

THE DEVELOPMENT OF COMMUNITY
BASED SERVICES IN MINNESOTA

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This report completes the first phase of an analysis of state and federal initiatives related to 'community-based services'. The ongoing efforts by the State Planning Agency in this subject area attempt to understand and describe major trends in human services planning, administration and delivery in Minnesota. It is anticipated that these analyses will assist state policy makers, i.e., the governor, legislators, agency heads and program directors, in their responsibilities for directing state activities.

Phase I was directed toward refining definitions and the underlying research and concepts embraced by the several alternatives to institutions. In Minnesota, the responsibility for administering institutions and developing alternatives resides primarily with the Departments of Public Welfare and Corrections. In the following phases, client and budget information, and administrative and methodology arrangements conducive to increased effectiveness of 'community-based services' delivered to Minnesota citizens will be studied.

Human Resources Planning Unit

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I. Introduction

This project of the State Planning Agency represents the first phase of an analysis of State funded activities referred to as "community-based services." The primary focus throughout the project has been on interpreting definitions and clarifying concepts.

Terms used in describing the activities were identified, and subsequent definitions of the terms were sought. Through an analysis of the definitions, the concepts being expressed were derived. Finally, the concepts themselves were analyzed and synthesized.

The project began with a review of State plans, budgets, and reports available within the State Planning Agency. This initial review served both as an introduction to State funded and regulated programs, and as a source of minimal preparation for the interviews conducted with staff members of twelve State departments, commissions, and councils.

The interviews focused on determining: 1) the role of the staff member's agency in the State human service delivery system; 2) the meaning of the term "community-based service" within the context of that agency; 3) the extent to which the agency was involved with "community-based services;" 4) the availability of literature on definitions and concepts; and 5) the availability of research on effectiveness.

The interviews revealed that little research had been done at the State level on "community-based services," at either a conceptual or operational level. In addition, the few definitions available through State or Federal sources proved incomplete or inappropriate for the purpose of this study.

Attention was next directed toward a survey of academic and professional literature, particularly within the fields of sociology and anthropology. The literature was approached through a key word search of abstracts. Although the literature search could not be viewed as exhaustive, it was extensive.

The inability to find definitions of the generic term "community-based service" compelled an examination of those more basic words imbedded in it, as well as terms and concepts known to be used in close relation to it. An understanding of the words "service" and "community" was sought since they help make up the term. An understanding of the term "institution" was sought as it is the basic word involved with the concept of "deinstitutionalization," something which was known to be used in close association with "community-based service."

Definitions of the terms "service" and "human services" were also attempted because they are fundamental to the language of State funded and regulated activities. It was hoped that such definitions would be of use to future analyses of the range of activities called "human services," as well as to be helpful in understanding the term "community-based service."

Throughout this report, the products of the analysis will be presented.

II. Definition of "Service"

"Service" is defined as an activity performed usually by a specially trained person providing another person with resources necessary to accomplish a task or satisfy a need.

"Service" is a commonly used but ambiguous term, which the study attempted to define across all fields through a survey of professional and academic literature, public documents, reports, statutes and regulations. The survey, although not exhaustive, was adequate for a study of this nature. In this section the definition is formulated, and a comparison is made with the related terms "program" and "system".

A representative sample of the products of the survey was a report entitled "Summary of the Proposed Allied Services Act of 1972" indicating how the Act defines various key terms. "Services", for instance, is defined as "...services needed to remove barriers to self-care, independent living, and self-support. . . . 'Human services' includes any services provided to achieve or maintain personal and economic independence" (p.1).

This explanation indicates what people the Act will be involved with; namely, those who depend on someone else for their support. But the document does not address what is a "Service?" At some point either the policy drafters or the service agencies implementing the Act will have to address this question. Upon what are they to base this definition? Defining "service as a service that..." only begs the question. Nevertheless, using the same word to describe itself is a common phenomenon in government writings, demonstrating a lack of critical thinking on the part of the authors.

Another attempt to define "services" was gathered from a document entitled "Developmental Disabilities Services and Facilities Construction Act, P.L. 91-517" issued January, 1971 by Rehabilitation Services Administration - Department of Health, Education, and Welfare. The Act focused on services for persons having developmental disabilities. For these people "services" means:

. . . specialized services or special adaptations of generic services directed toward the alleviation of a developmental disability or toward the social, personal, physical, or economic habilitation or rehabilitation of an individual affected by such a disability. The term services includes: diagnosis, evaluation, treatment, personal care, day care, domiciliary care, special living arrangements, training, education, sheltered employment, recreation, counselling, protective and other social and socio-legal services, information and referral, follow-along, transportation.

Once again the phrase "services are services that . . .," does not define the term. In this account there is also found the common tendency to label very broad categories of mixed concepts as services.

Although the document classifies some services as "generic" and some as more "specialized," questions must be raised about equating the concepts of "treatment," "education," "training," and "evaluation" with such divergent terms as "diagnosis," "domiciliary care" or "information and referral." The former terms relate to a vast array of activities that could be performed, whereas the latter are more specific. Furthermore, it is difficult to accept any of these examples as representing "services" without a clearer definition of what that term means.

A list of all social services provided by the Department of Public Welfare reveals the same kind of categorizing and labeling which was used in the Developmental Disabilities Act. Such titles as "Corrections

Services," "Services to the Aging," "Housing Services," "Volunteer Services," and "Mental Retardation Services" are used with seemingly no discretion as to what the term "service" stands for.

A paper by Funke (April, 1968) entitled "Coco Report" addresses the problem of the multiple use of the term "service." It points out that the word is used as a unit of organization such as in State Hospital Services, Public Health Service, or the food service of a hospital. It is also used in another context, which he calls the "program-service" usage. Here "service" is defined as a class of activities. Funke states:

The class is usually based on characteristics of the givers of service -- most often on the basis of profession or specialized training -- or on the characteristics of the recipients of services. Psychological services are the activities ordinarily engaged in by psychologists. "Mental Retardation Services" are services given to persons who are mentally retarded (p.4).

The single distinction Funke's definition makes as to what is a service, is that it is an activity performed by someone who is usually trained in a special way, and there is someone who is acted upon. What in this definition would exclude the activity of an experienced thief from being considered a service? Something is missing from Funke's definition - perhaps something assumed to be understood by the reader.

Referring to The Random House Dictionary (1967), one gets the sense of multi-definitional problems inherent in the word "service." The first meaning recorded refers to "service" as:

. . .an act of helpful activity: 2. the supplying or supplier of utilities or commodities, as water, electricity, gas, required or demanded by the public: 3. the providing or a provider of accommodation and activities required by the public, as maintenance, repair, etc. . . . 13. often services. the performance of any duties or work for another; helpful or professional activity: ex. Medical Services. (p. 1304).

"Helpful" is the qualifying phrase missing from Funke's definition. Perhaps the reason for its exclusion is the ambiguous meaning of the word "helpful." It is an adjectival form of the verb "help" which the same dictionary defines as:

1. to give or provide what is necessary to accomplish a task or satisfy a need; contribute strength or means; render assistance to; cooperate effectively with;
2. to save; rescue; succor;
3. to make easier or less difficult; contribute to; facilitate (p. 650).

Summarily one can speak of "service" to mean an activity offered or performed usually by a specially trained person (or even a specially programmed machine) which provides another person with those resources necessary to accomplish a task or satisfy a need. A priest hearing a troubled man's confession, a vending machine delivering a soda to a thirsty woman, a highway department planning and constructing roads for people who have to move from home to work, a comedian telling jokes, all are examples of service. An experienced thief would not perform a service by stealing someone's valuables.

Acceptance of this formulated definition of "service" brings up a problem of distinguishing the term from two other closely related terms, "program" and "system." According to Funke, the difference between "service" and "program" or "system" is the fact that the latter terms imply an expected outcome. He defines the words this way:

Programming. Programming is the specification and ordering of structures, activities, and events into a goal directed process called a system.

System. A system is a programmed combination of structures, activities, and events.

Program. A program is the written plan for such a system (p.4).

The difference between a service and a program is clear if these definitions are used. "Service" refers to the various activities being performed or offered to meet some need; "program" refers to the established plan bringing activities and structures into a goal directed pattern. The distinction is not clear, however, when needs and goals are loosely distinguished. For instance, at what point should the set of activities performed by specially trained personnel for meeting the needs of mentally retarded persons in adapting to society be called "Mental Retardation Services" or "Mental Retardation Program?" Funke would label the activities a "program" at the point where there is a written plan for coordinating the helping activities toward a goal directed order.

It is difficult to ascertain what there is about a written plan that makes the distinction so definite. It appears appropriate to label any outcome oriented set of helpful activities either a service or a program; although, as the desired outcome is more precisely defined, "program," as stemming from the language of PPBS (Planning, Programming, and Budgeting System), may be preferred.

III. Discussion of "Human Services"

An analytically useful definition of "human services" cannot be formulated, thus suggesting the lack of an accurate conceptualization of the activities being performed.

In analyzing the particular classification of services termed "human services," a document by Siloway and Burd (Nov., 1972) entitled "Human Services of the State of Minnesota," was reviewed. In the preface of the document, the authors state that they could find no specific definition of Human Services, and they did not try to develop one. They do, however, develop criteria for limiting the kinds of activities they were to address. The first criterion is the idea of a clientele who receive some benefit from the activity performed on their behalf. This is a very broad criterion which would require the inclusion of areas such as the formal educational system. Siloway and Burd apparently found the scope too wide for their purposes, so another criterion was formulated, that of Human Services being "remedial." Provision of a remedy implies the existence of an illness, problem, or exception to a norm. The activities of some people represent problems to society or a significant sub-group, and these "problem" people are designated as such according to prevailing norms and standards. The authors state, "We cannot define the set of norms here, but it may be important to do so for policy formulation" (p.2). Linking the two criteria together, the term "Human Services" is perceived by Siloway and Burd to mean: Those activities performed which benefit a clientele and remedy a social problem.

A document prepared by Heaney (Dec., 1972) from the Department of Health, Education, and Welfare, Social and Rehabilitation Service Division, entitled "Glossary of Terms in the Social Services," defines

Human Services as:

Those services provided to individuals or families in need which help them achieve, maintain, or support the highest level of personal independence and economic self-sufficiency, including health, education, manpower, social, vocational rehabilitation, food and nutrition, and housing services (p.30).

A draft of a "Working Definition of Human Services" issued by the Minnesota State Office of Program Development (Jan., 1973) reads:

Human Services are defined as those activities and programs which directly or indirectly enable and encourage people to function viably in society. Some human services seek to permit and to help people develop their abilities and skills to their own highest capacity. Other human services prevent, alleviate, or correct temporary or chronic social and health problems (p.1).

These definitions do not appear to represent accurately or adequately the activities taking place, nor do they make explicit the rationale behind the activities. The lack of analytical value of these definitions can be perceived by using the last two cited to answer three questions: Who is served? What is provided? What is the expected outcome?

1) Who is served? According to Heaney, "individuals or families in need" are served. According to the Office of Program Development, "people" are served. Obviously, qualification is required in both instances. In the first case, all people could be said to be "in need" to some extent, but neither this nor the second definition accurately portrays the fact that certain classifications of people are consistently the target of the services, while others are only minimally involved, and still others are never involved.

2) What is provided? Heaney's definition says help is provided in achieving, maintaining, or supporting the highest level of independence. The types of services listed include health, education, manpower, social, vocational rehabilitation, food and nutrition, and housing. There is a

conspicuous absence of those services called "corrections" from this list, a fact that must be questioned in lieu of the fact that most other sources would include it.

The Office of Program Development definition says some activities and programs are provided which develop people, while others prevent, alleviate, or correct people. As it stands, this part of the definition seems adequate for purposes of a conceptually sound and realistic statement on the activities called "human services."

3) What is the expected outcome? Heaney states that the outcome should be individuals and families who operate at the highest level of personal and financial independence. (The Office of Program Development says the outcome should be people whose skills and abilities are developed to the highest capacity, and people who do not pose a threat to the safety or health of society. Neither statement can be said to reflect the actual outcome of many of the programs and activities in operation, nor is it likely that they reflect the actual expectations of most of the people who fund, formulate, manage, or deliver the services.

For example, Heaney's definition is weakened by the fact that it does not include income maintenance as a human service activity. If included, it would have to be recognized that the outcome of such a service is often maintaining financial dependence on public monies rather than promoting economic self-sufficiency.

The Office of Program Development definition is weakened by the fact that many of the activities which it includes have not been effective in meeting the stated goals. For example, high recidivism rates in corrections indicate that the goals of correcting social problems and encouraging individuals to function viably in society are often not attained.

The point to be made from the preceding criticism is that an analytically useful definition of a term, especially a broad and ambiguous one such as "human services," requires accurate conceptualization of the existing object or state of being. The inability of this search effort to come up with an analytically useful definition of the term suggests that there is not an adequate conceptualization of the activities being referred to as "human services" by anyone involved with such activities.

IV. Analysis of "Community"

Use of the term "community-based service" requires analysis to determine what is meant by "community."

The idea of a base, a headquarters, or a location, is implied in the term "community-based service." It might be read, "services based in the community." This usage leads to the question, what is a "community?"

Finding little useful material from interviews or documents of State agencies, the academic and professional literature of the Social Sciences was reviewed. The literature yields a plethora of definitions of "community" with great volumes of space devoted to discussion of the concept.

Hillery (1955) reported the collection of 94 definitions of "community," and even then he admitted his was not a totally exhaustive search. His study provides an idea of the vast range of definitions for "community," increasing one's awareness of what sociologists and anthropologists mean when they use the term. Out of the 94 definitions, Hillery synthesized 16 different concepts of the term. 22 combinations of the 16 concepts were found which he formulated into classes and subclasses. All except three of the definitions clearly mention the presence of a group of people, a characteristic which he labeled, "social interaction." The three exceptions all were products of what is called an "ecological" orientation, thus he dichotomized these from the other 91. 69 of the 94 are in accord that "community" consists of persons in social interac-

tion within a geographic area having one or more additional common ties.

Kaufman (1959) adheres to the consensus reported in Hillery's collection by listing these elements as basic to the concept:

One, community is a social unit of which space is an integral part; ...community is a place, a relatively small one. Two, community indicates a configuration as to way of life, both as to how people do things and what they want - their institutions and their collective goals. A third notion is that of collective action. Persons in a community should not only be able to, but frequently do act together in the common concerns of life (p.9).

Although there is some difficulty accepting these elements as basic or necessary to delineate a "community," discussion will be deferred until more diverse interpretations are cited.

Sanders (1958) lists what he calls "the setting factors of a community." They include the following:

- 1) ecology -- a community is a territorially organized system co-extensive with a settlement pattern in which a) an effective communication network operates, b) people share common facilities and services distributed within this settlement pattern, and c) develop a psychological identification with the locality symbol - i.e. the name.
- 2) demography -- a community consists of a population of all ages, the younger being prepared to take over the work of the older. Members are recruited through the biological process of birth. The population must possess sufficient technical skills and knowledge to sustain life, either through a self-subsistence level or through specialized production and central market exchange.
- 3) culture -- community welfare is a value in itself and community ends are standards by which competing groups judge and adjudicate their claims. Also, the community achieves a normative integration since the ends of a community are more inclusive than any specific group within the community.

4) personality -- it has its own mechanisms for the socialization of new members and the development of the psychological identification with the locality symbol, i.e. the name,

5) time -- a community persists through time. It takes time to acquire a distinctive culture (p.189).

Sanders' interpretation, like Kaufman's and the majority of sociological-anthropological authors demands the presence of a contiguous geographical area set off by territorial borders, and an interacting people dedicated to the preservation of the products of their interacting. One envisions the figurative representation of a rural, common-ethnic, small-town in America as being the model used by these authors for a community.

Havinghurst and Jansen (1967) make some critical observations regarding the literature on "community" definitions. They claim that using the most frequent or popular elements of Hillery's classification scheme would restrict the field of community study to small groups of people with a simple social structure. They point out that there is value in studying a very large and complex population unit as a community; however, in their bibliographic listing, they exclude studies of large regions or of nations because they claim these units are too large in scope to effectively use existing community research methods. In conclusion to their discussion of various definitions of "community," the authors state:

It is useful to consider a community as a relatively autonomous social system, consisting of economic, educational, religious as well as political systems united in a community complex. Such an autonomous system would have to perform the four functions

called by Parsons: adaptation, goal-attainment, integration, and latent pattern-maintenance and tension management (p.9).

Havinghurst and Jansen are interested in those writings which undertake to provide data necessary for understanding one particular community. What they accept as determining a community does not necessarily represent the total range of possibilities. They point out that "community" could take on a national or international meaning, but they do not pursue this idea; they choose to stop at the point where research methods become limited. For this study's purposes it is valuable to examine more extensive considerations.

There is no reason to omit the consideration of the world as a community. McLuhan (1968) relayed this message in a book entitled War and Peace in the Global Village. More recently, an entire periodical entitled World (July 4, 1972) was established in order to address the issues of human existence on the ever-shrinking planet. The editors write:

The compression of the whole of humanity into a single geographic arena is the signal event of the contemporary era. The central question of that arena is whether the world will become a community or a wasteland, a single habitat or a single battlefield (p.1).

According to Dennis (1968), "community" has been variously conceived of as: a given area; a microcosm of a total social system; a locale of common opinion on topics of common interest; and a place of intensive locality-based social relationships. He claims "community" can no longer be thought of in the

microcosmic-sense, nor is it appropriate to view it as the area of the complete set of institutions. Dennis considers it useful to view it as the site of "locality social intercourse," as the location of a set of common experiences and as the center of locality norms and informal social control mechanisms (p.7).

It appears from Dennis' conception that the very large collection of populations such as megapolices, regions, nations, etc., should not be considered communities. "Community" should be a label restricted to a rather small geographical area in which various commonalities take place in an informal manner. This interpretation is interesting in that it finds something wrong with definitions which would allow large cities, regions, etc...to be considered communities. Dennis thus shapes a set of characteristics which only small areas can fulfill.

A. Interpretation as a Geographical Area

No factually accurate definitions of "community" as a given area can be formulated because human communication has transcended the necessity of physical proximity.

It is evident that the definitions of "community" attempted by many authors vary considerably as to whether it can be a small place, e.g., a small-town or village, or a very large place, e.g., a large city, a region, a nation, or even the world. The entire notion of "community" as a place may be either inadequate or inappropriate. Overall, the word has been used to mean either an area or a social relationship. All the definitions put forth thus far have used areal meanings. One can find no agreed upon or accurately measurable description of this area. Human jurisdictional patterns and social systems have become so complex that only very broad sets of characteristics can be laid down to represent them. The term "community" used as an area has been so diverse in interpretation that its use becomes virtually meaningless for conceptualization, unless its size and make-up is each time specified.

As mentioned above, "community" has also meant a social relationship. The relationship involves a group of people who share something. Various categories of definitions deal with "community" specifically as this kind of relationship. What has been categorized as an ecological perspective was

mentioned by Hawley (1944). He defines community as, "...an adaptive mechanism whereby a population utilizes and maintains itself in its habitat....An organization of interdependencies which constitutes the population a coherent functional entity" (p.398).

Reiss (1957) starts from Hawley's definition in saying that the basic distinguishing characteristic of the community is that it exists by organizing interdependencies. Reiss proceeds to show that, "...Because 'functionally differentiated units' are 'territorially integrated,' even though they often have a common center, there is 'an indefinite periphery or boundary' to the community"(p.18).

Reiss determines that it is impossible to put territorial boundaries around "the community" - something which he still seems to conceive of as a place. This is not consistent with Hawley's described concept of community as a mechanism, but at least Reiss points out that boundaries or limitations cannot be set on "this place."

Warner (1941) stays closer to Hawley's concept when he states:

The word community means a number of people who belong to a social group because of the fact that they share certain behavior, interests, feelings, and also certain objects (p.7).

Seemingly it would be inappropriate for a definition of "community" to be any more specific than that set forth by Warner. It covers the possible conceptualization of the

entire planet, a city, a neighborhood, or a group of Einstein scholars, as a community - but not necessarily any of them. Just as it is impossible to specify how large or small a community is in the areal sense, it is impossible to specify what or how much is shared in the social relationship sense.

B. Interpretation as a Social Relationship

An operational definition of "community" as a social relationship of sharing is the only one which can be presently formulated.

Wirth (1933) wrote a great deal on the concept of community, and although his ideas have been mostly discounted by other social writers (p.5), value can be found in his statement that:

Historically the community has been an expression that emphasized the unity of the common life of a people or of mankind. Even a superficial retrospect, however, reveals that this common life itself has undergone profound changes which have been reflected in changing scientific interests in the community. One of the chief tasks in every human group is that of generating a sense of all belonging together. In the face of the increasing mechanization of living, of national and cultural provincialism, of the more thoroughgoing segmentation of life and the more minute division of labor this task has become, . . . not less necessary but more difficult. In the transition from a type of social organization based on kinship, status, and a crude division of labor, to a type of social organization characterized by rapid technological developments, mobility, the rise of special interest groups, and formal social control, the community has acquired new meaning and has revealed new problems (p. 169 - underlined for emphasis).

This "new meaning" of community is as diverse as the number of authors who have attempted definitions. Realistically speaking, it is useless to try to describe the "community," if indeed it ever was possible. People need not live in close proximity in order to call themselves a "community" by anyone's standards. Take for example Australian farm families who live with such distance from each other that

radio is their most extensive means of interaction. They "visit" each other by radio, they "school" their children by radio, and they call for help in emergencies through the same means.

Wirth quotes the renowned philosopher, John Dewey, as saying:

There is more than a verbal tie between the words common, community, and communication. Men live in a community in virtue of the things which they have in common; and communication is the way in which they come to possess things in common (p.168).

Many authors have documented the phenomenon of man's loss of a sense of community as the modern industrial society develops. Greer (1962) points out that as the scale of society increases there is a widening of the radii of interdependence. Consequently, whether people know it or not, they become mutual means to individual ends. This increase in the scale of society has also meant an increase in the range and content of the communications flow. As a result of these factors, people become exposed to more conflicting norms than in the past. The consequence for the urbanite, says Greer, is individuation and social differentiation. There are no fixed, all-encompassing groups to which he is solely oriented. He is a citizen of many "worlds," with each having only part of his allegiance. At most, the urbanite can be said to live in "...communities of limited liability" (p.10).

Along these lines, Heberle's (1960) analysis of the concept "neighborhood" holds value for the concept of "community." He

states that the sociological problem is: to what extent and under what circumstances do persons inhabiting an area called a "neighborhood" interact socially in the specific ways expected of "neighbors" in the institutional sense.

This "institutional sense" means viewing neighborhood as a small number of people whose dwellings are adjoining and who are dependent on each other for mutual aid in emergencies. Custom prescribes what kind of aid may be expected and assigns definite roles to the occupants of the various dwellings involved. Neighbors are also entitled to share certain joyous or festive events in each other's lives. As the need for mutual aid declines in modern urban and rural locales, the function of the neighborhood tends to become less important. In this vacuum, the sociability aspects tend to predominate. As a consequence, association with one's neighbors becomes essentially a matter of choice (p.12).

The conceptualization of "community" as a distinct area, has been losing its meaning or value as human communication systems have eluded the necessity of proximity. Similarly, as the need for mutual aid declines, the meaning of "community" as a social relationship of sharing is threatened with losing its value. The existence of "community" in either sense of the word, is no longer a matter of necessity, as necessity has been defined so far in human history. Instead, the existence of "community" is becoming a matter of choice.

V. Definition of "Institution"

For the purpose of this study, "institution" is defined as a single setting within which residents engage in scheduled and supervised activities throughout their twenty-four hour day.

A literature search of the meaning of "institution" within the context of State financed and regulated programs was undertaken. The search focused primarily on the concepts of "social institution," "public institution," and "total institution."

Martin (1968), in an article entitled "Social Institutions: A Reformulation of the Concept," summarizes his findings of research on the meaning of the concept of "social institution." Through his review of past usages of the term "institution," he determined that "institutions have generally been defined either in terms of their membership (i.e., particular groups of individuals), in terms of specific behavior patterns or activities, or in terms of particular normative or value systems. Thus, actors, roles, and norms have variously been held as basic components of institutional structure" (p. 100). He cites fourteen different definitions of "social institution" in order to present the general meaning of the term and to illustrate the extent to which specific meanings of the term vary throughout the literature.

The author emphasizes that a clear and current definition of the concept "institution" is lacking. As a result of research, he concludes that there is "an apparent concensus on the general meaning of the term but a

notable lack of agreement on the specific meanings or 'referents' of the concept" (p. 100). Furthermore, he concludes that institution "has steadily come to serve as a catchword, an heuristic device, or a 'primitive term' to be used as a means for generalizing specific research findings to the level of system operations" (p. 100). The primary significance of Martin's research to this study lies not in the broad range of definitions he compiled but in his conclusion that there is a lack of theoretical and operational meaning for the term "social institution."

Based on Martin's findings, the term "social institution" was dismissed as too broad and too ambiguous in meaning to prove helpful in defining the term "institution" as used within State planning and programming. Attention was next directed toward the concepts expressed through the terms "public institution" and "total institution."

Public-Law 92-223, "Intermediate-Care-Facility Patients and Title XIX" defines "institution" as:

an establishment which furnishes (in single or multiple facilities) food and shelter to four or more persons unrelated to the proprietor, and in addition, provides some treatment or services which meet some need beyond the basic provision of food and shelter (p. 3872).

The Act also defines "public institution" as:

an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control (p. 3872).

For the purpose of Federal financial participation, the Act addresses only public institutions which are organized and certified to provide medical care. Nevertheless, if the definitions of "institution" and "public institution" were viewed separately and interpreted literally, any facility which provides food and shelter as well as treatment or services to four or

more individuals unrelated to the proprietor could be classified as an "institution." Likewise, any such facility funded and administered through a local governmental unit could be further classified as a "public institution." Within this context, state hospitals, state prisons, regional detention centers, county foster homes (with four or more persons), county group homes, county nursing homes, city jails, city hospitals, etc. could all be classified as "public institutions."

Neely (1965), through the abstract of his dissertation entitled "Administrative Supervision of State Public Institutions: A Proposed Reorganization for West Virginia," explains:

As used in this study, public institutions are those state-supported and state-administered institutions that have in their care individuals ranging from the inert 'human vegetable' to the homicidal maniac who are in need of custody, aid or treatment, and whose disadvantages of condition or personality have them accepted as a public responsibility (p. 2599).

As often found with the definition of "service," "public institutions" are defined as "institutions that...." Nevertheless, from the definition given one can infer that by "public" the author means state supported and administered and by "institution" he means a facility providing custody, aid or treatment to those statutorily defined as public responsibilities. If the definition is viewed mainly in terms of those whom the institutions serve, it quickly becomes apparent that a range from "inert human vegetables" to "homicidal maniacs" is not very functional for describing the population to be served.

A Modern Dictionary of Sociology (1969) defines "total institution" as "a place of confinement or partial confinement where persons of a specified type live, following a formulized life routine under the control and direction of a bureaucratic staff, and having limited contact with the rest of society" (p. 207). Examples cited include prisons, hospitals, army camps, and boarding homes.

In his book Asylums, Goffman (1961) similarly defines "total institution" as "a place of residence and work where a large number of like - suited individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life" (p. xiii). He suggests five possible categories for total institutions, based on the functions they perform:

- 1) institutions established to care for persons felt to be both incapable and harmless (e.g., homes for the blind, aged, orphaned, and indigent)
- 2) institutions established to care for persons felt to be incapable of self care and a threat to the community (e.g., mental hospitals)
- 3) institutions organized to protect the community against what are felt to be intentional dangers to it (e.g., jails and prisons)
- 4) institutions established to pursue some worklike task (e.g., army barracks and boarding schools)
- 5) institutions designed as retreats from the world while oftentimes serving as training stations for the religious (e.g., abbeys and convents) (pp. 4 - 5)

Goffman admits that the preceding classification is "not neat, exhaustive, nor of immediate analytical use;" nevertheless, he does consider it useful as a starting point from which he can proceed to discuss general characteristics of total institutions. He points out that none of the general elements he presents in and of themselves are attributable only to total institutions, nor is any one institution necessarily characterized by all the elements cited.

Goffman states that "a basic social arrangement in society is for individuals to sleep, play, and work in different places with different co-participants, under different authorities, and without an over-all ration-

al plan" (p. 5). According to Goffman, this is not the case with total institutions, where the barriers that normally exist between such daily functions are eliminated. Instead, individuals become identified with a specific group within a particular setting. Activities are tightly scheduled and closely supervised, all within the framework of a specific plan designed to meet the overall objectives of the institution. Social mobility is restricted and social distance between the individual and staff, as well as between the individual and the social unit from whence he came (e.g., family, neighborhood, etc.) is imposed.

Goffman's conceptualization of the "total institution" most accurately describes the term "institution" as used within the context of State agencies and State plans. For the purpose of further discussion within this paper, "institution" will be defined as a single setting within which residents engage in scheduled and supervised activities throughout their twenty-four hour day. Confinement within that setting, isolation from the larger society outside, and identification with a population similarly confined are all factors characterizing residents of the institution.

Since this study addresses only State services, further discussion of institutions will focus on those facilities funded and administered through State money - the traditionally incarcerating public institutions such as State hospitals and State prisons. This is not to deny the existence of institutions within the private sector (e.g., private hospitals and nursing homes), nor at other levels within the public sector (e.g., federal prisons, county nursing homes, regional jails, city hospitals, and possibly even county group homes or halfway houses).

VI. Development of "Deinstitutionalization"

The concept of "deinstitutionalization" represents a shift in treatment emphasis from public total institutions to experimental programs outside the institutions.

Rothman (1972), in an article entitled "Of prisons, asylums, and other decaying institutions," traces the development of the concept of public "total institutions" in this country. He explains that there was a major shift of attitudes from the passivity of the 18th Century to an optimism of the early 19th Century that poverty and crime, as well as insanity and delinquency, could be eliminated through the construction of "new environments" for the deviant and dependent. As a result, asylums and like facilities were established between 1820 and 1840 with the primary objective of rehabilitating individuals within a corruption-free environment. The original intent of bringing order to the lives of the residents through discipline and routine was eventually abandoned due to unanticipated conditions which developed in the next several centuries. By 1870, the facilities were overcrowded, insufficiently staffed, physically deteriorating, chaotic rather than well-ordered, and extremely expensive to maintain. Custody and security, rather than rehabilitation through incarceration, became the major objective of institutional programs.

Early in the 20th Century, the emphasis in treatment began its gradual shift from institutional confinement to experimentation with anti-institutional programs. Rothman attributes this "anti-institutional movement" to a growing awareness on the part of the general public that "incarceration is inhumane by current standards, destructive of inmates, incredibly expensive, and increasingly losing its legitimacy" (p. 16). As

examples of experimentation with non-institutional programs he cites foster care for the orphaned, out-patient clinics for the mentally ill, and probation and parole for juvenile and adult offenders. All but parole are seen as alternatives to confinement in traditional institutional settings; parole is viewed as an alternative to prolonged confinement.

Although desirable, Rothman emphasizes that goals such as solving the problem of crime or reforming the deviant are unrealistic. He urges that "we scale down our expectations and rely on such basic standards as human decency and economic costs" (p. 19). It is too much to expect that keeping the deviant and dependent within the community will break their anti-social patterns and promote normal behavior. Moreover, "we do not yet know whether the anti-incarceration movement will be any more effective than the original incarceration movement" (p. 13). Nevertheless, he maintains that non-institutionally based programs for treating the deviant and dependent can be no less effective than traditional institutional programs, and the price in terms of financial and social costs is bound to be less expensive.

Rothman never uses the term "deinstitutionalization." Nevertheless, his discussion of the "anti-institutional movement" or "anti-incarceration movement" accurately describes the development of the concept of "deinstitutionalization." Consequently, "anti-institutionalism" and "deinstitutionalization" can be used synonymously to mean experimenting with alternatives to traditional public total institutions.

VII. Definition of "Deinstitutionalization"

For the purpose of this study "deinstitutionalization" is defined as experimenting with alternatives to confinement in State institutions, through changes in location and/or changes in treatment methodology.

"Deinstitutionalization" within State planning and programming refers to a planned movement away from confinement within State funded and administered institutions. Basic to such a movement are the following assumptions:

- 1) Confinement in State facilities is an ineffective and expensive approach to treatment.
- 2) Confinement should be de-emphasized as an approach to treatment.
- 3) Treatment should be decentralized to locations more accessible to client populations.
- 4) Local jurisdictions (e.g., regions, sub-regions, counties, etc.) should share in and eventually assume responsibility for local problems and subsequent treatment programs.
- 5) Funding incentives should be reversed to encourage treatment through local programs rather than through traditional State institutions.
- 6) State institutions should eventually be closed down or turned over to the management and control of local jurisdictions.

Experimentation with programs which serve as alternatives to confinement within State institutions is basically the approach to implementing "deinstitutionalization." Emphasis throughout the experimentation is on changing the location of service delivery and/or changing the methodology of treatment or intervention.

The location change refers to moving away from the remote base of the "total institution" to one more accessible to the client population.

Supplanting total institutions to specific locales (e.g., regions, counties, etc.) implies reducing the use of the existing State institutions, and consequently reducing the populations within these institutions.

The methodology change refers to de-emphasizing and gradually removing confinement as the key factor in the treatment of the individual: the "problem" individual is treated in a setting and manner different from that of the total institution; greater access to the wider society is allowed; less formal administration of the individual's life is imposed; different approaches to treatment are employed (e.g., behavior modification, peer-group interaction, re-educative therapy, drug management, etc.), with resulting changes in expected client outcomes.

Location changes may only result in the establishment of smaller total institutions closer to where the problem individual resides (e.g., regional jails, county nursing homes, etc.). Methodology changes may only result in treating individuals within existing State institutions through an approach other than custody or confinement (e.g., group therapy within State hospitals, work release from State prisons, etc.). Nevertheless, the goal of "deinstitutionalization" appears to be the gradual movement away from confinement within State institutions, through changes in location and/or methodology of treatment intervention.

VIII. Consideration of "Community-Based Service"

The concept of "community-based service" parallels the concept of "deinstitutionalization."

Throughout the interviews with State agency staff, the concept of "community-base" was addressed. Several of the interpretations derived through the interviews will next be presented.

The Director of the Drug Abuse Program and the Commission on Alcohol Problems, referred to "community-based program" as those conceived, managed, and coordinated by Area Mental Health Boards, examples being: halfway houses, long-term established rehabilitation facilities, crisis intervention centers, etc.

The Director of the Developmental Disabilities Program stated that one of the goals of the Program is to make it possible for the developmentally disabled to live in their community and still receive services equal to those usually available in an institution.

The Planning Director of the Governor's Crime Commission, spoke of "community programs" as alternatives to detention or security facilities. Group homes, halfway houses, and pre-trial diversion programs were cited as examples.

The staff of the Governor's Council on Aging reported "community-based services," in the field of aging, usually refers to in-home services, such as meals on wheels and day care, rather than "institutional" services delivered within nursing homes and hospitals.

The Commissioner of the Department of Corrections, referred to "community-based services" as any interventive program operated by correctional agents within the context of the community. Included are:

diversion programs, special non-residential programs (e.g., store front centers), and community residential programs (e.g., group homes, halfway houses, etc.)

All of the preceding examples of "community-based" programs or services exist outside the State institutional setting, thereby providing alternatives to confinement within State institutions. Several also exist as alternatives to prolonged confinement in State institutions (e.g., group homes for juvenile or adult parolees, halfway houses for the chemically dependent, mental health centers for the emotionally or mentally impaired, home health care for the aged, day activity centers for the mentally retarded, etc.). In other words, many "community-based programs" serve as supplementary resources outside the institutional setting, facilitating the early discharge of many individuals from State institutions.

From the scattered interpretations of "community-based service" derived through the interviews, it was possible to make the same conclusions as those found with "deinstitutionalization". The concept of "community-base" involves changes in treatment location and/or changes in treatment methodology.

Through the interviews it also became evident that the same agencies referring to "community-based programs" were also talking about "deinstitutionalization". These agencies shared a common background of reliance on State institutions for treating their client populations (e.g., offenders, aged, drug dependent, mentally ill, mentally retarded, etc.). Within this context, their common interest in "deinstitutionalization" and "community-based service" could be better explained.

In addition, both the interviews and the review of plans revealed that the State agencies most involved with planning for "community-based services" and "deinstitutionalization" are the Department of Corrections and the Department of Public Welfare.

Action Planning for Correctional Change 1972, a report issued by the Department of Corrections states:

It is the Department's primary objective to decentralize and deinstitutionalize corrections programs by developing and expanding community programs through subsidies or other assistance wherever possible; to set up links between correctional institutions and the community wherever possible; and to transfer resources from institutional services to field community services (p. 8).

Report to the 1973 Legislature, a comprehensive plan issued by the Department of Public Welfare (Jan., 1973) presents eight major recommendations for "the future use of state institutions and for community based programs," which include:

- 1) Phase out state operation of state institutions as community based programs are developed.
- 2) Change funding patterns to promote the development of community alternatives to institutional care (p. 8).

Emphasis throughout the plan is on reducing the role of the State agency in providing direct services, reducing the number of State institutions as community alternatives develop, and modifying present funding patterns to encourage the use of community alternatives.

Both plans indicate the commitment on the part of these agencies toward "community-based programs." Although many other agencies are involved with treating individuals through local programs, these two agencies are most engaged in planning for both "deinstitutionalization" and "community-based programs." This phenomenon is best explained by the fact that the Departments of Corrections and Welfare are statutorily responsible for many problem

behaviors, as well as for funding and administering the existing State institutions.

In summary, the relationship of "community-based service" to "deinstitutionalization" was demonstrated through both the interview and plans. At times, the two terms seemed to be used to express an identical concept - experimentation with alternatives to confinement in State institutions. Rather than stop at this point, concluding that the terms express not only similar but also identical concepts, the study proceeded to further explore the meaning of community-based service: in the fields of its origin. The intent was to determine its relation to "community" as well as to "institution" through an analysis of the conceptual development of the term within the fields of mental health and corrections.

IX. Analysis of "Community Mental Health"

Two accounts of the development of "community mental health" are reviewed in order to synthesize the concepts which led to the use of "community-based services" in the field of mental health.

A perception of the concept "community mental health" is gained from a paper by Caplan and Caplan (1967). The authors trace the trends that have been emerging out of the psychiatric field since the early 1900's, and have grown into various aspects of a type of practice called "community psychiatry."

A glossary of terms in the paper, reported as used at the Laboratory of Community Psychiatry, Harvard Medical Schools, reads:

The term Community Psychiatry is used synonymously with Comprehensive Community Psychiatry and Community Mental Health to denote a focus on (a) populations; (b) all etiological factors - social, psychological, and physical; (c) all preventive, treatment, and rehabilitation factors - social, psychological, and physical; (d) correcting pathology, preventing illness, and promoting and maintaining positive mental health; (e) all types of prevention; (f) both service and research; (g) both intramural and extramural; (h) auspices which include governmental, voluntary community agencies, and private jurisdictions; and (i) programs in which administrators and workers may be drawn from the ranks of social science, psychiatry, other clinical professions, and administration (p.57).

Accurate though this transcription may be, there is no indication of how the term "community" relates to its use in "community psychiatry." The only thing stated which could plausibly refer to "community" is the fact that it denotes a focus on populations as opposed to individuals.

A more extensive explanation of "community psychiatry" is provided in the body of the text. The authors first point out that over half a century's evolution of various issues has led to the present field of practice. One of these issues, write the Caplans:

...has been the perception by psychiatrists of the extent of their responsibility toward the community, and the corresponding expectations which the lay public has had of them. The nature of such obligations and expectations reflected current theories of the etiology of mental disorder, and attitudes about the nature and efficacy of therapeutic and preventive programs. Associated with this has been the degree of isolation of psychiatrists in remote custodial institutions and within the core living space of the population, where they are exposed to the immediate influence of community pressures and the challenge of developing new ways in dealing with a widening range of cases in collaboration with other community care givers (pp. 1-2).

The authors proceed to depict the construction of the theory which looked upon mental disease as a deviation from a reality-based norm of behavior. The deviation could be determined by cultural, socio-economic and personal idiosyncrasies. Originally, separation from the harmful influences of the environment was the favored treatment for the disordered. It was then that the mental hospital came into widespread use.

There were early stirrings of dissatisfaction with the elements of separation and confinement. A mental hygiene movement was organized around 1910 which recognized that treatment modification was necessary. Emphasis was shifted from single patient treatment to the consideration of the mental health of an entire "community." This movement was led by the National Society for Mental Hygiene which viewed community:

...as composed of individuals whose mental health was impinged upon by a variety of biological, social and environmental factors. The Society thus identified its primary goal with that of the public health movement... in the prompt detection and control of unhealthy facets and incipient maladjustment by means of research, legislation, all-embracing community services, and public education (p.11).

Around the same time came the idea of the psychiatric practice being made available on a relatively small geographical-population basis, combined with a host of other "community care providers" in one or a number of proximate facilities.

The innovative ideas failed to become popularly accepted at the time. The authors suggest several reasons for the unacceptability of these early "community psychiatry" ideas: 1) the lack of psychiatric manpower and training resources; 2) the lack of knowledge on what environments and events precipitated mental disorder, such that plans for prevention were vague and populations at risk were undefined; 3) the lack of willingness among many psychiatrists to work in areas very different from that of their training; 4) relatively little collaboration of psychiatrists with social scientists, the experts in community research; 5) a lack of public interest (thus funding provisions) in community approaches (pp.21-22).

It was not until after World War II that a breakthrough to these obstacles occurred. There was a growing dissatisfaction with the environment of the hospital for the mentally ill and retarded, and some new approaches to patient care had been demonstrated in European wards. The Caplans report:

The Europeans demonstrated the practicability of open wards and free communication between the hospital and its local community, and developed the concept of 'therapeutic milieu' in which increased communication among patients facilitates their mutual rapport, and in which participation of patients in decision making and control of behavior maintains and improves their ego strength (p.27).

A therapist named Sivadon from France proposed dividing hospitals into administratively self-contained units, each of which would provide facilities and staff for the total treatment-rehabilitation process of a limited, patient-population size. This was the forerunner of the "catchment area" concept, where the community mental health unit accepts responsibility for patients living in a limited geographic district. The unit staff is able to develop associations with various community agencies and professionals who can collaborate on referral and aftercare.

Support for "community psychiatry" efforts was not evident on a large scale, however, until Congress passed the Community Mental Health Centers Act in 1963. This act authorized \$150 million to finance up to two-thirds of the cost of constructing comprehensive community centers across the country, plus \$126 million for research and treatment facilities for the mentally retarded. As the authors point out:

The regulations covering the 1963 Act defined the centers in terms of programs rather than buildings, and listed their essential elements. Each program in order to qualify for federal funds, must accept responsibility for serving the needs for prevention, treatment, and rehabilitation of the total community, irrespective of age, sex, or class, residing within easy access of the center in a geographic area with a population between 75,000 and 200,000 (p.46).

The Caplans mention the uncertainty as yet involved with coordinating mental hospitals with "community-based services." They acknowledge the need for continued care facilities for, "...a significant proportion of psychotic patients" (p.46) and at the same time, these mental hospitals must be integrated into the states' plans for community mental health.

The authors state that they are certain of one point, however, that is:

...the leaders of the country are committed to the new approach...to foster the organization of comprehensive services for total populations and to coordinate them so that they serve the diverse needs of every resident. This is in contrast to the past pattern of providing institutions and services to which some of those people may secure admission who qualify because their identity or the nature of their disorder fits the appropriate admission category (p.47).

The Caplan study serves as useful historical review of the development of community mental health theory and practice. However, discussion of the relationship of the term "community" to this field of practice is deferred until a clearer expression of the rationale behind the "community-based mental health services" movement is presented.

A study by Pasamanick, Scarpitti, and Dinitz (1967), which offers evidence for a successful home-care program for schizophrenics, also includes a brief capsulization of the mental hospital-community psychiatry history.

The authors select six major forces as responsible for the change in emphasis of mental health from the institution to the "community." These forces are:

1) Federal government involvement in the health and welfare field.

Federal action was demanded in providing "services" to the "public sector" because the cost became too great for states to meet. The formidable cost combined with the discharge of over 380,000 men with neuropsychiatric disabilities at the end of World War II, made apparent the necessity for continued federal funding support of new mental health unit construction, manpower training programs, and research and development projects (p.12-13).

2) The general trend of psychiatric practice in the United States.

For convenience reasons most psychiatric practitioners enter private practice and see mostly upper-middle-class patients who are most often treated with psychotherapy. The authors comment:

The psychiatrist who went into public mental hospital service was confronted with the problem of dealing with psychotic patients of low socio-economic status in a physically undesirable environment, far removed from the stimulation of the urban area and medical colleagues, and for a traditionally low salary. Why should a physician enter public employment under these circumstances? Few did (p.14).

The authors conclude that as soon as patient care and treatment is returned to the "community," psychiatry is more likely to become part of the customary practice of medicine (p.14).

3) The cumulative impact of psychodynamics theory on public attitudes.

Freudianism and its offshoots initiated an enormously successful educational campaign which has altered public attitudes toward mental illness, such that much of the lay public and many professionals see no significant difference between frustrating problems of living and mental illness. Thus, there was a concurrent lessening of demand to remove the mentally disordered from the rest of a society which could be viewed as somewhat maladjusted itself (p.15).

4) The development of the "therapeutic" community. This theory, developed in the early 1940's, held that the relationship among patients, between patients and staff, and among staff can be structured to insure the maximum benefit - or minimum harm - to patients. As the authors relate:

The goal is to create a conflict-free, warm encouraging, reassuring environment with a minimum of stress for the patients. In this setting, patients can participate more freely in activities, help and guide each other, gain insight into the nature of their disabilities through meaningful interaction with others and test their behavior against the reality of involvement in group living. The psychological damage incurred in unfortunate interpersonal experience in the past can be overcome by learning how to establish new and satisfying ones (p.17).

Although the authors admit the "therapeutic community" approach may not meet the reality of sound interaction in the larger, high stress, mobile, industrial society, it helps improve tolerance and acceptance of the mentally ill by the rest of the public. They say, the more the mental hospital resembles the general hospital, the less the stigma attached to mental illness (p.17).

5) The drug revolution and the tranquilized hospital. These factors are presented as having had more effect on the mental hospital than all the other changes combined. The authors make the statement:

With tranquilizers, fewer patients need be hospitalized; those hospitalized are easier to work with and to care for; the mental hospital loses its bars and burly attendants and comes to resemble a general hospital; personnel at all levels can be more readily attracted, treatment more easily implemented, and patients more rapidly discharged (p.17).

- 6) Anti-institutional determinations. Negative aspects of the institutional setting and mode of treatment provided impetus for a search for alternatives. The authors list several potential debilitating factors:
- a) The patient loses the interpersonal supports of family, friends, and "community," thus may lose incentive to recover; and this also may facilitate further withdrawal from reality.
 - b) The institutions characteristically lack opportunities for patient stimulation, which results in the decaying of intellectual and social functioning.
 - c) There often develops an "inmate society," where the patients "subvert" the hospital structure for their own ends. This apparently makes for a worsening of the therapeutic milieu.
 - d) The fact that they are in a confinement setting imposes a "sick role" on patients, which stigmatizes them even long after release (p.17).

The movement of a large part of the treatment of the mentally ill out of total institutions reflects the reversal of trends set in motion extensively in the nineteenth century. Before that time, asylums did exist, even as far back as 4th century A.D., but for the most part, the mentally disturbed members of society were maintained at home (p.8). It was primarily the dispossessed individuals in the growing cities who, if their aberrant behavior was extensively observed, would be thrown into the asylums. Up to 1840, there were only 14 public asylums in the United States containing 2,500 patients.

Not long thereafter, Pasamanick et al, state, it became obvious that:

The urban industrial community had become so complex that it could no longer feed, clothe, shelter, tolerate, or maintain deviant, disruptive or dependent persons locally or in the family. As a result, the custodial institution - the huge mental hospital and the massive, maximum security prison, now differentiated from the county poor house and the workhouse were created to facilitate the removal from and the care of burdensome and intolerable members from the community on a permanent or long-term basis (p.9).

Custodians were gradually replaced with professional therapists and caregivers, but the elements of confinement and isolation were still emphasized. Up to even the present, the provision of treatment or remedy as a function of the mental hospitals is questionable, if it exists at all. (Reader is referred to Newsweek January 29, 1973, pp. 46-47). Some of the most modern and seemingly comfortable facilities serve only to confine the individuals and contribute to their de-humanization.

It appears the trend has approached full cycle, as discussion now entails sending as many of the mentally disordered and impaired individuals as feasible, back into the "community" from whence they came.

This paper raises the question, is there a "community" to return to, and ultimately are the terms "community mental health" and "community psychiatry" meaningful?

The investigation of the term and concept "community" reported earlier, suggests that it is virtually meaningless to consider the population collections of cities, counties, regions, etc., as communities purely for their own sake. "Community" is supposed to connote the presence of a sharing process - a flow of materials, ideas, feelings, etc., that can be received, accepted, and passed on. Since virtually none of the population collections in our society share all aspects of life, as was

true of many of the collectives before industrialization (e.g., tribes, villages, small towns, etc.), there is no basis for calling them communities, without qualifying what is being shared, and by whom.

Before applying this suggestion to the field of mental health, it ought to be made clear just what was being said about "community psychiatry" or "community mental health."

From the excerpts of the literature presented here, these various meanings for "community psychiatry" or "community mental health" can be synthesized:

- 1) Treatment of the mentally impaired and disordered in settings closer to the residences and zones of interaction of the general society.
- 2) Attempt to prevent (i.e., to treat sooner) disorder from reaching a severe condition such that separation and confinement are required.
- 3) Attempt to make the mentally impaired and disordered more acceptable to general society.

The first interpretation refers to the deinstitutionalization movement, that is, the discussions and designs to remove as many of the disordered and impaired as possible out of the total institutional settings closer to the locale of the patient's origin. Apparently, professionals would like to resort to treatment-settings other than total institutions, but the nature and condition of some disorders require separation and confinement from the general society. Whether the design is to reduce the time of confinement required by the disordered individual, or the distance traveled to the place of confinement, the relation to "community" is not clear. It is not appropriate to refer to this as Community Mental Health. The label "locality-based mental health" more accurately describes the concept involved, and the phenomenon occurring.

The second interpretation refers to the planned or implemented efforts at having professional intervention resources within a relatively short-time radius from the problem situation and actors. Such vehicles as Community Mental Health Centers, Drop-In Counselling Offices, Crisis Intervention Centers, Telephone Counselling Referral Programs, Police Drop-In Centers, fall into this category. The rationale behind this movement is that, if life-situational problems are more or less "nipped in the bud," the chances of them leading to severe personality disorders or seriously maladjusted individuals, is lessened. Professional problem solving instigated close to the source of the problem, implies that paid professionals or other specially trained societal members, take over more of the functions once managed by the nuclear and extended family. Crisis-management, conflict-resolution, behavioral adaptation, were once aspects of survival for which the family and clan members depended upon each other. It seems to be the present trend that familial interaction creates more or greater problems than the individual or other family members can solve. As professional problem-intervention increasingly takes the place of informal, voluntary intervention, the label "community" more appropriately refers to the group of professional problem solvers, who share their treatments and remedies with the disordered and impaired.

The third interpretation ties in closely with the first two in that it deals with: a) the treating of the disordered or impaired individual, and b) the ability of the general society to interact with him or her. Covering the latter point first, Pasamanick et al, make reference to the dissemination of Freudian ideas as increasing the understanding of mental illness on the part of the lay public. This they see as leading to an

increased public acceptance of the disordered individual either as being "sick" and requiring "remedy," or as a damaged product of a maladjusted environment requiring restoration. There is a question to be answered however: is the public understanding of the causes and cures of mental disorder meant to foster a greater tolerance for the abnormal behavior of all individuals, or greater support for intense professional intervention and treatment? The answer has significant meaning in determining precisely who is considered a member of the "community."

This brings us to the treatment aspect of the third interpretation. Pre-industrial, Euro-American society somehow found a place for its mentally disturbed persons; most were maintained in the home, some even contributed to the family economy. Presently, a few theorists call for the integration of all individuals, no matter how aberrant their behavior, into the activities of main-stream society. However, it appears that the majority of the public (both professional and lay) would rather that the more "abnormal" persons somehow be made "normal" before integration is attempted. Drug therapy, shock therapy, and other forms of behavioral modification are the treatments most heavily relied upon for "normalizing" the disordered individuals. These have proved to be the most efficient, and many times the most effective means to the prescribed ends. As such, it would appear that "community" in this interpretation, could more explicitly be called "community of the normal."

It is likely that "community mental health" and "community psychiatry" are not meant to refer to "community of professional problem solvers," or to "community of the normal;" rather, they most likely refer to the jurisdictional area in which services take place - i.e., "locality-based mental health."

It is the suggestion of this report that the word "community" not be used by the professional practitioners or public agency administrators in reference to the programs, practices, or populations being dealt with in the field of mental health. The meaning of the term is too ambiguous to be of practical use in describing the actual operations in the field. And, it might be added, the operations of the mental health field are too diverse to be represented accurately by one term.

X. Analysis of "Community Corrections"

The meaning of "community-based service" within the field of corrections is analyzed through a review of recent literature on "community corrections".

Rothman (1972) discusses the gradually increasing trend in this country since the early 1900's to experiment with alternatives to institutions, particularly within the fields of child care (e.g., orphanages), aging (e.g., almshouses), mental health (e.g., asylums), and corrections (e.g., prisons). Although he never uses the term "community-based programs" in describing these alternatives, the same examples which he cites of anti-institutional programs have been presented through other sources of literature and through the interviews as examples of "community-based programs." Moreover, his conceptualization of anti-institutional programs as alternatives to institutionalization has similarly been implied by others, and at times, even explicitly stated by others, as the meaning intended through their use of the term "community-based services."

For example, the "Metropolitan Development Guide" (April 12, 1973), issued by the Metropolitan Council of the Twin Cities Area, states that "programs which attempt to rehabilitate the offender outside of an institution are generally termed 'community-based corrections.'" The report explains that the term "community-based corrections" includes a variety of programs, including group homes for juveniles on probation or parole, pre-trial diversion programs such as project De Novo in Hennepin County, traditional probation, intensive probation such as the P.O.R.T. program in Rochester and the Bremer House in St. Paul, special institutional release programs, and parole (p. 24).

The August 27, 1971 issue of "Corrections Corner," a newsletter published by the Department of Corrections, focuses on State community corrections. Reference is made to Section 241.32, passed by the 1971 Legislature, which gives the Corrections Commissioner responsibility to: "establish and operate community correctional centers, or contract with existing public and private agencies for separate custody and specialized care and treatment of persons under his custody." Six basic concepts, developed by former Commissioner David Fogel with the intent of contributing "to a movement of offenders away from institutions toward community settings," are presented:

- 1) Treatment of offenders in their home communities; 2) Diversion of offenders away from institutions to the fullest extent possible; 3) Minimization of institutional experience for those who must be incarcerated; 4) Creation of a floor of human care and constitutional practice for institutions; 5) Differentiation of offenders for treatment and management purposes; and 6) Integration of offenders into "establishment" roles (p. 1).

Among the variety of community corrections programs featured in the newsletter is P.O.R.T. of Rochester (Probationed Offenders Rehabilitation and Training). P.O.R.T. is described as "a community-based, community-directed, community-serving residential center for treatment of law offenders who otherwise would be in state correctional institutions." The project, which serves offenders from the Rochester area, was begun in 1969 as a result of concerns that "viable alternatives to incarceration be available to convicted offenders, both adult and juvenile" (p. 3).

Kenneth Schoen, present Commissioner of Corrections, addresses "community corrections" in a paper entitled "Residential Community-Based Correctional Programs" (1973). Schoen states:

The concept of "community corrections" is by no means a sudden innovation in the field of corrections in Minnesota. The trend toward bringing the offender, whether he be juvenile or adult, out of the isolation of remote institutions began developing conceptually in the minds of Department Administrators and the public nearly a decade ago. Nonetheless, the rapid acceleration toward greatly increasing programming in community-based corrections has, indeed, occurred quite recently (p. 1).

The "1972 Guide to the Minnesota Department of Corrections" reports that "historically the Department allocated its resources to maximum security incarceration as a method of rehabilitation" (p. 1). Although maximum security incarceration is considered necessary for some offenders, it is no longer viewed as an effective intervention methodology for the majority. High recidivism rates are presented as proof of its ineffectiveness. "Deinstitutionalization" and "decentralization" of programs are proposed as goals of the Department, to be accomplished through "the reduction of institutional populations by reducing direct admissions, providing alternatives to institutionalization and reducing length of stay" (p. 2). Emphasis is placed on the "use of community corrections as alternatives to institutionalization on the state level," with probation, parole, halfway houses, group homes, work release, volunteer programs, employment assistance, and group residence cited as examples (pp. 3 - 4).

The December, 1972 report of the 42nd American Assembly entitled "Prisoners in America" explains that "the primary purposes of confinement are to protect the public from the offender and to discourage the commission of crimes." The report points out, however, that confinement has proved an ineffective approach to the rehabilitation of most offenders; consequently, incarceration is recommended only as a last resort. Likewise, traditional probation and parole are discussed as ineffective methods of rehabilitation; mention is made that "the trend in the last decade has been to supplement

them with other community-based programs." Constraints such as community resistance and insufficient resources which frequently hamper implementation of community-based programs are acknowledged. Nevertheless, through this report the members of the Assembly advocate increased involvement of the general public in the field of corrections and continued experimentation with "alternative programs and services" (pp. 4-6).

Basic to the concept of "community-based corrections" appears to be a movement away from incarceration or prolonged incarceration in State institutions. The literature thus far cited has consistently referred to "community-based programs" as alternatives. Traditional correctional institutions, characterized by isolation and confinement, have been acknowledged as inappropriate and ineffective in the treatment of many individuals. Consequently, creating alternatives to State institutions through experimentation with changes in treatment locality and methodology has been advocated. These alternative programs, i.e., "community-based programs," are viewed as a potentially more effective approach to treating offenders as well as a vehicle for reducing institutional populations. Within the context of "deinstitutionalization through alternatives," the relationship of the concepts "community-based corrections" and "institutions" is apparent.

Use of the term "community-based" to express the concept of "deinstitutionalization," however, is both inappropriate and confusing. "Anti-institutional" or "non-State institution based" would more accurately communicate the concept. But these terms carry with them the negative

connotations attributed to the term "institution." "Community-based", although vague in meaning, evokes a more positive response from legislators, the general public, offenders, staff, etc. As a result, this more politically functional and socially acceptable term continues to be used with increasing frequency to express a concept which has been advocated within corrections for many years, but only recently has become the subject of growing public attention.

The relationship of "community-based corrections" to "institution" has been presented in terms of deinstitutionalization through alternatives. The relationship of "community-based corrections" to "community," however, is a much more difficult concept to comprehend. Basic to the dilemma is the ambiguity inherent with the term "community".

Throughout much of the literature on "community-based corrections", it appears that "community" means anyone, any place, and any resource, etc. outside the State institution. Such a conceptualization of "community" as "other than State institution" has little or no value. Nevertheless, references are continually made to "community-based corrections" as a movement "away from the institution" and "toward the community".

Action Planning for Correctional Change 1972, a plan issued by the Department of Corrections, reveals a further interpretation of "community" when used in relation to "community-based corrections". Included within the plan as examples of "community-based programs" are county jails, county workhouses, regional jails, and regional detention centers (p. 9). Although temporary confinement of offenders within an isolated setting exists as the primary function of several of these facilities, they have been classified by the State Department of Corrections as "community-based programs".

Within this context, "community" means "local," i.e., other than State. The facility, located within a specific county, multi-county area, or region, exists to serve individuals apprehended in that jurisdiction. Local public funds help to finance its operation. The facility is planned for and staffed at the local level, and administered by a local governing official or board. In essence, it is a locally-based total institution.

Although the corrections plan makes frequent mention of these facilities as well as other locally funded programs (e.g., correctional group homes for juveniles, half-way houses, pre-trial diversion programs, etc.) as "community-based," the relationship of all these programs to "community" is never clearly explained. "Locally-based," "county-based," or "regionally-based" would be more appropriate terms than "community-based" for expressing the concept of "local," i.e., other than State. Such terms as "locally-administered" or "locality-administered" may be desirable but would also be inaccurate in most situations because the local units of government are seldom autonomous in setting policy and managing correctional programs; city and county jails, county probation and parole can be cited as exceptions where considerable local autonomy does exist. Nevertheless, the majority of correctional programs in the State operate with State and/or Federal funds, and are consequently subject to meeting standards set and enforced by regulating agencies such as the Department of Corrections or the Governor's Crime Commission.

From the literature cited it can be concluded that "community-based corrections" relates primarily to the concepts of "institution" and "de-institutionalization" rather than to the concept of "community." To perceive of "community" as "other than State institution" or "other than State funded and administered" does not at all approach an accurate

conceptualization of "community."

How does one define the "community" which, as the term "community-based corrections" implies, serves as the base for the program? Is it the group of professionals (i.e., legislators, state or regional planners, correctional agents, county commissioners, private agency staff, judges, etc.) involved with planning and administering correctional programs? Is it the vast range of resources (i.e., funding, facilities, staff, etc.) necessary to implement programs? Is it the area (i.e., region, county, township, neighborhood, etc.) distinguishable from other areas by geographic and political boundaries? Is it the residents of the neighborhood where a residential group home is located, with or without their involvement? Is it the offenders themselves? Is it a combination of all of these, some of them, or none of them?

Once the "community" is identified, the question "is it possible for offenders to become a part of that community?" should be addressed. Much attention is dedicated to the fact that alternatives to correctional institutions must be found, but there appears to be a lack of effort in addressing whether integration of offenders into various communities of non-offenders is feasible. As was pointed out earlier, the key concept behind "community" is the sharing process. Apparently, the localities in which correctional programs are based contain people who share some things with each other, thus, the label "community."

If offenders are to obtain some benefit from correctional programs because of the fact that they are located closer to a "community," it would seem necessary for them to become a part of the sharing relationship - i.e., become integrated into the community. Integration is apparently an intended feature of community-based correctional efforts. The following definition presented by Commissioner Schoen in the report

"Residential Community-Based Correctional Programs" (1973) emphasizes this point:

Essentially, community corrections programs for the referred law violator are such that they have a high degree of integration with everyday "normal" community life (non-offender interrelationships), which has a high degree of insulation and segregation from community life and non-offender interrelationships" (p.2).

Little material is available, however, in which the feasibility of integration is discussed or analyzed. Without such material it is impossible to determine how "community corrections" relates to "community."

Unless it can be demonstrated that a phenomenon such as "community" does exist, and that correctional programs are integrally related to it, terminology such as "community-based corrections" will only serve to express concepts which could more accurately be communicated through the term "locally-based corrections."

XI. Summary

Service: Definition of the term "service" was sought from its use and interpretation in public documents, laws, regulations, State and Federal administrative guidelines, and planning and programming descriptions. These sources did not offer an adequate clarification of the term. A definition was formulated which reads:

Service is any activity offered or performed usually by a specially trained person which provides another person with those resources necessary to accomplish a task or satisfy a need.

It is useful to emphasize that a service is performed by someone to meet a need of someone else. The delivery of effective service demands that the serving agent be aware of the need of the person being served. Identification of the need, as in precise a manner as possible, is the only way in which expected outcomes can be indicated and treatment planned and therefore, the only way effectiveness can be assessed.

Human Service: This is a broad, generic label for all the activities under consideration in this analysis. Although a couple of definitional attempts have been made, none were found to have accurately and succinctly described the range of activities referred to as "human services." A definition ought to clearly represent the conceptual interpretation of reality. In order for a definition to be appropriate, the conceptualization must accurately represent perceived reality. It appears that perception and ordering of the activities and events which take place in the realm of caregiving, problem-solving, and order-keeping

services to humans, has so far not been managed. The activities and events must be realistically identified and rationally ordered so that common conceptualization across all agencies and disciplines can occur.

Community-Based Service: Like "human service," this is a generic label which carries no accurate, concise definition. There are several different concepts being expressed in its use, most of which deal with the evolving effort to alter the environments and methodologies of treating physical impairments and behavioral disorders.

Generally, the concept of "community-based service" involves finding alternatives to State financed and administered institutions which are relatively few in number and scattered in location. The alternatives represent vast categories of changes ranging from simply moving the location of institutional-type settings and treatments, to administering innovative programs, therapies, and treatment techniques in places considered to be more convenient to the "problem" individual and/or more amicable to his or her development.

The lumping of these changes under the label "community-based service" makes it difficult to determine exactly what is being altered and what remains the same. For purposes of analysis and evaluation, such labeling offers only confusion and distortion.

Part of the distortion is inherent in the fact that the term "community" has been used in unqualified ways to such an extent that its meaning has become ambiguous. There is no intrinsic definition of the word "community" in the sense that "community-based service" has thus referred to it. It once had meaning as a specific sort of locale and

the population within, but this is no longer possible. The only current sense within which "community" has meaning is one describing the presence of a social relationship of sharing between individuals or groups.

Saying that a service is based in a community, begs qualification as to what is the specific make-up of this location and its inhabitants such that they can be called a "community."

Implications of the findings of this analysis, and recommendations based on the findings, will be presented in the "Conclusions" section of the report.

XII. Conclusions

It is important to correlate the findings of this study with some of the most recent written material coming forth from State agency sources, offering some sort of conceptual structure to the area of social-problem intervention. A document entitled Behavioral Disabilities: A Recommendation (Dec., 1971) was prepared by a task force originally formed to assist in the development of a State plan for socio-emotional problems. The task force was under the supervision of [redacted] of the Comprehensive Health Planning Program, and was made up of staff members from various social-intervention-type agencies involved in the areas of mental health, inebriacy, mental retardation, and corrections.

The final report and a preceding draft give a useful representation of the findings of the task force. A statement of value regarding a common conceptual framework for the social-intervention activities is found in the draft version of the report. It says:

...despite the differences among persons who have problems identified as mental illness, retardation, chemical dependency, and anti-social behavior, there are commonalities in the behaviors exhibited and in the response required by society... (T)he advantage of a common conceptual framework for behavioral disabilities is that one can define the behaviors which constitute 'problems,' rather than categorizing people under such broad labels as 'mentally ill' or 'inebriate' (p.4).

The report goes on to indicate that there is a sequence of interdependent factors involved in such problems as crime, drug

use, retardation, and mental illness, and the following factors are set out as the process of labeling someone as a "social problem."

1. There is a behavior who commits an action in a particular setting.
2. An observer perceives the action in the setting and,
3. evaluates the action according to some preconceived norm or standard of acceptability.
4. Finally, the observer's tolerance level determines whether or not the action becomes a social problem.

When behavior is evaluated as being deviant, sick, abnormal, or illegal, the reaction of society is to put stereotyped labels on the behavior. The behavior, in turn, reacts to such labeling, especially if it is established through public processes such as trials, probate court hearings, and commitment procedures, by accepting the label of deviant and believing that he or she must follow the deviant role. It then becomes increasingly difficult to assume a more conventional identity, or to play a more conventional role. The report calls this factor, crystalization of the disabling behavior.

The report points out that a change in any or all of the four interdependent factors could offer a solution to the crystalization problem. In other words, efforts could be aimed at changing the behavior, the setting, the standards of acceptance, the observer, or any combination of them. In whatever area the efforts are applied, the report recommends that the role of the State should be gradually refined to one of control and regulation of service provision, not direct service delivery itself. Support is given to the movement of service provision

to "community" service agencies, as it was felt that the role of "community" agencies to recognize and provide for the needs of its citizens should be expanded (draft version, p. 12).

The present analysis has some observations to offer to the Behavioral Disabilities Report and other work promoting the expansion of community-based services and the relinquishment of the State's role in the direct handling of problem behaviors.

There can be found no adequate information coming from State sources as to how "communities" are to deal with the behavioral problems which the State itself found too complex and costly to solve. The information has been plentiful which demonstrates that separation and confinement are neither very effective nor efficient means of treating the behaviorally disabled. It would not seem reasonable to expect institutionalization in structures located closer to the "patient's" home (e.g., nursing homes, county jails, etc.) to be any more effective or efficient a solution. The alternatives then, are limited to: a) changing the behavior in settings other than total institutions; b) changing the location in which problem behaviors reside, work, and interact socially; or c) changing the standards of acceptance and the degree of tolerance of the observers.

The latter two alternatives have not been advocated or implemented on any large-scale basis. The first alternative appears to be the one of interest to professional personnel dealing with the societal problem behavior, yet precise

conceptual development of the preferred solutions has not been made clear. In effect, how is the problem behavior to be changed in such a way that he or she becomes a part of the "community?"

This is not to say that attempts are not being made at altering problem behaviors to such an extent that they become "community acceptable." Many programs and services do make some of the mentally ill, inebriate, retarded, and criminal offenders acceptable enough to the "community" such that they can reside and work amongst the "normal" population. However, these attempts have not been given official recognition as a classifiable set of intervention techniques. They have been treated in the separate categorical problem areas simply as aspects of "community-based programs."

Virtually no data exists at the State level concerning cost or effectiveness evaluations of these techniques; nor are observable, any attempts at providing a common conceptual framework for these attempted solutions to what is now designated as a common set of problems (i.e., behavioral disabilities).

As the State turns over its direct service responsibilities to the auspices of the localities, it appears exceedingly necessary for the higher level of government to provide administrative assistance in the form of direction and guidance as to what type of problem-solutions the "community" ought to offer. If behavior-problem people are not to be categorically stereotyped and put away in confinement settings, then what is the type of intervention needed, and where does it take place?

The State agencies involved in the intervention of the behaviorally disabled should begin to take an analytical look at the activities called "community-based services," in order to make clear to the "communities," what are the most effective and efficient methods for integrating the behaviorally disabled into the population which could not before tolerate their behavior.

In summation, certain findings and recommendations can be linked.

1. Terms used commonly in the language of those activities performed and administered by State agencies called "human services," are ambiguous. The same terms used by a number of agencies, represent a variety of different meanings.

Agencies should do away with the practice of "jumping on the bandwagon" when popular labels and more positive sounding words are used to represent the activities and events that actually occur.

In particular, the words "service" and "community" ought to be used with more discretion, if used at all. The words "activity" and "locality" respectively, are recommended as replacements.

2. The concepts underlying the terms used in "human service" language are often unclarified and undeveloped. State agencies are generally unable to accurately portray the goals of their activities, nor clearly represent the methods needed to overcome the problems involved in reaching the goals.

An intense effort towards analytical and empirical research is needed in solidifying the conceptual framework which can be used in providing direction to the treatment-intervention activities performed by those responsible for service delivery and goal attainment. As the State organizations gradually phase out of the area of direct service delivery, they should continually pick up the responsibility for the research needed to determine "human service" goals, and most effective and efficient means to attain the goals.

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Developmental Disabilities Program Office

Division of Vocational Rehabilitation, Minnesota Department
of Education

Governor's Citizens Council on Aging

Governor's Commission on Crime Prevention and Control

Governor's Commission on Drug Abuse

Minnesota Commission on Alcohol Problems

Minnesota Department of Corrections

Minnesota Department of Health

Minnesota Department of Manpower Services

Minnesota Department of Public Welfare

Minnesota Office of Economic Opportunity

Organization and Program Analysis Division, Minnesota Department
of Administration