decisions that transferred public moneys to the private sector as originating solely at the state level. Moreover, data on public mental health expenditures give no evidence that states have abandoned their responsibility to the mentally ill (although some deplorable exceptions have been noted, particularly in New York).

Finally, although Figure 1 shows that the greatest rate of deinstitutionalization occurred only after a number of significant public programs were enacted, attributing all reductions to those political and economic decisions ignores the other forces that bring about change. This view also fails to account for the enormous time lag between the introduction of an innovation (e.g., psychotropic drugs) and the widespread use of that innovation, and for a similar time lag between enactment of a program and its actual implementation. Although this paper deals only with political and economic decisions contributing to deinstitutionalization, the varied forces cited earlier also had an important, if indeterminate, effect.

The State Mental Hospital

The initial political motivations for deinstitutionalization must be seen from the vantage point of conditions in state mental hospitals in the 1950s and 1960s. The situation was perhaps best summed up in 1958 by the then president of the American Psychiatric Association, Harry Solomon (Robitscher, 1975: 145–146):

After 114 years of effort, in this year 1958, rarely has a state hospital an adequate staff as measured against the minimum standards set by our Association, and these standards represent a compromise between what was thought to be adequate and what it was thought had some possibility of being realized. Only 15 states have more than 50 percent of the total number of physicians needed to staff the public mental hospitals according to these standards. On the national average registered nurses are calculated to be only 19.4 percent adequate, social workers 36.4 percent, and psychologists 65 percent. Even the least highly trained, the attendants, are only 80 percent adequate. I do not see how any reasonably objective view of our mental hospitals today can fail to conclude that they are bankrupt beyond remedy.

But criticism of state mental hospitals was voiced by others in addition to the psychiatric profession. In most states, it was a few other physicians, supporters of civil liberties, and social reformers who were primarily responsible for urging deinstitutionalization policies (Bardach, 1972; Bradley, 1976). Most of these early advocates saw the traditional medical model—which labeled every deviance as a disease calling for “treatment”—as a primary cause for the problems of the state hospitals (Szasz, 1970).

It is difficult to overstate the brutality of the conditions these reformers were trying to end. The mental health system, from the commitment process to the state hospitals themselves, led to almost unspeakable indignities, privations, and denials of civil rights. Witness, for instance, the case of Kenneth Donaldson.² Incarcerated against his will from 1957 until 1971, Mr. Donaldson had never been judged dangerous to himself or others, had never lost his ability to hold a job, and may never have been mentally impaired. In another instance, a woman was released in 1978 after spending thirty years in a Washington, D.C., mental hospital (Stevens, 1978). Poor and Spanish-speaking, she was originally admitted to a mental facility because no other institution would care for her problem—typhoid fever. In Alabama, as a result of the *Wyatt v. Stickney* suit,³ several residents of the state hospital were discovered who had no organic or mental problems at all. Yet they had become permanently “functionally” mentally retarded because they had been mistakenly placed in an institution at an early age and raised there.

Greystone Park State Hospital, with a main building that is a hundred years old, and whose foundation is purported to be larger than any other in the world except that of the Pentagon, is another example (Lamendola, 1972). Located in rural northwestern New Jersey, it housed more than 7,000 persons during the 1950s and had an inpatient population of more than 4,000 as late as 1970. According to those familiar with the hospital, it was not until 1976 that ac-

²*O'Conner v. Donaldson*, 422 U.S. 563 (1975).

³*Wyatt v. Stickney*, 344 F. Supp. 373 and 387 (M.D. Ala. 1972); *aff'd sub. nom. Wyatt v. Aderholt*, 503 F. 2d 1305 (5th Cir. 1974); personal communication with counsel for plaintiffs and the United States.

tive mental health treatment was offered, largely as the result of direct court supervision and a reduction of the inpatient census to 1100 (Clarke, 1979b).

These examples do not directly invalidate Rose's arguments, but they do suggest that the motives of early reformers were far different from those he ascribes to them. The state mental hospital, where people were often incarcerated although they had committed no crime and were offered no compensatory "treatment," was an evil unto itself; almost any other setting was thought to be more humane and almost any system that permitted deinstitutionalization was thought to be a beneficial alternative. For the Ken Donaldsons who resided in state hospitals, this meant release directly to the community. For the chronically *medically* disabled, it meant release to nursing homes. And for others, whose illnesses were not completely disabling, although their functional abilities were not as great as Mr. Donaldson's, it meant release to a kind of limbo where abuse and maltreatment, as well as community disruption, could occur. When weighed against the existing alternative, however, the balance for this third group—the ones supposedly injured by deinstitutionalization—may well have been in favor of release.

The Advent of Federal Programs

This tremendous drive to give more dignity and freedom to those incarcerated in state hospitals also led to a fortuitous marriage between state deinstitutionalization efforts and two federal programs: Medicaid (enacted in 1965), and Supplemental Security Income, or SSI (enacted in 1972). Although never designed specifically for the mentally disabled, these two programs abetted a reduction in the size of state hospitals. For the aged, chronically ill residents—many of whom never really belonged in a mental hospital and were placed there only because of organic brain syndromes, poverty, and the lack of any other institution to care for them—Medicaid offered a way of paying for needed medical care in more appropriate settings. For those who could manage in the community, SSI meant a guaranteed federal minimum for welfare

payments. What was more important, SSI frequently resulted in expanded definitions of eligibility that, for the first time, guaranteed welfare payments to the mentally disabled.

The advent of these programs placed potent fiscal incentives at the service of mental health reformers. By the time Medicaid regulations were sorted out in 1967, it was clear that the federal government would subsidize from 50 to 80 percent of the cost of providing care to medically ill mental patients, simply by moving them to private nursing homes. This meant the possibility of bringing additional money, with relatively few restrictions, into an already underfunded, overcrowded system, an opportunity that reformers leapt at.

The acuity of hindsight makes it easy to argue that such fiscal incentives were the real reason for the proliferating deinstitutionalization policies. In fact, however, early advocates of deinstitutionalization had to go out of their way to convince state budget agencies that there were fiscal as well as humane incentives for depopulating state institutions (Goodman, 1974; Shaffer, 1973; Pederson, 1974; *Minneapolis Star*, 1974; Edwards, 1976; Clarke, 1979a). Rather than explaining the *motives* of deinstitutionalization, the federal fiscal-windfall argument more properly accounts for its widespread success. Deinstitutionalization became the ideal social reform; it permitted liberal politicians to free mental patients, and at the same time allowed conservative politicians to save millions of dollars. The success with coalition-building, however, should not obscure the recognition that it was the reformers, not the fiscal conservatives, who had provided the initial impetus.

Similarly, although Medicaid and many SSI systems are state-administered, it was the federal government, not the states, that made a conscious decision to transfer public moneys to the private sector. Both Medicaid (except for patients over sixty-five or under eighteen), and SSI (except for a monthly personal allowance and, after 1976, except for facilities with fewer than sixteen beds), prohibit the payment of federal funds to public institutions. Thus the states were faced with the choice: either obtaining extremely favorable matching funds on the condition that care be provided in private facilities, or going it alone in public facilities. Given the multiplicity of the demands on state tax dollars, the decision was an easy one. Had federal policy been at least evenhanded in its treatment of public facilities, a clearer case could be made that states did indeed

wish to transfer public moneys to the private sector. Given the strong *federal* fiscal incentive to fund private providers, however, and the lack of any similar incentive to provide care in public facilities, it seems both misleading and inaccurate to attribute this policy solely to decisions made by state governments.

Moreover, it should be pointed out that the bias of Medicaid and SSI in favor of the private sector is not atypical of federal programs. Other instances are comprehensive health planning and the community mental health centers program. The best example, however, is the history of the community action program and the "Alabama syndrome" (Moynihan, 1969). Throughout the 1960s and much of the 1970s, federal policy makers viewed state governments as obstacles to change rather than as beneficent public providers. Many federal human service programs of the past two decades sought to bypass the states as much as possible, either through direct entitlement or through the use of proprietary and nonprofit groups. To attribute this change to decision makers at the state level ignores the fact that they were reacting to, rather than creating, such a policy.

The Economic Motive

Speculation about the cost savings for state governments in deinstitutionalization should be weighed against the actual fiscal experience of states in this area. Rose's estimates of cost savings experienced in New York, for instance, tend to be misleading. These calculations do not include an average cost for Medicaid, for which each SSI recipient is automatically eligible, and they undoubtedly severely underestimate costs for such services as licensing and inspection, housing subsidies, vocational rehabilitation, and administration, not reflected in the costs of direct service. Rose also fails to point out that deinstitutionalized persons residing in nursing homes on Medicaid—usually at a higher per diem cost than in state hospitals—account for a large portion of state costs, even though there are federal matching funds. In addition, he does not clearly distinguish his own figure of \$9,000 per year in cost savings from the

General Accounting Office (GAO) estimate of \$20,000 over ten years, or \$2,000 per year. Although both are evidence of substantial incentives to deinstitutionalize, the figures differ by several magnitudes.

A recent study (Weissert et al., 1979) casts doubt on the cost estimates of providing community care made by both Rose and the GAO. The Weissert study shows that, at least in the medical area, outpatient care is considerably more cost effective than inpatient care only if the direct costs of institutional care are taken into account. But when total health, homemaker, and day care expenditures are added together, outpatient care actually proves more costly.

A further problem with the factors cited by Rose, as evidence of the fiscal imperatives to deinstitutionalize, is the 314 (d) program of the Public Health Service Act. It is true that 15 percent of the moneys must be set aside for mental health services, and that 70 percent of those funds must be used at the local level. What Rose fails to note, however, is that before 1975 the 314 (d) appropriation was never higher than \$90 million (Advisory Commission on Intergovernmental Relations, 1977). Thus the average amount of money that eventually trickled down to each state for community mental health services was only \$270,000. This is hardly sufficient to induce massive changes in an average state budget for mental health—in 1974, \$76 million per year for institutional care alone (Bureau of the Census, 1975).

The most serious flaw in all such calculations is that they do not accurately assess the fixed costs of maintaining state institutions. As advocates of deinstitutionalization have found to their considerable dismay, reducing the size of inpatient populations has not freed large amounts of money, either for community care, as they would have hoped, or for reduced state budgets, as Rose would imply. The economies of scale of the large custodial institutions dictate that there can be no dollar-for-dollar reduction in budgets when patients are released, even in institutions that provide efficient and high-quality care. In the middle 1960s, when rapid deinstitutionalization began, state hospitals were so severely understaffed that no net reductions in expenditures or staff took place. Instead, with the release of the more functional patients and a gradual end to enforced patient labor (peonage), state hospital personnel were placed under new pressures to provide service to those left behind, a considerably more disabled population. The added problems of inflation, rising

admission rates, restrictive civil service systems in the states, labor union and local political pressure, stricter accreditation and reimbursement standards, and, in recent years, closer civil rights scrutiny and energy problems, have only served to further escalate costs.

The entire argument that states have experienced considerable savings, because of deinstitutionalization, should be recognized for what it is, an untested hypothesis. The actual experience of state legislators, governors, and administrators in coping with rising social demands, in the face of constitutional requirements for a balanced budget, is not likely to validate this hypothesis. Over the period of rapid deinstitutionalization from 1965 to 1975, when many new pressures were being placed on state governments to increase their expenditures for social welfare, urban affairs, education, and environment, state mental hospitals received a diminished *proportion* of the state budget, from 3.4 to 2.8 percent of the total (Bureau of the Census, 1965–1975). The dramatic increase in *total* state spending (and income) during this period, however, meant that actual expenditures for state hospitals escalated.

As shown in Figure 2, from a nationwide total of approximately \$1.5 billion in 1965, expenditures for mental institutions grew to approximately \$4.3 billion in 1975—a 187 percent increase. (Figure 2 shows that this trend continued through 1977, when expenditures reached \$5.1 billion, or 2.7 percent of total state budgets.) It is important to note that most of this increase occurred before the first major “right-to-treatment” suit was decided in *Wyatt v. Stickney* in 1972. Thus, in the decade following 1965, when the number of resident inpatients in mental hospitals was falling rapidly, state governments were not saving money. In fact, they were spending almost three times more for their hospitals than before rapid deinstitutionalization began.

Advocates of deinstitutionalization who strongly believed it would save money for state governments have found that economic realities have proven them wrong. Today, most such advocates say only that, *in the long run*, deinstitutionalization should cost no more than traditional inpatient care. In the interim, however, deinstitutionalization is likely to increase costs. The authors of one recent study, which recommended reducing the size of Oklahoma’s state hospitals, told a legislative committee that implementation of their recommendations might *increase* state costs by at least \$4 million a year (Clarke and Bradley, 1978).

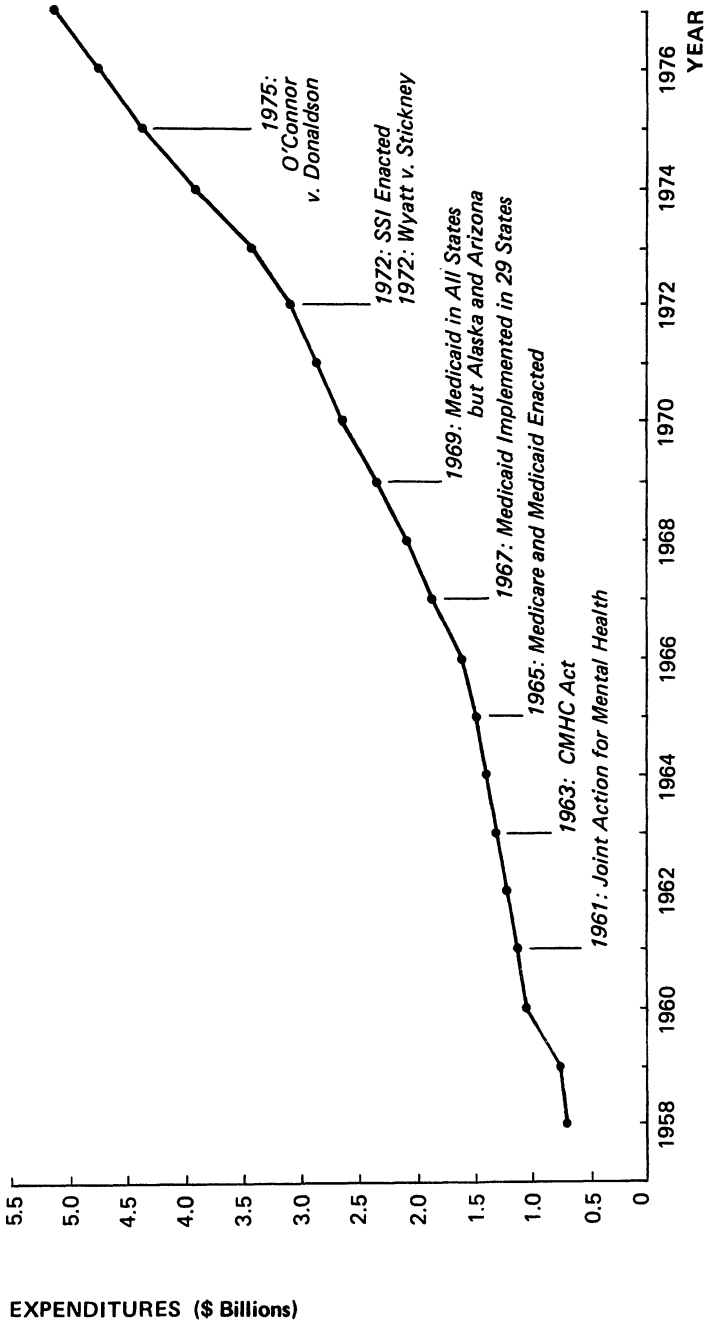


FIG. 2. State Expenditures for Mental Hospitals: Current Operation, 1958-1977. Source: Bureau of the Census, U.S. Department of Commerce, *State Government Finances* (annual publications, 1958-1977). Washington, D.C.: U.S. Government Printing Office. Note: The data include federal as well as state spending. Further breakdown is not possible, but federal revenue constituted no more than 1 to 2 percent in 1977.

Deinstitutionalization Today

As the expenditure data indicate, there is little evidence that the states have abandoned their responsibility for the chronically mentally disabled, even during massive deinstitutionalization efforts. Even though state governments sought to utilize federal funds wherever possible, there is no indication that they did so for the purpose of getting out of the mental health business. Rather, those states that have been the most skillful in utilizing federal funds—e.g., California, Massachusetts, and New York—have also made the greatest commitment of state funds and efforts to provide decent care for the mentally ill. Not all of these programs have worked well, and some have amounted to outright abandonment. But deinstitutionalization must be seen in a realistic light as a relatively new, almost experimental, complex effort to deal with a group of extremely poor and severely disabled citizens.

The failures of the deinstitutionalization movement are many, but there is no solid evidence that patients have been harmed to any greater degree than if they had remained in institutions.⁴ Moreover, far from sliding into neglect, as did the early state hospital movement, deinstitutionalization seems only to have gathered strength among those who make public policy. The central question they face today is no longer *whether* to deinstitutionalize, but *how*. Numerous public policy reports,⁵ experienced state administrators (Allerton, 1976), and the President's Commission on Mental Health (1978) are advocating a reduced, though permanent, role for state hospitals. Unlike the huge facilities of another era, they are to be smaller, better equipped, and better staffed, treating acutely ill patients as

⁴There are some data showing a decline in functional ability in patients moving from hospital to community, but they have never been compared with data showing a decline in function accompanying hospitalization in the first place.

⁵See, for example, California Legislature (1974); Arthur Bolton Associates (1974); Human Services Research Institute (1978); Department of Health, Education, and Welfare (1978).

well as a minority of the chronically disabled for whom long-term institutionalization is the only alternative. For most of the mentally ill, however, various community-based programs are being called for.

Many valuable lessons have been learned from early efforts in deinstitutionalization (Sandall, 1976). Various programs in California, Missouri, New York, Washington, D.C., Wisconsin, and elsewhere have demonstrated that deinstitutionalization of chronically mentally disabled patients can be carried out successfully. Communities need not be turned into ghettos, wage earners need not be put out of work, private entrepreneurs and professionals need not defraud the government, and patients need not be victimized.

One example of a successful program is the St. Louis Community Homes Program (recently renamed Places for People, Inc.), which takes long-term, chronic mental patients out of the hospital and places them in supervised apartments throughout the city (Sandall et al., 1975). Participants in the program not only receive medication and therapy, but they are also assisted in acquiring the skills necessary to function in everyday life, skills that frequently have atrophied after long periods of institutionalization. How to budget, cook, clean a house, use a municipal bus system, and eventually find a job are all parts of the program. The staff members who assist former patients were once assigned to inpatient services in the state hospital, but have been retrained to assist patients in the community. Funds for the program have been gathered from a variety of sources, including SSI, Title XX (social services), Rehabilitative Services, Medicaid, and others. Community disruptions from the program are minimal, and all but 10 to 20 percent of the patients are able to cope with independent living.

At the federal level, the Community Support Program (CSP) has been initiated to help other states learn from, adapt, and improve upon successful programs like those in St. Louis (Turner and TenHoor, 1978). Unlike most other federal social programs in recent memory, it does not call for a "new era," it does not design a grand scheme, and it does not establish a new, quasi-independent political and social infrastructure. Far from being merely a "mopping-up operation," the CSP seems uniquely original, a federal program that calls on state administrators to use what is already known. Yet, this modest goal holds the opportunity for more real improvement in the lot of the deinstitutionalized chronically mentally ill than all other federal mental health programs.

What of the Future?

In the late 1960s and early 1970s, it required bold leadership, innovation, and risk-taking for reformers to persuade governors, state legislators, and the public that an alternative to the existing institutional mental health system was possible. What was devised at the state level as a result of these efforts did not always prove beneficial to patients or the public, and a considerable backlash has set in. Some analysts attribute mercenary or venal motives to state efforts at deinstitutionalization. Many communities feel they would be better served if the mentally ill continued to be sent far away. State labor unions resist threats to their jobs, and the public resists higher federal, state, or local taxes for any purpose, be it mental health, highways, or education.

Too many critics of the deinstitutionalization movement have failed to offer any better alternatives. They seem to imply that patients should not leave state hospitals until they are “cured”—thereby showing a highly inaccurate notion of the nature of chronic mental illness and the treatment hospitals have to offer. These same critics also seem to imply that a state hospital, in spite of all its inherent restrictions of personal freedom, is somehow necessarily preferable to a less restrictive setting that fails to provide constant supervision and treatment. Experience with state hospitals, going back more than a hundred years, casts doubt on the validity of that assumption.

Critics of deinstitutionalization also fail to note that, whatever the origins of the movement, the courts have now injected new constitutional imperatives for moving patients out of state hospitals. All across the country, federal courts have reaffirmed that the most basic rights of our democratic society pertain to the mentally disabled. Citizens cannot be locked away if they have committed no crime, can survive safely in the community, and are not dangerous to themselves or to others—even if they are “crazy.” Moreover, even when patients do meet the criteria for commitment (and mental health professionals are notoriously unreliable predictors of dangerousness), they must be placed in settings that are no more restrictive of their personal freedom *than is necessary to treat their incapacity*.⁶

⁶Shelton v. Tucker. 364 U.S. 479 (1961).

In sum, from an analytical viewpoint, deinstitutionalization seems beset by a misperception of its origins, a misreading of its economic history, and a misunderstanding of the nature of chronic mental illness. From a practical viewpoint, deinstitutionalization seems beset by inexorable legal demands for less restrictive care, as well as by a lack of funding. But neither state nor federal policy makers seem likely to commit massive new amounts of money to deinstitutionalization. Thus, the near future will probably witness a slower rate of exodus from state hospitals, better coordination of existing programs, adaptation of already successful models of community care, and innovation only at the fringes of public policy. Given the problems of the past ten years, this may be the best medicine that could be prescribed.

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