©1990 The Institute of Mind and Behavior, Inc.
The Journal of Mind and Behavior
Summer and Autumn 1990, Volume 11, Numbers 3 and 4
Pages 301 [55] - 312 [66]
ISSN 0271-0137
ISBN 0-930195-05-1

Deinstitutionalization: Cycles of Despair

Andrew Scull

University of California, San Diego

Examining the period from the rise of the asylum in the nineteenth century through the current debates about the failures of deinstitutionalization, this paper provides a critical perspective on the history of Anglo-American responses to chronic mental disability. It concludes with a pessimistic assessment of the prospects for the future evolution of public policy in this area.

As modern Western societies have grappled with the scourge of mental disorder, debates about how to deal with the chronically mentally disabled have periodically erupted into the political arena. At various times over the past two centuries, both public and professional sentiment have swung to one extreme or the other: embracing, at certain historical moments, an extraordinary optimism about the likely impact of new approaches to treatment; at others, relapsing into a numbing pessimism, hopelessness, and despair. On the whole, I shall argue that the historical record unfortunately makes the latter position the most plausible prognosis for both the present and the foreseeable future, and certainly we seem presently to be in one of those periods when informed opinion is on the brink of despair about our prospects. But I say this with great reluctance, since one of the effects of even realistic pessimism is that it tends to worsen an already grim outlook, for who can summon the energy to fight an essentially hopeless battle?

An earlier version of this paper was presented at a conference on "Fostering Useful Knowledge About What To Do With/For The Chronically Mentally Ill" held at UCLA on February 12 and 13, 1988. I am very grateful to David Cohen for his incisive comments on that early draft.
Requests for reprints should be sent to Andrew Scull, Ph.D., Department of Sociology, C-002, University of California at San Diego, La Jolla, California 92093.

Asylums for the Mad

While from one point of view, specialized institutions for the mad have a long ancestry in the Western world – one we can trace back, for example, to the monastic foundation of Bethlem (Bedlam) in the English-speaking world, and to the Arab-inspired asylums of medieval Spain – in another, the centrality of the asylum dates only from the early nineteenth century. In one of those surges of optimism to which I previously referred, Victorian lunacy reformers were captured by a utopian vision of what reformed, purpose-built monuments of moral architecture could accomplish, engaging in a kind of therapeutic Dutch auction in which expectations about the curability of insanity were built up to quite extraordinary heights. The sense, as Dwyer (1987) recently put it, that there was "an economics of compassion" seized the imagination of a generation of reformers and philanthropists, and prompted the construction of vast networks of publicly supported asylums in Britain, Western Europe, and the United States. To invest substantial capital sums in the construction of state hospitals, and to provide therein for the application of the powerfully restorative techniques of the new moral treatment, was, if the proponents of reform were to be believed, to opt for the cheapest of all policies in the long run – for the initally sizeable investiment in treatment facilities would all but guarantee the restoration of seventy, eighty, ninety per cent of the mad to sanity, swiftly reducing the burden of serious mental disorder to almost vanishingly small proportions.

Sadly, of course, in the face of these utopian fantasies, reality proved more than a little recalcitrant. It was recognized at the outset of the reform process that previous neglect and mismanagement had rendered a sizeable fraction of the first patients the new institutions would admit beyond hope of cure, for even the most enthusiastic proponents of moral treatment held that its impact diminished sharply if therapy was delayed and the disordered allowed to become chronic. But the assumption was that once the new system of asylums permitted early recognition and intervention, the problem of chronicity would assume quite minor proportions. Suggestions by the less sanguine that plans should be drawn to care for a population of the permanently disabled met with little support. In England, for example, the 1844 Report of the wonderfully named Metropolitan Commissioners in Lunacy – the foundation for the legislation making construction of state funded asylums compulsory – had noted that

> the disease of Lunacy . . . is essentially different in character from other maladies. In a certain proportion of cases, the patient neither recovers nor dies, but remains an incurable lunatic, requiring little medical skill in respect to his mental disease and frequently living many years. A patient in this state requires a place of refuge, but his disease being beyond the reach of medical skill it is quite evident that he should be removed from Asylums instituted for the cure of insanity in order to make room for others whose cases have

> not yet become hopeless. If some plan of this sort be not adopted the Asylums admitting paupers will necessarily continue full of incurable patients . . . and the skill and labour of the physician will thus be wasted upon improper objects. (Report, 1844, p. 92)

The legislation of the next year accordingly licensed local authorities to make separate provision for the chronic. But, as in the United States, no one pressed for its implementation, and no such facilities were erected – at least until much later in the century.

The emerging profession of psychiatry was particularly vocal in its opposition to such schemes. On both sides of the Atlantic, alienists argued that such receptacles for the chronic, while superficially attractive, would necessarily be productive of a repetition of the very abuses of the mentally ill that the new asylums had been set up to avoid. In particular, they urged that it would be difficult, if not impossible, to recruit suitable staff, and to maintain the requisite morale and dedication in institutions that were avowedly custodial, and since there remained a possibility of cure, however remote it might seem, in even the most confirmed cases of lunacy, it would be both cruel and unwise to consign the chronic to places where efforts directed toward their restoration would cease. Public authorities, reluctant to incur the expense of erecting and providing for two separate institutions, happily opted for the immediate capital savings of a single asylum for curable and incurable alike.

Warehouses for the Unwanted

Cures, of course, if not quite as rare as hen's teeth, proved far more elusive than the asylum's proponents had advertised. And as asylums steadily silted up with the chronic and incurable, exactly the conditions predicted by the opponents of separate facilities for the permanently mad began to characterize the asylum system as a whole. Morale plummeted; the quality of the attendants (never particularly high) fell further still; funding levels declined, as politicians saw little reason to invest "extravagant" sums in a holding operation; and the insitutions grew ever larger and more unmanageable. At the theoretical level, psychiatrists responded by adopting grimly deterministic hereditarian and somatic accounts of mental disorder which explained away their failures to cure (and indeed such theorizing had an additional virtue, in that it provided a eugenic argument for the seclusion of the mad); but such "scientific" reinforcement of an existing pessimism came at the cost of adding a vicious further twist to the downward spiral that now gripped public asylums.

In a few jurisdictions, there was even a revived flirtation with the idea of separate institutions for the chronically ill. In the late 1860s, the authorities in London, for instance, constructed two institutions for the permanently

mad – at Caterham and Leavesden – huge, cheerlesss establishments housing between two and three thousand inmates (Scull, 1979). And New York State, in a move heavily criticized by the American psychiatric establishment, opened the Willard Asylum for the Chronic Insane in 1869 (Dwyer, 1987). But the attempt to shunt aside the chronic, and reestablish the primarily curative mission of the other asylums, proved a dismal failure. Within a few years, in fact, it became difficult to distinguish the institutions for the chronic from their supposedly therapeutic brethren. In both sets of institutions, more inmates left each year in coffins than walked out of the gates restored to sanity. The immense, decaying buildings in which thousands of patients now endured a dreary and monotonous existence, themselves offered mute testimony to the fact that the asylum had become, as it was to remain for three quarters of a century, "a mere refuge or house of detention for a mass of hopeless and incurable cases" (Granville, 1877a, p. 8). Within these warehouses of the unwanted,

> the classification generally made is for the purpose of shelving cases; that is to say, practically it has that effect. . . . In consequence of the treatment not being personal, but simply a treatment in classes, there is a tendency to make whole classes sink down into a sort of chronic state. . . . They come under a sort of routine discipline which ends in their passing into a state of dementia. (Granville, 1877b, pp. 388; 396-397)

By the closing decades of the nineteenth century, some of the best informed critics of mental health policy had become convinced of the pernicious effects of incarceration. S. Weir Mitchell, for example, the dean of American neurologists, came before the annual meeting of American state hospital superintendents to issue an indictment of their practices. Deeply affected by his encounter with the harsh realities of the American mental hospitals, he complained that "in the sadness . . . of the wards . . . the insane, who have lost even the memory of hope, sit in rows, too dull to know despair, watched by attendants; silent, grewsome [sic] machines which eat and sleep, sleep and eat" (Mitchell, 1894, p. 19). Henry Maudsley characteristically rounded upon those inclined to protest the proposition that asylums were "monstrous evils": "[those] who advocate and defend the present asylum system . . . should not forget that there is one point of view from which they who organize, superintend, and act, regard the system, and that there is another point of view from which those who are organized, superintended, and suffer, view it" (1871, p. 427). For visitors who lacked the peculiar blindness induced by a position as superintendent of such an insitution, few things could be more depressing than "the sight of so many patients in the prime of life sitting or lying about, moping idly and listlessly in the debilitating atmosphere of the wards, and sinking gradually into a torpor, like that of living corpses" (Massachusetts State Board of Charities, 1867, p. xl).

Worse still, such publicly acknowledged therapeutic impotence threatened to reward psychiatrists with an even more marginal professional status than they had previously enjoyed, for it coincided with a marked upturn in the fortunes of their fellow medical practitioners, as the antiseptic revolution in surgery, the bacteriological revolution in medicine, and the reform of medical education and training came together to produce a sharp improvement in the profession's public image and position in the marketplace. The isolation of the syphilitic spirochete in the early twentieth century created a false dawn of hope that similar breakthroughs were at hand for a biological psychiatry, but state hospitals soon lapsed back into their slumbering state – and psychiatrists, despite spasmodic experiments with a variety of somatic treatments (convulsive therapies, insulin coma therapy, lobotomies), continued to preside over medical backwaters.

Indeed, from many points of view, the first half of the twentieth century witnessed a worsening of the situation in the asylums (and, concomitantly, a deterioration in the standard of care for the chronic). In the first place, the closure of the state almshouses brought with it an influx of the senile and the decrepit, for whom the mental hospital now became the only refuge. Between 1904 and 1923, the proportion of asylum inmates in residence for more than five years grew from 39.2 per cent to 54 per cent. In Massachusetts, the average length of hospital confinement had risen to 9.7 years by the late 1930s, and nearly 80 per cent of the beds were occupied by chronic patients (Grob, 1983, pp. 196–197). Nationwide, the total number of mental patients increased almost fourfold between 1900 and 1940, from 150,000 to 445,000, with the largest fraction of the increase coming in the ranks of the elderly. In New York State, for instance, 18 per cent of first admissions in 1920 suffered from senility or arteriosclerosis; by 1940, this had risen to 31 per cent (pp. 180–182). Clearly, these were not patients who posed threats to public order, or who could be expected to benefit from therapeutic interventions.

Secondly, despairing of making therapeutic progress with such recalcitrant raw materials, and conscious that their claims to professional competence, in the words of an internist at Harvard Medical School, "seemed so evanescent to most [medical] practitioners as to border on the ludicrous. . . (Bock, 1933, p. 1092), organized psychiatry increasingly attempted to establish a base for itself outside the institution, at as great a remove as possible from contact with the chronic patients who cluttered up the dormitories and dayrooms of the state hospitals. Psychopathic hospitals, research institutes, outpatient wards in general hospitals, mental hygiene clinics, child guidance centers, all offered the prospect of some respite, an "escape from the seemingly insoluble and depressing problems of the traditional mental hospital" (Grob, 1983, p. 240). As Grob further notes (p. 287), by 1956, only 17 per cent of the membership of the American Psychiatric Association were employed by

state hospitals. And as they broadened their own occupational base and sought to acquire a more tractable and treatable clientele, psychiatrists silently attenuated their commitment to institutional care, and abandoned the chronically crazy to their fate. Mental hospitals, as Albert Deutsch (1973) put it, became "the shame of the states": a set of institutions characterized, in the words of another critic from the 1940s, by

> Inadequacy, Ugliness, Crowding, Incompetence, Perversion, Frustration, Neglect, Idleness, Callousness, Abuse, Mistreatment, Oppression. (Wright, 1947, p. 123)

At the nadir of their public regard, such psychiatric snakepits came under a new form of assault in the 1950s, as sociologists honed in on their therapeutic inadequacies and failings. A series of critical studies, reaching a crescendo in Erving Goffman's *Asylums* (1961), with its indictment of the baneful effects of the "total institution," recast the image of the mental hospital and forced home the message that "in the long run the abandonment of the state hospitals might be one of the greatest humanitarian reforms and the greatest financial economy ever achieved" (Belknap, 1956, p. 212). So far from being a positive force, hospitalization was now portrayed as having profound iatrogenic effects, its grossly deforming environment serving only to manufacture and stabilize chronicity.

The Panacea of Community Treatment

But a new panacea was lurking in the wings. Deinstitutionalization and treatment in the community could rapidly reverse the ill-effects of a badly mistaken century-old innovation in social policy. "By bringing [the mentally ill and other deviants] back into the community, by enlisting the good will and the desire to serve, the ability to understand which is found in every neighborhood, we shall meet the challenge which such groups of persons present, and at the same time ease the financial burden of their confinement in fixed institutions" (Alper, 1973, pp. vii-viii). Community care, and the social management of mental illness,[1] it was confidently predicted in the 1950s and 1960s, would revolutionize the outlook for the mentally ill, and finally resolve the nagging problems posed by chronicity.

[1]The introduction of the term "mental illness" is perhaps the proper occasion to comment briefly on some terminological issues. Embedded in whatever vocabulary one elects to use in discussing mental alienation is a whole complex of claims and presuppositions. One ventures here into what Steven Lukes has called "essentially contested terrain" where one can find no neutral ground. The use of such terms as "mental illness" invites accusations that one has thoughtlessly swallowed psychiatry's claims to rationality and disinterested benevolence, and uncritically accepts the so-called "medical model" of mental disorder. Yet the selfconscious avoidance of this terminology is linguistically awkward, and besides, it has unfortunately come to be associated with

How innocent and naive this all seems now. The mental hospital census, having declined slowly between 1955 and 1965, dropped precipitously over the next two decades – not primarily, as some have alleged, because the phenothiazines provided a technological fix for the psychoses, but rather in response to a broad expansion of social welfare programs, growing fiscal pressures on the states, and the opportunity to transfer costs away from the state budget, helped along, in a more minor key, by the interventions of public interest lawyers who sought to make it more difficult to employ the police power of the state to compel the mentally ill to enter psychiatric treatment facilities (see reviews of evidence on this point in Aviram, Syme, and Cohen, 1976; Gronfein, 1983, 1985; Lerman, 1982; Scull, 1984, pp. 79–94; 169–172).

This transfer of care was supposed to mark a glorious Paradise Regained for the denizens of the backwards, and to preserve future generations of "mental patients" from the damaging effects of institutionalization. Instead, as we are now all too acutely aware, the outcome has been "the wholesale neglect of the mentally ill, especially the chronic patient and the deinstitutionalized" (Langsley, 1980, p. 815). State and federal payments to the burgeoning entrepreneurial class "servicing" the chronically mentally disabled are scarcely munificent, and at best could be expected to purchase the most basic forms of custodial care. Worse still, under the conditions which now prevail, market failure is structurally guaranteed. A large number of atomized, uninformed consumers, whose mental condition renders them all-but-capable of initiative or of exercising meaningful choice, has been discharged into a hostile community and these people have been left to cope as best they can – in the

---

two equally unsatisfactory positions: either that one has embraced the romantic nonsense propounded by sociologists under the guise of labelling theory or that one accepts the equally pernicious Szaszian argument that mental illness is myth. I find none of these choices appealing. The medical personnel who claim the ability to decide for the rest of us what constitutes "mental illness" suffer from embarassing intellectual vulnerabilities, to say nothing of an all-too-visible therapeutic impotence; and psychiatrists are, of course, deeply and inextricably involved in the definition and identification of what consitutes madness in our world – in ways which render the notion that mental illness is a purely naturalistic category, devoid of contamination by the social, a patent absurdity. But to recognize that, at the margin, what consitutes madness is fluctuating and ambiguous, indeed theoretically indeterminate, is very different from accepting the proposition that mental alienation is simply the product of arbitrary social labelling or scapegoating. Such views play down the degree to which behavior recognized as mad is genuinely problematic. To ignore the enormity of the human suffering and the devastating character of the losses sustained by the victims of this form of communicative breakdown, or, alternatively, to lay blame for their plight simply and solely on the shoulders of a misguided or actively harmful profession is to embrace a romanticism with which I can have no truck. In the absence of a vocabulary that is neutral in these respects, reasoned discussion of our underlying difficulties, at least among persons of different theoretical persuasions, remains exceedingly elusive and difficult, the various factions all too often simply talking past one another. Faced with this problem, I have chosen to refer almost interchangeably to madness, mental illness, mental disturbance, and the like. Though this leaves no one wholly satisfied, I hope it at least reminds us that real issues lie behind our choice of words, issues that remain problematic and ought not to be rendered invisible through any linguistic sleight of hand.

virtual absence of state supported aftercare or follow-up services. Their plight has created fertile ground for the emergence of a new trade in lunacy, resembling the private madhouses of eighteenth century England (Parry-Jones, 1972), an industry almost wholly unregulated by the state. (Indeed, in a double sense, the state can hardly *afford* to regulate this industry in anything but a cosmetic fashion: a serious attempt at regulation would demand the commitment of substantial resources; and if any state attempted to insist on adequate standards of care, given current reimbursement levels, it would simply dry up the supply of beds.) Since the income of those speculating in this species of human misery is almost wholly inelastic (being fixed by the welfare payments that are their "clients' " principal source of income) profits are strictly dependent on paring costs. With the volume of profit inversely proportional to the amount expended on the inmates, the logic of the marketplace ensures that the operators of the board and care homes, the nursing homes, and the "welfare" hotels (which now form the primary locus of care for the seriously psychiatrically disabled in our society) have every incentive to warehouse their charges as cheaply as possible. It ill behooves us to protest if such places subsequently turn out to be a poor alternative to living; or to express surprise that decarceration "has not succeeded in ameliorating precisely those alleged results of institutionalization that [supposedly] led to it: the sociocultural and interpersonal isolation, degeneration and stigmatization of patients; the assymetrical [sic] dependency and vast power differences between patients and non-patients; the encouragement of chronicity contained in the treatment system and related social policies" (Estroff, 1981, pp. 116–117).

Prospects for the Future

That the new programs marked, not a humanitarian reform, but "the demise of state responsibility for the seriously mentally ill and [a] crisis of abandonment" (Gruenberg and Archer, 1979, p. 458) was already apparent to many as the seventies drew to a close. Reaganite callousness and fiscal conservatism has, of course, subsequently made a terrible situation worse. Chronicity has always implied indigence, and in modern capitalist societies necessarily prompts reliance on the public sector. But the state welfare apparatus is a demoralized, disorganized, fragmented, and increasingly underfinanced entity, beyond all question incapable of responding in any adequate fashion to the need. And even in the "kinder, gentler America" we now allegedly occupy, run by a Republican administration that displays a somewhat less visceral ideological hostility to the unfortunate, the realities of the budgetary catastrophe Reagan has left for his successor largely preclude the possibility of serious initiatives to palliate the situation.

And here, it seems to me, is the nub of the problem we confront. Those

who speak of "fostering useful knowledge about what to do with/for the chronically mentally ill" [the title of a recent NIMH sponsored conference held at UCLA] invoke a rational model of policy formation at odds with what we know of the real world: if only we can foster some useful knowledge, the research community suggests, the situation of the chronically crazy (or whomever) can be expected to improve – a comforting notion for academic researchers. But the reasons for our current difficulties lie only partially, *very* partially, in the shortage of good ideas or workable programs. More seriously, one must question whether the issue of adequately responsive care for the seriously mentally ill is ever likely to have sufficient crowd appeal to stand out from the throng of supplicants seeking to feed at the public trough.

Let me itemize some of the difficulties: even the most compassionate and dedicated psychiatrists are now close to despair, and many of them have already joined the exodus of their less scrupulous colleagues to the greener pastures provided by less disturbed patients with private insurance coverage. Work with the chronically crazy is not only poorly paid, frustrating, and all-too-often lacking in intrinsic rewards, it is also professionally *declassé* and stigmatized. Chronic schizophrenics are mostly an unattractive lot, statistically unlikely to become more than marginally contributing members of society even under the best of circumstances. In a large fraction of the population, their condition attracts fear, loathing, and hostility, and such sympathy as their plight evokes scarcely weighs heavily enough in the balance sheet to offset the liability their persistent and permanent dependency represents in the competition for scarce resources. Perhaps their families can form a more effective lobbying group on their behalf. Certainly, in recent years, such family lobbies as the *National Alliance for the Mentally Ill* have been acquiring a growing measure of influence, helping to set research and practice agendas for the mental health bureaucracy. But here, too, the difficulties are great: the interest of the families and the psychotic by no means entirely coincide, and one must therefore have real concerns about the biases family activists may introduce into public policy-making. Nor is it clear that such activist groups are even broadly representative of the constituency they most obviously seem to represent. Given the social ecology of mental illness, many of the families of patients have few political or organizational skills and are unlikely to join such lobbying efforts; for others, the sheer burdens of coping with a mentally disabled or hallucinating relation are often such as to preclude public action; and the stigma attached to mental illness remains so strong that still others are reluctant to draw public attention to its presence in their family.

Biological psychiatry, as always, promises us that a medical solution is almost within our grasp. It would be nice if one could believe it. I fear one might as well be waiting for Godot. After almost two centuries of medical assurances on this front, psychiatrists' credibility ought to be wearing rather thin. Aside

from its role as the monopolistic provider of the ambiguous blessings of psychopharmacology (a form of intervention whose iatrogenic effects are the subject of increasingly worried commentaries in the professional literature), psychiatry makes only marginal contributions to the management of the chronically crazy. The illusion that curative care is available, or on the brink of becoming available, serves to distract us from recognizing the essential irrelevance of expensive medical personnel when it comes to the provision of the supportive social care most mental patients need.

Meanwhile, the overall budgetary situation is close to calamitous, so that serious new initiatives on any number of politically *attractive* fronts are having a hard time securing a hearing. Chronic mental patients have never ranked very highly in political beauty contests. Their poverty, persistent dependency, and the seemingly ineradicable stigma attached to their condition combine to send them to the back of the queue, needy but essentially friendless. The sidewalk psychotic may be esthetically offensive to the sensibilities of the more fortunate, destructive of some of the remaining civilities of urban existence, and occasionally a real threat to the economic or physical well-being of the community as a whole. The mentally disturbed hidden from view in more domestic surroundings may impose all-but-intolerable burdens on family members. But neither set of problems seems acute or threatening enough to prompt collective responses proportional to the gravity of the need.

I think the parable for our times is the NIMH Community Support Program. An initiative designed to damp down the rising public clamor about the deficiencies of deinstitutionalization, this program was allegedly a response to the problem of how to deliver improved services to the chronically mentally ill. In the first seven years of its existence, it disposed of the munificent total of some 34.4 million dollars for the entire country. If one may judge by the number of large scale projects devoted to monitoring its progress,[2] expenditures to *study* the program must not fall all that far short of the money used to fund it. Yet as a fig leaf for the failures of public policy, the Community Support Program is so tiny as to leave the obscenity of our current circumstances in full view.

References

Alper, B. (1973). Foreword. In Y. Bakal (Ed.), *Closing correctional institutions* (pp. vii-x). Lexington, Massachusetts: Lexington Books.

Aviram, U., Syme, S.L., and Cohen, J. B. (1976). The effects of policies and programs on reduction of mental hospitalization. *Social Science and Medicine, 10,* 571–577.

Belknap, I. (1956). *Human problems of a state mental hospital.* New York: McGraw-Hill.

[2]I know of two of these in California alone, both absorbing large amounts of highly trained (and very expensive) professional labor: at UCLA, under the supervision of Dr. Oscar Grusky, and at Stanford University, run by Dr. W. Richard Scott.

Bock, A.W. (1933). Psychiatry in private practice. *New England Journal of Medicine, 208,* 1092–1094.
Deutsch, A. (1973). *The shame of the states.* New York: Arno. (originally published in 1948)
Dwyer, E. (1987). *Homes for the mad: Life inside two nineteenth century asylums.* New Brunswick, New Jersey: Rutgers University Press.
Estroff, S. (1981). Deinstitutionalization: A socio-cultural analysis. *Journal of Social Issues, 37,* 116–132.
Goffman, E. (1961). *Asylums: Essays on the social situation of mental patients and other inmates.* Garden City, New York: Doubleday.
Granville, J.M. (1877a). *The care and cure of the insane* (Volume 1). London: Harwicke and Bogue.
Granville, J.M. (1877b). Testimony before the *House of Commons Select Committee on the Operation of the Lunacy Law, 1877.*
Grob, G. (1983). *Mental illness and American society, 1875–1940.* Princeton: Princeton University Press.
Gronfein, W. (1983). *From madhouse to main street: The changing place of mental illness in post World War II America.* Unpublished doctoral dissertation, SUNY Stony Brook.
Gronfein, W. (1985). Psychotropic drugs and the origins of deinstitutionalization. *Social Problems, 32,* 437–454.
Gruenberg, E., and Archer, J. (1979). Abandonment of responsibility for the seriously mentally ill. *Millbank Memorial Fund Quarterly, 57,* 485–506.
Langsley, D.G. (1980). The community mental health center: Does it treat patients? *Hospital and Community Psychiatry, 31,* 815–819.
Lerman, P. (1982). *Deinstitutionalization and the welfare state.* New Brunswick, New Jersey: Rutgers University Press.
Massachusetts State Board of Charities. (1867). *Annual Report* (Volume 4).
Maudsley, H. (1871). *The physiology and pathology of mind.* New York: Appleton.
Mitchell, S.W. (1894). *Address before the Medico-Psychological Association.* Philadelphia.
Parry-Jones, W. (1972). *The trade in lunacy.* London: Routledge and Kegan Paul.
Report of the Metropolitan Commissioners in Lunacy for 1844. (1844). London.
Scull, A. (1979). *Museums of madness: The social organization of insanity in nineteenth century England.* London: Allen Lane; New York: St. Martin's Press.
Scull, A. (1984). *Decarceration: Community treatment and the deviant: A radical view* (2nd edition). New Brunswick, New Jersey: Rutgers University Press.
Wright, F.L., Jr. (1947). *Out of sight, out of mind.* Philadelphia: National Mental Health Foundation.