

# The Historical Basis for State and Local Discretion Over the Treatment of Serious Mental Illness and the Consequences of its Erosion

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Historically, state and local governments have held primary responsibility for caring for those with mental illness who cannot care for themselves. State and local governments have had broad discretion in determining the modality and intensity of care or treatment for mental illness, as well as the venue in which that care happens. Given that treatment of mental illness is not and has never been a precise science, this discretion has allowed for the care of individuals with mental illness to evolve with emerging scientific understandings of mental illness, innovation of treatments and medications, fiscal cycles, staffing shortages due to world wars, and social mores (Taylor 2009; Harrington 2019; Insel 2022).

In the latter half of the Twentieth Century, the responsibility and discretion afforded to state and local governments over the treatment of mental illness was eroded by the federal government. But at the same time as the federal government undermined the authority of state and local governments, federal agencies themselves failed to assert primary responsibility for the treatment of mental illness. As a result of these impositions by Congress and federal agencies, state and local governments have been left with inadequate latitude to effectively address the challenges of mental illness in their communities.

## **Emergence of State Responsibility Over Mental Illness**

Psychiatric institutions emerged out of a genuine need for intensive, residential respite for mentally ill individuals who were not adequately cared for while living within early American communities. The first American public psychiatric institution, the Publick Hospital for Persons of Insane and Disordered Mind, predates the American Revolution. The decision of the Virginia House of Burgesses to use public funds to build and maintain a hospital for people with mental illness is exceptional in its assertion of the public's responsibility to care for those who cannot care for themselves. Francis Fauquier, lieutenant governor of the colony of Virginia, implored the House of Burgesses to take up the plight of "a poor unhappy set of People who are deprived of their senses and wander about the Country" (Journal of the House of Burgesses, November 6, 1766). "Confinement and proper Provision" for those "who cannot help themselves," he insisted, was the civilized and humane course of action for the colony's government (Journal of the House of Burgesses, November 6, 1766).

The condition of mentally ill Americans was severe. Individuals with mental illness were highly stigmatized and seen as potentially demonic, or simply as nuisances unworthy of public care or the few, rudimentary clinical interventions existed (George et al 2023). Families were seen as the principal caretakers of people with mental illness, even into adulthood. Those without families or who were too unruly to be confined in the home wandered transiently, as Fauquier warned, or were incarcerated in public jails via a court proceeding that involved a jury rather than the diagnosis of a physician (McClellan 2014).

Institutions like the Publick Hospital were created to address the problem of neglecting mentally ill individuals into homelessness and incarceration—problems that are once again endemic to mentally ill people today following the dismantlement of those very institutions over the last several decades.

By 1890, every state legislature provided public funds to support the care of its mentally disordered residents in asylums (George et al 2023).

## **Discretion Afforded to States Fosters Early Treatment Innovations**

The emergence of such institutions was also the result of new philosophies of how to care for those with mental illness and new theories about what caused such illnesses—the first of many examples of treatments evolving in parallel with changes in clinical and social understandings of mental illness. Early forms of psychiatric care focused on creating comfortable, low-stimulation environments in which a mentally disordered individual might find stability and rest (George et al 2023). These “asylums” were designed to be refuges from the realities of living in a modernizing community. Community-based care was anathema, in the asylum framework, largely because the stresses of communities were seen as the very root of the illness itself.

To those who endorsed the asylum model, these therapeutic environments “metamorphose[d]” patients through their architecture, grounds, and daily rhythm of work and recreation (Harrington 2019). The asylum itself was the cure to mental illness.

As physicians developed new understandings of mental illness worldwide, America’s psychiatric institutions evolved and incorporated new types of treatment. The central goal of psychiatric institutions remained, as Virginia’s Fauquier implored in 1766, “to endeavor to restore to them their lost Reason” (Journal of the House of Burgesses, November 6, 1766). Yet, these institutions often fell short of that goal because of the shortfall of space and staffing compared to the number of individuals committed to their care (Roth 2020). After answering the initial call to serve the needs of the indigent mentally ill, many state and local governments neglected to maintain parity between public funding and the number of individuals committed to the care of psychiatric institutions (George et al 2023).

Where the original asylum concept was intended to provide treatment through its therapeutic milieu, many institutions became so crowded and under resourced that their environmental influence on patients was far more deleterious than salubrious (Roth 2018). Without the option of treating patients through environmental therapy, superintendents turned to clinical interventions to attempt to treat their patients, or at least maintain order within their overwhelmed facilities. The superintendents embraced new experimental medical practices from Europe, such as bathing and wrapping patients in extremely hot or cold water (George et al 2023). Many of these practices tormented patients, even if they were the equivalent of “evidence-based practices” of their time.

# States Adapt and Reform as Client Populations Evolve

In response to the dire conditions in overcrowded asylums and the resignation towards the curing of mental illness that such institutions represented, a new movement emerged in the early Twentieth Century. Supporters of “mental hygiene” saw mental illnesses as pathologies that could be treated through a combination of emerging medical and psychotherapeutic interventions. In this paradigm, mental disorders could be prevented and treated like any other illness, and treatment, like with other illnesses, should be carried out in specialized hospitals—mental hospitals (Harrington 2019; George et al 2023).

The medicalization of the asylum system was accomplished through the professionalization of psychiatry among physicians in concert with political pressure on state legislatures to centralize administration of asylums and turn over control from non-medically trained superintendents to physicians (Harrington 2019; George et al 2023). State legislatures codified these sweeping changes into public policy and converted public asylums into public mental hospitals.

These mental hospitals were intended to cure mental illnesses, rather than provide long-term custodial care. But the hospitals were typically just adapted versions of the previous asylums. While nurses and physicians were more numerous in mental hospitals than in asylums, they remained in the minority of the staff through the first half of the Twentieth Century (Taylor 2009).

Staffing ratios worsened as localities utilized expansive commitment procedures to offload populations that they had historically cared for to the state-funded mental hospitals. Most notably, elderly patients suffering from various forms of cognitive decline were transferred from local almshouses to mental hospitals (George et al 2023). These geriatric patients were permanently impaired, which conflicted with the original recovery-orientation of mental hospitals.

Other patient subpopulations also faced little prospect of recovering from their illnesses. By the end of the Nineteenth Century, as many as 14 percent of Americans living in urban areas had contracted syphilis (Tramont 2004). Approximately one in four of those infected developed chronic symptoms that caused severe neurological damage, which often presented symptomatically similar to serious mental illness (Tramont 2004). In many mental hospitals, between 10 and 20 percent of their admissions were tertiary syphilis patients. While the antibiotic Salvarsan was released in 1912 to treat earlier stages of syphilis, preventing many new cases of tertiary syphilis, it provided no relief to those already suffering the most advanced stages of the disease.

The optimism around prevention, treatment, and recovery faded as many of the promises of the mental hygiene movement remained unfulfilled and state mental hospitals saw their populations more than triple over the first decades of the Twentieth Century (George et al 2023).

# War Mobilization and Conscription Creates New Challenges for State Hospitals

At the outbreak of World War II, America's mental hospitals were already in critical condition. Overcrowded with patients, many of whom were irrecoverable either due to the nature of their illness or their age and senility, state mental hospital systems contained hundreds of thousands of patients nationwide (Taylor 2009). Often located on the remote sites of past asylums, state hospitals struggled to recruit and retain psychiatrists, nurses, and other staff (Taylor 2009). Following the entrance of the United States into the war, many staff at state mental hospitals either joined the war effort voluntary or were conscripted into the military (Taylor 2009). Overcrowding that had created unsafe staffing ratios in the hospitals were made unconscionably worse by the war mobilization. A single attendant on duty could be responsible for as many as 140 patients (Taylor 2009).

To alleviate the staffing crisis, the Civilian Public Service (CPS)—a partnership between the Selective Service and several pacifist churches that allowed alternate national service for conscientious objectors to conscription—allocated units to several state hospitals (Taylor 2009). Between 1942 and 1947, more than 1,500 conscientious objectors filled in as staff at dozens of state mental hospitals around the country (Taylor 2009).

These men provided crucial relief to state mental hospitals. But they also became the most vocal critics of the conditions they witnessed in the state hospital systems (Taylor 2009). These conditions were due, in part, to longstanding defects in the system, but the CPS units also entered state hospitals when more than half of their staff had mobilized for war, making bad conditions much worse (Taylor 2009; Torrey 2014). Moreover, hospitals that were already in dated condition forwent maintenance and repair as labor and resources were diverted towards mobilization (Taylor 2009).

The public criticism voiced by CPS staff garnered the attention of former First Lady Eleanor Roosevelt and national media, creating immense political pressure for states to reform their hospitals (Taylor 2009; Torrey 2014). States created new standards and training for hospital staff and invested in improvements to facilities (Taylor 2009; Torrey 2014). Federally, President Truman signed the National Mental Health Act in 1946, creating the National Institute of Mental Health and tasking it with researching further improvements.

Conditions in state hospitals improved considerably over the next half-decade, with several states more than doubling their appropriations for building upgrades, staffing, and care (Taylor 2009; Torrey 2014). States adopted standards for use of restraints and staffing levels. While plenty of hospitals remained in need of investment and reform, advocates had many examples of success to which they could point (Taylor 2009; Torrey 2014).

# States Embrace Post-War Reforms and New Innovations in Treatment

The post-war period saw the introduction of several new treatment modalities. Electroconvulsive therapy, developed by Italian researchers, was particularly effective with patients suffering from severe, chronic depression, and remains in use today (Harrington 2019). Surgical interventions, such as prefrontal leukotomies and transorbital lobotomies, held a great deal of promise at the time for the sickest patients, though the side effects of the blunt procedures were sometimes worse than the original illness (Harrington 2019). Approximately 40,000 surgeries were performed in the U.S., out of over 500,000 mental hospital patients nationwide, mostly between 1949 and 1952 (March and Geloso 2020). An evolved and much more precise version of psychosurgery is still used today, but only with strict ethical reviews and patient consent (Rosenfeld and Lloyd 1999).

Other medical developments dramatically improved the quality of care in mental hospitals and began to alleviate overcrowding that persisted even after state legislatures made new investments. The antibiotic Penicillin, released to the American public in 1945, proved extremely effective against even the most advanced forms of syphilis, helping tertiary syphilis patients recover and leave institutions for the first time (Tramont 2004; Harrington 2019). In 1954, the Food and Drug Administration approved chlorpromazine for psychiatric use in the treatment of serious mental illnesses like schizophrenia (Torrey 2014; Harrington 2019). Marketed as a chemical alternative to lobotomies, state mental hospital administrators quickly adopted use of the drug to release patients with milder forms of schizophrenia, strong family support, and a high likelihood of compliance with medication (Torrey 2014; Harrington 2019). Psychosurgeries fell out of practice except in the most serious cases (Harrington 2019).

For the first time in a century, the number of people cared for in state mental hospitals declined in 1956 (Torrey 2014). Yet, states mental hospital systems retained discretion over which patients were well and compliant enough with their medication to be released from institutional care. With this balance of improved treatment options and clinical discretion over the proper venue for specific patients to receive care, state mental hospital systems appeared to be on the right track.

# Federal Agencies Craft Plans to Reform Mental Health Treatment Nationwide

The biggest shift in public policy nationwide followed the groundwork laid by the National Mental Health Act (1946). With President Truman's signature, the National Mental Health Act entered the federal government into the arena of mental health policy for the first time (Torrey 2014). Tasked with researching recommendations for improvements to mental health policy, the National Institute of Mental Health (NIMH) became a powerful force in favor of the federalization of mental health services (Torrey 2014). Robert Felix, the first director of

the NIMH and a critic of mental hospitals, successfully lobbied Congress to authorize NIMH grantmaking not only for research but also for provision of services, overcoming objections from Senator Robert A. Taft (R-OH) and Representative Clarence J. Brown (R-OH) that such grantmaking was an overexertion of federal authority in a domain historically in the purview of state and local governments (Torrey 2014).

Between 1948 and 1960, the NIMH's budget grew from \$2.1 million to \$67.5 million, funding research, education and advocacy efforts, as well as grants to community clinics for mental health—but notably no grants were intended for state mental hospitals (Torrey 2014). Over that same period, state and local funding for community-based psychiatric care followed suit, increasing from \$10 million to \$80 million, while funding for state hospitals declined slightly to \$927 million in line with declines in patient populations (Gorman 1961). As a whole, mental health care averaged approximately 6 percent of state budgets nationwide (Gorman 1961).

The Joint Commission on Mental Illness and Health, created by Congress through the Mental Health Study Act (1955), echoed the NIMH's support for federal intervention on mental health policy (Torrey 2014). The Joint Commission released its final report, *Action for Mental Health*, in 1961. Its indictment of the state mental hospital system was clear:

“It is self-evident that the States for the most part have defaulted on adequate care for the mentally ill... Federal aid will be needed, in large sums... the Federal government should be prepared to assume a major responsibility for the mentally ill insofar as the States are agreeable to surrendering it” (*Action for Mental Health* 1961).

Yet, the Joint Commission was still sympathetic to the role of state legislatures in determining the right direction for their states. In an address to the National Governors' Conference in 1961, Mike Gorman, a member of the Joint Commission, saw the role of federal funding as providing “incentives” to states to adopt preferable policies, rather than mandating certain changes (Gorman 1961). While community treatment was at the core of the *Action for Mental Health* recommendations, Gorman spoke positively of the well-funded, treatment-oriented veterans' mental hospital system as a model for the future of state mental hospitals (Gorman 1961).

## **Federal Agencies Question the Role of State Governments in Mental Health Policy**

Officials at the NIMH were less certain of the need for state mental hospitals at all. NIMH director Felix predicted, “public mental hospitals as we know them today can disappear in 25 years... all the various types of emotionally disturbed patients can be handled in the community” (Torrey 2014).

One of the most famous NIMH-funded research projects was conducted by sociologist Erving Goffman and culminated in the publication of *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*, also in 1961. Goffman's research questioned the medical

basis of psychiatric institutions and argued that such institutions socially conditioned patients to appear psychotic rather than responding to genuine psychiatric symptoms (Goffman 1961). Goffman's sweeping conclusions were based on research in one hospital and were not compared to similar research among seriously mentally ill individuals living in the community. Goffman's research heavily influenced the agenda of the NIMH as well as academic researchers and philosophers who took a growing interest in delegitimizing America's psychiatric hospital system (Torrey 2014; Harrington 2019).

Another notable NIMH-funded study conducted in 1961 examined the impact of phenothiazine on 344 schizophrenic patients across nine hospitals, concluding that three-quarters of patients improved significantly compared to the control group (Guttmacher 1964). While phenothiazines, such as chlorpromazine, were already used by many state mental hospitals, the success of this study generated tremendous optimism for their expanded use as a means for depopulating state hospitals and treating schizophrenia in community-based clinics (Torrey 2014; Harrington 2019).

Yet, much like Goffman's NIMH-funded research, the trial did not study mental illness or its treatment in the community. The success of a medication delivered in an institutional setting does not necessarily assure success in community-based clinics where the patient's environmental factors may vary considerably, and medication compliance is far less consistent. The limitations of such medications were confirmed in a follow-up study by the same NIMH investigators, which found that patients who received phenothiazines were re-hospitalized at higher rates than the control group (Schooler et al 1967).

Other studies outside the purview of the NIMH raised similar concerns. Brill and Patton (1962) found that readmissions to New York State mental hospitals increased by 50 percent following the discharge of patients using phenothiazines.

Neither the Joint Commission nor the NIMH could produce research from the United States that defended their insistence on community-based care for the seriously mentally ill, whether through pharmaceutical treatment or psychotherapy (Torrey 2014).

## **Congress Creates Parallel Federal Mental Health Care System**

Despite the limited evidence for community-based mental health care for serious mental illness, such policies formed the entirety of the federal mental health plan recommended to Congress by the NIMH and Joint Commission. As Congress debated the plan, state officials raised concerns about the limitations of community-based care and the federal government's involvement in mental health policy. Dr. Paul Hoch, commissioner of the New York Department of Mental Hygiene, warned Senator Jacob Javits (R-NY) that the federal plan did not adequately accommodate differences between state hospitals systems and client populations, nor did it integrate into his state's existing continuum of care (Hoch 1963).

Contrary to Gorman's state-centered proposal to the National Governors' Conference in 1961, the federal Community Mental Health Act (1963) created a pool of funds that were open to non-profit entities as well as public agencies. As a result, the Community Mental Health Act (1963) created a siloed system of care that rarely coordinated with state mental hospital systems (Torrey 1988; Torrey 2014). The regulations for federally funded community mental health centers (CMHC) did not even reference state mental health hospitals (Torrey 2014).

Between 1966 and 1980, 789 community mental health centers were created nationwide, with \$2.7 billion in federal funding (Torrey 2014). Other new federal programs created additional incentives for states to release patients from state mental hospitals even as the federal system for community mental health centers failed in their principal purpose to provide care to that population. In 1965, Congress amended the Social Security Act to create Medicare and Medicaid, the latter of which sought to exclude seriously mentally ill people from receiving benefits while institutionalized through the Institute of Mental Diseases exclusion. This exclusion, however, perversely incentivized states to release patients from state mental hospitals, where the full cost burden rested on state budgets, and provide care in community mental health centers, which benefitted from both Community Mental Health Act funding and federal Medicaid subsidies (Torrey 1988; Torrey 2014).

Yet, few of these centers primarily treated patients with serious mental illness who had been discharged from state hospitals. The NIMH reported that between 1968 and 1978, only between 3.6 percent and 6.5 percent of patients at CMHCs had been discharged from a state hospital (Torrey 2014). Throughout the 1970s, the proportion of CMHC patients treated for schizophrenia never reached even 20 percent at its height, and at its lowest was 10 percent (Torrey 1988). Despite CMHC regulations stipulating that centers must provide inpatient and partial hospitalization care, only half of facilities built inpatient beds, and such services accounted for less than 6 percent of offered programs (Torrey 1988). By 1976, NIMH research on the implementation of CMHCs concluded that few CMHCs coordinated with state hospitals to care for discharged seriously mentally ill patients, and CMHC directors ranked such coordination as the least important goal of their centers (Windle and Scully 1976).

## **State Mental Hospitals Improve While Federal Community Care Fails**

By 1981, states had shuttered 432,633 mental hospital beds nationwide since 1955 (Torrey 2014). Those who remained in state mental hospitals received far better care than ever before. For example, New York's mental hospital system reduced its patient population from 94,000 to 24,000, while increasing its staffing from 24,000 to 37,000 over the same period (Torrey 1988). Nationwide, state hospital spending only declined 3 percent between 1969 and 1981 (Torrey 1988). In 1986, 41 percent of mental health care spending remained focused on inpatient care (Roth 2018). Patients also benefited from federally sanctioned oversight of their conditions of care through the Protection and Advocacy for Mentally Ill Individuals Act (1986). Congress empowered state-level protection and advocacy programs to investigate and remedy cases of abuse and neglect in state mental hospitals and other settings.

For those patients who had been released into the community without proper aftercare by Community Mental Health Centers, the situation was far worse. Bahr (1973) and Rossi (1989), in their studies of homelessness, noted the increasing presence of seriously mentally ill individuals among homeless populations that were historically dominated by alcoholics. While homeless mentally ill individuals were eligible for many state and federal financial and health care in the community, they often struggled to navigate the administration of those benefits due to their illness, whether it was treated or untreated (Rossi 1989). Tens of thousands of others were incarcerated in jails and prisons, with 6.4 percent of inmates suffering from untreated serious mental illness by 1983, compared to an estimated less than two percent prior to deinstitutionalization (Torrey et al 2010). In California, a study of a cohort of patients released from Napa State Hospital found that 41 percent of them had been arrested within three years (Torrey 2014). In Philadelphia, between 1975 and 1979, police responses to incidents related to mental illness increased 227 percent compared to an increase of only 5 percent for felony-related crime (Torrey 2014).

With unprecedented emphasis on community-based care and greater flexibility for states on how to use federal community mental health funding following reforms in 1981, state mental hospital systems focused their care on only the most seriously ill patients (Torrey 2014).

## **Congress Restricts State Discretion Over Treatment of Mental Illness**

Following Congress's passage of the Americans with Disabilities Act (1990), the Department of Justice issued rules in 1992 that dramatically altered the discretion afforded to state mental hospital systems over who could remain in their care. The new regulations, specifically 28 CFR § 35.130(d), imposed a mandate on state services, including mental hospitals, to provide care in the most integrated setting appropriate to the needs of an individual. Under these regulations, state mental health systems struggled to retain clinical discretion over providing care in institutional settings.

After 28 CFR § 35.130(d) took effect, federally funded protection and advocacy for individuals with mental illness (PAIMI) organizations began to reference the new regulation in letters to state mental hospitals demanding the release of certain patients (Ehrlich 2018). In several cases, PAIMIs initiated or joined lawsuits against state mental hospitals. Citing 28 CFR § 35.130(d), Disability Law Project sued the state of Pennsylvania in *Helen v. DiDario* (1995) and Disability Law Center sued the state of Maryland in *Williams v. Wasserman* (1998). According to reports by the Substance Abuse and Mental Health Services Administration, approximately 30 percent of PAIMI activities were focused on civil rights violations under the ADA rules by 1997 (Substance Abuse and Mental health Services Administration 2011).

Following the Supreme Court of the United States' ruling in *Olmstead v. L.C.* (1999), PAIMI organizations reported for the first time a greater percentage of civil rights complaints than either abuse or neglect complaints among their clients in 1999 (Substance Abuse and Mental health Services Administration 2011). By 2004, more than two-thirds of the workload of PAIMI organizations focused on civil rights complaints, and the number of clients they served nationwide grew by 31 percent (Substance Abuse and Mental health Services Administration 2011).

State mental hospital systems struggled to respond to the pressure created by threats of federal litigation. State spending on inpatient mental health care collapsed, falling from 41 percent to 17 percent of mental health budgets between 1986 and 2009 (Roth 2018). By 2000, 44 state hospitals were closed in the previous decade alone, permanently removing 40,000 hospital beds that had served the most seriously mentally ill and difficult to manage patients (Torrey 2014). These individuals, now in the community with as little support as prior discharges but with even higher needs, rarely succeeded. The individuals released in the later stages of deinstitutionalization were far more likely to end up in prison than those in prior stages (Raphael and Stoll 2013). The proportion of state prisoners reporting symptoms of psychosis climbed above 10 percent along with 16 percent of people in jail by the early 2000s (James and Glaze 2006; Steadman et al 2009). By 2000, between 40,000 and 72,000 people were incarcerated who would have likely received inpatient care in a state mental hospital prior to the later stages of deinstitutionalization (Raphael and Stoll 2013).

Others were simply left on the street. In 2005, the U.S. Department of Housing and Urban Development reported 132,000 homeless individuals with serious mental illness, of which 51,633 lived outside (HUD 2005).

Over the decades following *Olmstead*, state mental hospital systems continued to close beds and allocate a growing proportion of beds to forensic patients who are in the criminal justice system but need mental health care to face trial. Only 20,000 state mental hospital beds remained for non-forensic patients by 2016, compared to 50,000 in 2005 (Fuller et al 2016).

Without access to necessary care in mental hospitals, mentally ill individuals continue to suffer. The number of mentally ill people living outside climbed by 30 percent between 2005 and the latest U.S. Department of Housing and Urban Development report from 2024 (HUD 2024).

## Restoring State Discretion Over Mental Illness

States created psychiatric institutions to address the plight of mentally ill people living on the streets or in prisons without humane, dignified care. Throughout their history, many mental hospitals fell short of Francis Fauquier's optimistic vision of facilities that provide "proper Provision" for those "who cannot help themselves" (Journal of the House of Burgesses, November 6, 1766). But today, states have long since achieved that optimistic vision. States cannot, however, utilize these facilities to their full potential because of federal policies that have unduly excised the discretion of state mental health systems to care for individuals who now, like in the colonial era that catalyzed the creation of the first mental hospital, live "deprived of their senses and wander about the Country" (Journal of the House of Burgesses, November 6, 1766).

Psychiatric institutions emerged out of a genuine need for intensive, residential respite for mentally ill individuals who were not adequately cared for while living within early American communities. Today, that same need remains as dire as ever.

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