Metropolitan State Hospital:
An Endeavor in Interlocal Planning

by

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Submitted to the Department of Urban Studies and Planning
in Partial Fulfillment of the Requirements for the

Bachelor of Science

and

Master of City Planning

at the

Massachusetts Institute of Technology

May 1994

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JUL 12 1994
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Abstract

The thesis documents the reuse planning process for the closed Metropolitan State Hospital to learn how complex group planning efforts are managed and how they may be improved. The thesis presents guidelines for public sector group decision making and negotiation. The thesis then discusses the reasons for the closure of state mental hospitals and the steps of the Massachusetts property disposition process.

While the outcome of the Metropolitan State Hospital reuse planning may be appropriate, the process used to achieve that outcome should be modified for use in other planning processes. The thesis concludes that an initial creative step is useful in community planning processes for allowing the members of the interest groups to formulate their views on the planning issues before actual alternatives are proposed. The thesis also concludes that an unbiased person from outside of the planning process is valuable for managing the process and providing a written record of the process results.

Implementation of these recommendations will help to ensure that the planning process is efficient and will help guard against conflicts caused by misunderstanding and misrepresentation.

Thesis Advisor: Philip Herr
Title: Adjunct Professor of City Planning
Acknowledgement

Thanks to everyone who provided me with their valuable input for my thesis.

They know who they are.
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Public Sector Decision Making

In an effort to understand the ways in which communities make planning decisions, this thesis focuses on the Metropolitan State Hospital reuse planning process. The Hospital property is owned by the State of Massachusetts and straddles three diverse communities. The interaction required between the State and the communities to determine a reuse plan for the Hospital property provides a wonderful context for learning how planning processes are designed, how ideas emerge, and how conflicts are resolved. By documenting the extensive planning process that has occurred to date, the thesis will determine the lessons that can be drawn for administering similar interlocal planning processes. Specifically, I will argue that the community groups must create a forum for determining and legitimizing their individual interests before creating and deciding among different alternatives. I will also argue that someone with no stake in the planning issues should be responsible for managing the decision making process and for keeping a written record of the results.

Introduction

In 1991, the Commonwealth of Massachusetts entered into its last phase of state hospital closure and consolidation, a process which had begun in the mid-1960s due to fiscal incentives and to changing treatment techniques for the mentally ill and mentally handicapped. Of the twelve original state hospitals for the mentally ill, seven
have been closed and declared surplus by the State Department of Mental Health. According to Massachusetts law, the State Division of Capital Planning and Operations (DCPO) takes control of surplus properties in order to dispose of them. Through consultations with public officials and, sometimes, private groups, DCPO decides whether to transfer the properties to a different state agency, to a local public agency, or to a private entity or individual. For large properties, the disposition process can be quite complicated since public officials and private citizens will often propose a wide variety of uses for DCPO to consider. Further, once DCPO completes its reuse recommendations, the State legislature must approve them. Obtaining the approval of the State legislature can be difficult if a legislator and his or her constituents favor a reuse that DCPO does not recommend. In fact, disposition legislation has only been filed for a couple of the seven closed Department of Mental Health hospitals, and the legislature has not approved any of the bills.

In order to understand how DCPO makes the complex decisions required in large property disposition processes, I have chosen the Metropolitan State Hospital disposition as a case study. The Metropolitan State Hospital (hereafter referred to as Met State) was declared surplus in September, 1992. The Met State disposition is in some ways more complicated for DCPO than the other hospital disposition processes because the Met State property straddles three communities, rather than just one or two. Since the interests of the three Met State communities differ, there are a large number of reuse proposals for DCPO to consider. In order to receive input from the three communities, DCPO asked the community officials to each appoint a Reuse Task
DCPO and the three Task Forces have met frequently for the last two years to discuss reuse options for Met State. The disposition process for Met State is not yet complete, although DCPO and the Task Forces have established a detailed framework for the possible reuse options. The thesis will document the preliminary Met State planning process that has been completed to date. Based on what is learned from the Met State case study, the thesis will then present recommendations for conducting similar interlocal planning processes.

I learned of the Met State reuse planning process through my internship with the City of Waltham Planning Department. The City of Waltham is one of the three Met State communities. While I was not an actor in the Met State process, my internship gave me the opportunity to attend Met State meetings, speak with people directly involved in the process, and obtain written materials produced throughout the process. In addition, my thesis advisor, Professor Philip Herr, is a planning consultant and a non-voting Task Force member for the Town of Belmont, which is another Met State community. Professor Herr's involvement in the Met State process allowed me to obtain materials produced before I became an intern with the City of Waltham.

The thesis begins with general guidelines for managing multi-party decision making and negotiation. Chapter Two then explains the history behind the deinstitutionalization of the mentally ill that led to the closure and consolidation of the Massachusetts state mental hospitals. Chapter Three describes the Massachusetts property disposition process. Chapter Four documents the decision-making method
used by DCPO and the three communities to conduct the preliminary planning stage of the Met State disposition process. Lastly, Chapter Five presents recommendations for conducting similar decision-making processes involving more than one community.

**Group Decision-Making Guidelines**

This section will discuss several guidelines for group decision making. In the case of Met State, group participation in the disposition decision making process is recommended by State legislation. While the legislation suggests that DCPO create an advisory committee, the legislation does not prescribe a specific process for working with the committee to formulate property reuse restrictions. For the Met State process, DCPO created the three community Reuse Task Forces to serve as its advisory committee. The process initiated by DCPO resembles an unassisted negotiation, which is only one of a number of decision making models. According to some of the Task Force members, the process has been a long and painful one. The thesis attempts to determine whether the decision making model selected by DCPO and the Task Force members is an appropriate one for complex planning efforts. Authors Doyle and Straus present several criteria for group decision making processes that they have employed to reconcile opposing interests in the public, private, and non-profit sectors:

1. There must be a common focus on content.
2. There must be a common focus on process.
3. Someone must be responsible for maintaining an open and balanced conversation flow.
4. Someone must be responsible for protecting individuals from personal attack.
5. And, in general, for the duration of the meeting everyone’s role and responsibility
must be clearly defined and agreed upon. The ability of the Met State process to meet these criteria will be discussed in Chapter Five.

Group decision making processes can also be enhanced by recording the discussion from the meetings. Assigning a neutral person to take minutes at every meeting is beneficial in order to:

1. Have a formal statement of the group's accomplishments.
2. Have a record of all intermediate decisions that lead to and supply a basis for the major decisions.
3. Protect against misunderstanding and misperception by individual members.
4. Act as a running account of group process. In the Met State case, minutes were taken by a neutral person at a few of the first meetings, but no one has been responsible for taking minutes since then.

If meeting members have differing perceptions, whether based upon different memories, disagreement over facts, or different values, conflict will result. Group conflict is not necessarily unfavorable, but poor handling of conflict is.

Many of the difficulties of group conflict management arise because the group does not have procedure to turn to for coping with conflict. Following a plan encourages rational analysis to take precedence over emotional outburst. Fundamental to any plan is the possibility of negotiation.

Negotiation is one method of resolving conflict. Negotiation "is back-and-forth communication designed to reach an agreement when you and the other side have

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3Ibid., p. 113.
some interests that are shared and others that are opposed. Several types of negotiation are discussed below.

**Unassisted Negotiation**

An unassisted negotiation is one in which the parties have come together on their own to make a decision and to resolve any differences. No intermediary from outside of the participating groups has been asked to conduct the negotiation process.

There are three conditions for the success of unassisted negotiations:

1. The issues in dispute, as well as the array of ... parties, should be relatively few in number and readily identifiable.
2. The [parties] must be able to establish sufficient channels of communication to permit joint problem solving.
3. The uncertainty surrounding the outcome of unilateral action must be moderately high for all [parties].

Most groups in a decision-making process will first attempt unassisted negotiation to resolve any conflicts. The transition from decision making to unassisted negotiation is a simple one, and most groups shift back and forth between the two modes during the decision-making process. If, however, the parties in the group determine ahead of time that they will not be able to meet the above criteria, or if their attempt at unassisted negotiation has resulted in deadlock, the parties may try assisted negotiation.

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Assisted Negotiation

An assisted negotiation is one in which the parties have retained the services of an intermediary, who may either serve as a facilitator, a mediator, or a nonbinding arbitrator. As a facilitator, the intermediary is the least involved with the substance of the negotiation. Instead, the facilitator focuses on administering the process and maintaining clear lines of communication among the parties.

The facilitator focuses almost entirely on process, makes sure meeting places and times are agreed upon, sees that meeting space is arranged appropriately, and ensures that notes and minutes of the meetings are kept. He or she sometimes acts as a moderator, usually when many parties are involved.\(^6\)

If the facilitator has strong negotiating skills, but is not able to produce agreement acting just as a facilitator, the group may ask the facilitator to shift roles and act as a mediator.

As a mediator, the intermediary is more involved with the substance of the negotiation than a facilitator, while still maintaining the responsibility for administering the process. A mediator is expected to meet confidentially with the parties in order to learn about their interests and to suggest options that will move them closer to agreement. Parties use the mediation approach when the process is moving too slowly with just a facilitator, or they are unable to present options for discussion on their own due to their rigid public positions.

If the parties are not willing to discuss different options, because they are firmly committed to their positions, they may decide to have an intermediary act as a

\(^6\)Ibid., p. 152.
non-binding arbitrator. Having a non-binding arbitrator allows the parties to learn how an impartial "judge" would rule on the disputed issues, without having to be bound to the arbitrator's decision. As a non-binding arbitrator, the intermediary is focussed primarily upon the substance of the negotiation, since s/he is required to present a decision to the parties.

In nonbinding arbitration, the disputing parties still control the design of the process, but the intermediaries take more responsibility for devising possible solutions. ... Obviously, then, the intermediaries in nonbinding arbitration must be substantively knowledgeable—even more so than mediators. Ideally, they understand not only the complexities of the issues in dispute, but also the legal processes that may come to bear if all else fails.\(^7\)

Occasionally, the intermediary's functions may shift among the three roles, but not without the consent of all the parties.

Intermediaries must be "neutral." They must not have direct social, economic, or political ties to any of the parties or the issues. "It is almost impossible to run a fair, nonmanipulative meeting when you have a personal investment in the subject matter."\(^8\) Parties to an assisted negotiation retain control because of their power to disqualify the intermediary if they feel s/he is biased or incompetent.

\[T\]here are several types of assisted negotiation which are not binding, and which proceed only with the continuing assent of the negotiating parties. In other words, all parties must be satisfied with the settlement reached through such a consensual process, or there is no settlement. Because the stakeholders retain veto power over the final outcome, they retain a vital measure of control.\(^9\)

\(^7\)Ibid., p. 178.

\(^8\)Doyle and Straus, p. 33.

\(^9\)Susskind and Cruikshank, p. 138.
The process in the Met State case has primarily operated as an unassisted negotiation. The State Division of Capital Planning and Operations (DCPO) convened the three community Reuse Task Forces, and there was tacit agreement that the DCPO Project Manager would manage the meetings. The three Task Forces hired a planner from the regional planning agency to help them develop and choose among reuse options. The planner completed some of the tasks of a facilitator at several meetings. She took minutes, arranged meetings, and prepared the agendas, but never conducted the meetings. The planner was considered to be neutral because she did not favor any particular agency or group. The planner was paid through the use of a state planning grant, and she stopped attending Met State meetings when the funding ran out in 1993. Since that time, the community Task Force members have not hired a replacement.

**Swamp-Yankee Planning and the Ecologue Workshops**

Swamp-Yankee planning and the Ecologue workshop process, planning methods developed at MIT, provide useful guidelines for evaluating the Met State reuse planning process. Swamp-Yankee planning, which is tailored for small Northeastern towns, relies on seven basic principles to be observed by planners: lead from the side, discover and rely on latent agreement, make "intentional" plans, plan to plan in cycles, integrate planning and action, design participation, and respect uncertainty.¹⁰ One of the most important intentions of Swamp-Yankee planning is to allow community residents to own the planning process. In order to own the process,

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the residents must generate their own ideas for action commonly through a brainstorming process, rather than simply reacting to ideas proposed by community leaders or outside agencies.

The Ecologue workshop process is a technique that can be used to implement Swamp-Yankee planning.

The essence of ecologue is a set of workshops, with both small-group and all-together sessions, the small groups having been assembled on a shared-interests basis, such as where in the community they live, or their age-group (teen, elder, neither), or their economic interest (businessperson, property owner, developer). The work begins with as little topical predefinition as possible, relying on the outcomes of brainstorming to provide definition of appropriate topics for further exploration.11

By creating groups of residents based upon their similar interests, the Ecologue process facilitates discussion and encourages agreement within the groups. The interest-based affinity groups created in the Ecologue process must be chosen carefully to ensure that no one is excluded because they do not identify with any of the groups.

After the affinity groups are created, they begin a brainstorming session to understand their task and to develop their own views and concerns. Brainstorming is simply a technique designed to foster group identity and to allow all members of the groups to have their views heard and legitimized. If instead each group was represented by one person, the rich diversity of ideas available in the group could be inadvertently screened out by the predispositions of the representative. Brainstorming ensures that all the members' ideas are given equal standing during the creative stage.

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11Ibid., p. 15.
After the brainstorming sessions, the affinity groups come together to share their findings and to find areas of concurrence between the groups. As issues become framed as topics for action, task forces are created around those issues. It is the job then of the issue task forces to develop specific proposals for implementation. Chapter Five will discuss the similarities and differences between the Swamp Yankee planning process and the Met State reuse planning process.

To understand why the Met State disposition process is happening, the following chapter describes the social, political, and economic factors that led to the closure of seven Massachusetts Department of Mental Health hospitals.
Deinstitutionalization of the Mentally Ill

The Rise and Fall of Large State Mental Hospitals

"In the eighteenth century, Americans began turning to institutions to care for their mentally ill, first in workhouses and almshouses, next in asylums and hospitals, and finally in large state-run mental hospitals."\(^{12}\) These institutions were originally designed to isolate the mentally ill and the mentally retarded from society and from the pressures of daily living. Over the last several decades, theories of the methods of care for socially segregated groups, including the mentally ill, have evolved from isolation of the groups in large institutions to their integration into the community. The state mental hospitals are now considered obsolete and inappropriate for a large proportion of their mentally impaired clients. The rise and fall of these large state mental hospitals illustrate the evolution of mental health ideology.

Large state mental hospitals were created in the mid-nineteenth century to take advantage of economies of scale and to house the chronically mentally ill, a group of patients considered unresponsive to treatment and, therefore, incurable. The number of chronically mentally ill patients had been growing rapidly in the mid-1800s, due to massive population growth from immigration. Previous methods of care for the

mentally ill used in the asylums, which preceded state mental hospitals, did not prove suitable for the huge caseload of chronic patients.

The care provided in the asylums was known as "moral treatment." "The essence of moral treatment was its belief that mental patients could learn behavioral self-control through a corrective relationship with a benign authority figure." With large numbers of chronically ill patients to care for, small group treatment sessions with an authority figure became nearly impossible to manage and produced few results. In order to more easily care for the chronically ill, the large state mental hospitals were created. Towards the end of the nineteenth century, as the mentally ill population grew, the hospital costs escalated. Inevitably, the priority for the hospitals became the custody rather than the treatment of their patients.

Although officially a medical institution in which treatment was presumed to be the legitimate, announced purpose, in practice, the actual functions served by state mental hospitals were (1) to provide inexpensive custody, control, and segregation of persons who were disruptive of social order or burdensome to their families; (2) to provide stable employment and health-welfare benefits for their staff (and, historically, they did serve as the arena for the professionalization of psychiatry); (3) to provide a cottage industry in towns with few or no other economic resources; and (4) to operate as a backup or "dumping ground" for cases deemed inappropriate or unacceptable by other health and welfare organizations and community practitioners.14

The centralization of mental health care at the state level was caused in part by the belief that local asylums did not provide adequate care for their patients, and that state hospitals could be organized and monitored more efficiently.

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13Ibid., p. 6.

The first state to centralize control of its asylums was New York, which created the position of State Commissioner of Lunacy in 1873. ... The commissioner convinced the legislature to pass the State Care Act of 1890, requiring that New York's counties send all of their mentally ill to state hospitals for care in centralized facilities. The immediate result of this act was a staggering increase in the population of the state hospitals: in the decade following passage, the state hospital census in New York State went from 5,402 to 21,815, largely because the counties reclassified their senile elderly as mentally ill and shifted much of the cost of their care to the state. The State Care Act quickly became a model for the rest of the country.\textsuperscript{15}

At the beginning of the twentieth century, the mental hygiene movement emerged as an outgrowth of the Progressive Era. The founders of the movement, unhappy with the custodial care and severe overcrowding in the state mental institutions, believed that

institutions (prisons or mental hospitals) could coexist with, and even sponsor, non-institutional programs.... Institutions dominated the system so as to make other options almost impossible to realize.... They imagined that non-institutional programs might take away some clients from the institution, that probation might spare an offender from a term in a state prison, that a community clinic might spare a patient from a stay in a state hospital.\textsuperscript{16}

Unfortunately for the founders, the existing mental health system was not yet ready to turn its patients out from the institutions into the community. State hospital superintendents wanted to hold onto their powerful position as primary care givers rather than become a supplement to the non-institutional programs. Although the mental hygiene movement did not alter the methods of care in the early 1900s, it did contribute to the changing ideology that led to the deinstitutionalization of the mentally ill and the community mental health movement several decades later.

\textsuperscript{15}Johnson, p. 12.

Factors that Contributed to Deinstitutionalization

In the mid-1900s, several factors either amplified the mental health community's dissatisfaction with state mental hospitals or created opportunities to reduce the need for them: the deteriorating conditions of the state mental hospitals, the invention of new treatment drugs, the shift in attitude toward the care of the mentally ill, the emergence of new legal rights for the mentally ill, federal legislation that directed attention away from state mental hospitals, and new federal programs that allowed states to shift mental hospital patients to federal welfare rolls.

Conditions in State Mental Hospitals

The conditions within, and of, the state mental hospitals were deteriorating rapidly. The care provided within the hospitals had worsened to the point that simple custody was barely achieved.

In the 1940s, journalists began to expose inhumane conditions in overcrowded and understaffed State mental hospitals (Deutsch, 1948; Gorman, 1948). At that time, sedation and restraints were used more often than necessary, and little active therapy was available to hospital residents. The custodial nature of care made many hospitals seem more like prisons than therapeutic havens. Reform-minded professionals and lay persons alike began to perceive these institutions as inherently detrimental to patients, and they looked for ways to improve hospital conditions and create better treatment alternatives (Foley and Sharfstein, 1983; Goffman, 1961).

A Life magazine article from 1946 contained graphic descriptions and pictures of the appalling environment in which hospital patients were forced to live. This media

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exposure of the conditions within the state hospitals encouraged the public to view the hospitals as places of disrepute.

The conditions of the state hospitals also began to deteriorate as states turned their attentions to other forms of mental health care. The majority of the hospitals were built in the 19th century, but states were reluctant to invest money into needed rehabilitation or capital construction for facilities that were becoming outmoded. Dangerous living conditions resulted, causing the public to demand an alternative to state mental hospitals. As the states responded to the calls for alternatives, the states continued to divert funds away from the hospitals, continuing the cyclical decline of the hospitals' physical conditions.

Advances in Drug Treatment

In the 1950s, several psychotropic drugs were created that helped control symptoms of mental illness, particularly the symptoms of schizophrenia.

The use of drugs gave the staff [of state mental hospitals] greater confidence in its own efficacy and helped dispel the feeling of hopelessness and apathy that had captured the mental hospital. All these conditions gave impetus to administrative changes such as eliminating restraints, minimizing security arrangements, and encouraging early releases.  

Certain patients in the state mental hospitals who took the medications were then able to be released into the community. The drugs could be administered anywhere, so the former patients did not have to be readmitted to the hospitals. "For the first time in

almost two hundred years the patient population of the mental hospitals was decreasing."

Shifts in Attitude toward Treatment

Social policy changed in the mental health community, as well as in other segregated institutions (such as those for criminals and the physically disabled), from reliance on institutional custodial care to case-by-case review of individuals and reliance on community care programs. This shift in attitude was due in part to the conditions of the state institutions and also to the realization that the mentally ill and other populations are very diverse and that different persons can benefit from different types of treatment. Not all of the residents of the state mental hospitals were chronically ill, and, therefore, did not need to be kept in the hospital on a long term basis. Integration into, rather than isolation from, the mainstream of society was considered beneficial for the mentally ill who were thought to be stigmatized by their residence in the state hospitals and their separation from the community.

New Legal Rights for Mentally Ill Persons

In the 1960s, several state and federal courts and state legislatures began to establish certain rights for the mentally ill. The first right was the right to treatment, which meant that custodial care was not sufficient. The second right was the right to live in the "least restrictive environment."

The principle of least restrictive handling of governmental interests was first set forth by the Supreme Court in a noninstitutional context, in Shelton v.

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Following this precedent, legal experts in the fields of mental health and retardation argued that the state has an affirmative obligation to search for alternatives to commitment that are less restrictive than a state hospital, whenever the state's purposes could be carried out 'as well or better.' In addition, a state had a duty 'to limit confinement to the least restrictive institutional setting and to discharge the committed patient outright, or to less restrictive community alternatives, once continued institutionalization could no longer be therapeutic.'

The third right was the right to voluntary admission to state mental hospitals. "State legislatures began to pass laws that required that persons be mentally ill and dangerous to themselves or others before they can be involuntarily committed." These latter two rights virtually guaranteed a further decline in the state mental hospital census.

Federal Legislation
In the mid-1900s, federal legislation was the impetus for the move towards deinstitutionalization of the state mental hospitals. The National Institute of Mental Health was created in 1946, providing a national focus for mental health policy. "The National Mental Health Act of 1946 provided training grants for mental health manpower, created networks of community clinics, and stimulated research into causes, diagnoses, and treatments of mental diseases." In 1955, the Mental Health Study Act was passed, which produced a study published in 1961, entitled *Action for Mental Health*. This study provided a basis for the development of a national deinstitutionalization policy. The Community Mental Health Centers Act of 1963

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20 Lerman, p. 159.

21 U.S. Department of Health and Human Services, Deinstitutionalization, p. 5.

mandated community mental health centers that would provide inpatient, outpatient, emergency, and partial hospitalization. By focusing attention on community mental health centers, the federal government was encouraging states to transfer patients from the state mental hospitals into the community, in other words, to deinstitutionalize the mentally ill.

**Funding Shift from State to Federal Government**

The federal government inadvertently encouraged its deinstitutionalization policy by creating federal welfare programs. States, of course, wanted to take advantage of this opportunity to obtain federal funds. "Just as the county was eager to shift a part of its social problems to state support (pre-1930), so were the states eager to have external funds replace--or reduce--reliance on traditional, state-subsidized institutionalization (post-1950)." Patients in state mental institutions, however, were not eligible for these federal welfare programs. In order to obtain federal funding, states reclassified many mental hospital patients by placing them in community settings. For example, if a state hospital patient was over 65 years old and was transferred into a nursing home, the patient's costs could be paid by Medicare; if the patient was transferred to a general hospital, the patient's costs could be paid by Medicaid.

The creation of the Medicaid program in the mid-1960s created fiscal incentives that further promoted a shift in the locus of care from State institutions to community-based treatment programs, notably nursing homes and general hospitals. In addition, the Federal Supplemental Security Income (SSI) Program, and later the Supplemental Security Disability Insurance (SSDI)

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23 Lerman, p. 39.
Program, provided direct entitlements to mentally disabled individuals living in the community. As a result of the confluence of these laws and policies, the State hospitals' census was reduced nationally from 560,000 in 1955 to 216,000 in 1974; it fell to 100,000 in 1989 (NIMH 1991b).24

One of the welfare programs mentioned above, Supplemental Security Income (SSI), which was created in 1972, replaced Aid to Permanently and Totally Disabled (APTD). Unlike APTD, SSI provided 100 percent federal assistance, and removed any funding requirements for the states. In anticipation of SSI, states quickly transferred persons out from state mental institutions, where they could not be funded under APTD, to general hospitals or other community settings, where they would be APTD eligible.

Prior to SSI, from 1962 to 1970, the number of adult APTD recipients grew from about 421,000 to 866,000—a gain of 106 percent in eight years. In only four years from 1970 to the eve of SSI on December 31, 1973, the number of adult APTD recipients soared to about 3 million persons—a gain of 247 percent.25

These federal policies, in combination with the new drug treatments and social and legal rights of the mentally ill, ensured that the deinstitutionalization of the mentally ill was in full effect all across the country.

Brief History of Massachusetts Mental Health Administration

The Commonwealth of Massachusetts has a long history of providing services to its mentally ill residents. In 1832, the Worcester Lunatic Asylum was established as the first state program for the mentally ill.


25 Lerman, p. 94.
The State Board of Insanity, which was created from the State Board of Lunacy and Charities in 1898, was the first state agency specifically established to oversee mental health programs. The Commission on Mental Diseases was established in 1916, and, three years later, became a Department of Mental Diseases. Subsequently, in 1938, the Department of Mental Health was formed. ... By the early 1950's, there were twelve state hospitals serving some 23,000 persons, representing an all time high in the state hospital census.26

Like the rest of the states, Massachusetts began establishing a community-based system of care after the passage of the federal Community Mental Health Centers Act of 1963. "Over a twenty year period (1960-1980), ninety percent of the clients in the Massachusetts state hospitals were discharged to the community, where it was anticipated that a full spectrum of treatment and support services would be provided."27 Federal legislation was not the only factor that encouraged provision of acute care services of the mentally ill outside of Department of Mental Health (DMH) hospitals.

The designation of mental health care as a reimbursable service under many health insurance plans spurred the development of private mental health clinics, which served large numbers of persons who required outpatient care. ... As private mental health services became widely available for those with insurance, DMH became the provider of last resort, for persons lacking these resources.28

During the 1960s and 1970s, three of the twelve state mental hospitals were closed, and the remaining nine were virtually ignored by the state administrators and legislators. Resources were diverted away from the state hospitals to the community

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26 Commonwealth of Massachusetts, Executive Office for Administration & Finance, Division of Capital Planning and Operations, Design Guidelines for Mental Health Facilities (2/89), v. 1, p. 15.

27 Ibid., p. 6.

28 Ibid., p. 16.
mental health centers and other community programs. As conditions in the state hospitals deteriorated, a new advocacy group formed in the early 1980s, the Alliance for the Mentally Ill of Massachusetts, made up primarily of family members of chronically mentally ill patients. At the same time, a report was issued by the "Special Senate Committee to Review Commitment and Release Procedures of the Department of Mental Health, which had investigated the conditions at the state hospitals in the wake of a brutal murder committed by a prematurely-released state mental patient." As a result of the report and the efforts of the Alliance for the Mentally Ill, Governor Dukakis submitted to the legislature his *Special Message on Mental Health* in 1985.

[T]he *Governor's Special Message*, entitled "A Comprehensive Plan to Improve Services for Chronically Mentally Ill Persons," called for massive investments in both capital and operating funds for the state’s inpatient facilities, coupled with equally substantial investments in community services. For the first time, public policy supported both the institutions and the community-based system, and articulated the role for each component in a complete system of care.

In 1988, the Department of Mental Health (DMH) published a Status Report to the *Governor's Special Message on Mental Health*. DMH determined that the promise of the Special Message had been "fulfilled" and that "DMH is becoming the provider of choice, not the provider of last resort, for seriously mentally ill persons and their families." 

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29 Ibid., p. 9.

30 Ibid., p. 10.

In January 1991, Massachusetts' new Governor, William Weld, took office. In the summer of 1991, Governor Weld's administration published *Actions for Quality Care*, which called for the closure of four more of DMH's state hospitals: the Gaebler Children's Center, the Metropolitan, Northampton, and Danvers state hospitals. Another state hospital, Bridgewater Hospital for Sexually Dangerous Persons, was transferred to the Department of Corrections. Patients from the closed hospitals were sent to the remaining DMH hospitals, community residences, general hospitals, nursing homes, or Mental Retardation Schools. The following excerpt from *Actions for Quality Care* gives reasons why the state decided to consolidate the hospitals.

The Commonwealth's inpatient facilities system, which was built to accommodate over 35,000 individuals at its peak, today cares for 6,200 clients. Encompassing some 10,500 acres and over 1,000 buildings, stretched over 34 campuses, the inpatient system is grossly oversized for the number of people in its care. Moreover, of those 6,200 individuals receiving care in institutions, at least 2,200 would be more appropriately cared for in community-based settings. Today, the state's inpatient facilities, which do fill an important need for very specific kinds of clients, would be appropriately-sized with capacity to care for 4,000 clients (Special Commission, 1991).

*Actions for Quality Care* also called for enhancements to the community mental health center system through maximization of Medicaid reimbursement opportunities, development of additional residential beds, and development of a public managed care system under the auspices of a local mental health authority.

**Current Status of Massachusetts Mental Health Services**

Out of the twelve Department of Mental Health hospitals once in operation, four hospitals remain open under the auspices of DMH: Medfield (175 beds),
Taunton (330 beds), Westboro (240 beds), and Worcester (225 beds). There are also two Department of Public Health hospitals with large DMH facilities: Shattuck and Tewksbury. Since the two Department of Public Health hospitals are accredited by the Joint Commission on the Accreditation of Healthcare Organizations, and since fewer than 50% of the patients are cared for by DMH staff, the hospitals are eligible for Medicaid reimbursement.

The Department of Mental Health also owns and operates seven Community Mental Health Centers (CMHC), which provide inpatient and outpatient care. Four of the CMHCs operate outside of the Metropolitan Boston area, and provide strictly acute care services. The other three CMHCs, which are within the Metropolitan Boston area, provide a combination of acute and continuing care services. Since five of the centers have 16 beds or fewer, they are not considered Institutes for Mental Disease (IMD) and so are eligible for Medicare and Medicaid reimbursements. In total, DMH operates 1,130 beds for the care of the mentally ill, with 160 at CMHCs and 970 at the state hospitals.

In order to take advantage of cost savings and flexibility offered by private vendors, DMH utilizes approximately ten private non-profit CMHCs for 20-25% of its clients. The private CMHCs are able to receive Medicare and Medicaid reimbursements and insurance payments.

Although there is no income eligibility standard to receive services, most often persons with insurance or financial resources are served in private facilities.

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This is, in large part, a function of the intentional diversion by DMH of persons with resources to other settings. ... This diversion is an essential element of the Department’s efforts to reduce overcrowding in its hospitals.\(^\text{33}\)

All seven of the DMH hospitals that have closed have been placed under the control of the Massachusetts Division of Capital Planning and Operations (DCPO). Once the hospitals were declared surplus to the needs of the Department of Mental Health, DCPO began the disposition process, which results in either the transfer of the hospital properties to another governmental agency or the sale of the properties to a private entity. To date, none of the hospital disposition processes have been completed. The following chapter will discuss the legal and administrative requirements for state property disposition, as they pertain to the state hospital properties.

Chapter Three

Massachusetts Property Disposition Process

The closure of the seven Massachusetts Department of Mental Health hospitals set in motion a lengthy planning process. Whenever a state facility is closed down, the state agency that controls the facility must decide whether to keep the property or declare it surplus to the agency's needs. If the agency decides that the property is surplus, then the State Division of Capital Planning and Operations (DCPO) manages the disposition of the property.

Chapter 7 of the Massachusetts General Laws, as amended by Chapter 579 of the Acts of 1980 and Chapter 484 of the Acts of 1984, directs the Division of Capital Planning and Operations (DCPO) to manage the Commonwealth's real property. One of DCPO's key property management responsibilities is the surplus real property disposition process. This process can result in:

- transfer of the care, control, and use of property between state agencies;
- lease or conveyance to local or county or other public agencies;
- sale or lease to non-governmental user, following a competitive proposal selection process.  

In general, DCPO disposes of small surplus properties, consisting of one building or parcel of land. When a property or facility is closed by a state agency, DCPO may begin the reuse planning process in anticipation of the agency's declaration of surplus. For large properties, like the state mental hospitals, the facility may be closed for

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34 Commonwealth of Massachusetts, Executive Office for Administration and Finance, Division of Capital Planning and Operations, Real Property Disposition Process, 11/86, p. 1.
many months before the declaration of surplus is signed by the state agency. The time lapse allows the state agency to make a well thought out decision regarding the agency’s current and future needs for the property. Once the declaration of surplus is signed, DCPO can begin its formal property disposition process.

The DCPO Real Property Disposition Process

1. When a property is no longer needed by a state agency, the agency informs its Secretariat, or DCPO if it is an Executive Agency, that the property is surplus to its needs.

2. The Secretariat either:

   Notifies DCPO that the property is no longer needed by the agencies in the Secretariat, and documents the rationale for the decision in the agency capital outlay budgets and 5-year plans.

   OR

   Recommends transfer of the property to another agency or vendor under its purview. Once DCPO approval is obtained, transfer between agencies within Secretariat is completed.

3. If the Secretariat determines that the property is surplus to the agencies in the Secretariat, DCPO certifies the Secretariat’s declaration of surplus and notifies all Secretariats and Executive Agencies of the availability of the property. This state agency polling process typically occurs for four weeks.

4. DCPO receives state agency use proposals and either:

   Declares the property surplus to state need if none of the proposals is feasible and consistent with the agency’s capital outlay budget and 5-year plan.

   OR

   Transfers property to other state agency if substantive and feasible proposal is received. Legislative authorization is required for significant changes in use. Once DCPO approval is obtained, transfer of control and use between agencies is completed.

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5. If DCPO declares the property surplus to state need, DCPO then notifies local and county governments of property availability and requests substantive proposals for direct public use of the property. DCPO receives proposals and either:

Determines that the property is surplus to public need if no proposals are received or the proposals lack substance and the possibility of resources to accomplish that purpose.

OR

Selects a proposal and holds a public comment on reuse terms and conditions that should be included in the land disposition agreement and deed or lease. Legislative authorization is required for disposition to the governmental body. Once Legislature authorizes the disposition, DCPO executes deed or lease to a public agency.

6. If DCPO determines that the property is surplus to public need, and the property is of considerable size or value, DCPO initiates the process of disposition to a non-governmental entity by convening one or more public hearings or meetings of a local advisory group to assist DCPO in setting development guidelines for the property. Local officials, legislators and citizens participate in these advisory groups, and the guidelines are incorporated into authorizing legislation and a Request for Proposals (RFP). This local advisory process is the focus of the thesis.

7. Legislative authorization for the disposition of the property is sought. (Certain agencies, including the Department of Public Works, have prior legislative authorization to dispose of property, in which case legislation for the disposition of individual parcels is not required.)

8. Provided legislative authorization is obtained, property is appraised as to the highest and best use and uses with any proposed restrictions or encumbrances.

9. DCPO invites proposals for the property through advertisements in the Central Register and local newspapers for 4 weeks. Public hearing notice is also published in the Central Register and local papers.

10. Requests for Proposals are distributed. Proposals are received and reviewed by DCPO and advisory group. Public hearing held to present proposals and solicit public comment.

11. Proposal selected by DCPO. DCPO circulates notice of disposition to local government and legislature at least 120 days before disposition is completed. Land disposition agreement (LDA) or lease negotiated.

12. Land disposition agreement and deed or lease are executed. DCPO transfers property to non-governmental user.
The twelve steps described above do not necessarily occur sequentially. In the case of large properties, DCPO may conduct portions of the state and local polling processes concurrently. This is useful if it becomes clear that a state agency and a local agency would like to control different portions of the property. Administering the polling processes concurrently allows DCPO to consider the options for a reuse package for the entire property.

**Legislative Authorization**

Depending upon the reuse options being considered for the surplus property, legislative authorization is required in order for DCPO to complete the disposal of the property. Legislative authorization is required in three cases: when the property is transferred between state agencies and will undergo a significant change in use; when the property is sold or leased to a local or county government; or when the property is sold or leased to a non-governmental entity. A significant change in use for a property is defined as "either a change in the purposes for which such building is currently used or a change in use in excess of fifty per cent of the usable floor space...." 36 Since all seven of the closed state mental hospitals will be undergoing a significant change in use and/or will be transferred to a local governmental agency or non-governmental entity, DCPO must seek legislative authorization for their disposal.

While legislative authorization is only mentioned briefly in the DCPO Real Property Disposition Process and in Chapter 7 of the Massachusetts General Laws,
obtaining legislative authorization is one of the most important steps in property disposition. No amount of planning on the part of DCPO can guarantee that the state legislators will approve the property disposition legislation. Of course, the state legislators will be more likely to approve the legislation if their constituents support it. For DCPO, obtaining the approval of the legislators and constituents of the community, or communities, in which the property resides is crucial. Particularly for large properties, where the impact of any chosen reuse will be widely noticed, DCPO often asks for input from the community legislators and constituents. Gaining community input helps DCPO produce a wise reuse plan and often expedites legislative approval.

In deciding how to obtain community input, DCPO is guided by Chapter 7 of the Massachusetts General Laws.

The deputy commissioner [of DCPO] may convene an advisory committee to advise him on reuses and to recommend reuse restrictions for property declared surplus. If an advisory committee is convened, the deputy commissioner shall invite the representatives to the general court from the city or town in which the property is located to serve on the committee. The deputy commissioner shall prepare a preliminary report on his findings, which shall include both his recommendation, and those of the advisory committee if established, for reuse restrictions for the property.\(^\text{37}\)

In addition to asking state legislators to serve on the advisory committee, DCPO often asks local public officials and citizens to serve on the committee. DCPO is also required by law to hold public hearings to invite community input and to explain any actions to be taken with the property. Acquiring the input of the community officials

\(^{37}\text{Ibid.}\)
and citizens in the preliminary planning stages is valuable for DCPO in obtaining the support of the state legislators before disposition legislation is even filed.

When DCPO decides that the reuse options and reuse restrictions have been sufficiently clarified and agreed upon, DCPO will draft the property disposition legislation. Chapter 7 of the Massachusetts General Laws provides DCPO with requirements for disposition legislation.

If the deputy commissioner [of DCPO] is recommending the approval of a bill proposing the disposition of a parcel exceeding two acres, said report shall include: (1) a description of the property including its current use, structures, and approximate metes and bounds; (2) the value of the property, determined through procedures customarily accepted by the appraising profession as valid for such purposes, calculated both for (a) the highest and best use of the property as currently encumbered and (b) uses and encumbrances that would be imposed by the bill if enacted; (3) all current and foreseeable direct public uses identified by following the division’s procedures for such purposes as they apply to the property to be disposed; (4) other potential public and private uses of the property; and (5) any other information the general court may require. 38

If an advisory committee has been created, DCPO may decide to present the draft legislation to the committee in order to gain their approval and expedite legislative approval. When the proposed bill is completed, DCPO submits it to the Governor of Massachusetts. The Governor is then responsible for actually filing DCPO’s legislation with the state legislature.

If the legislation is not passed, then DCPO or a state legislator can submit legislation again with any revisions that may improve the chances of passage. Once legislation is passed, then any transfer of the property, or portion of the property, to a state agency is complete. If the legislation approves transfer to a local or county

38 Ibid.
government, then that agency has the opportunity to purchase or lease the property from the state. If the legislation approves transfer to a non-governmental entity, then DCPO begins marketing the property, or portion of the property, and drafting a Request For Proposals (RFP). The Request For Proposals refers to the reuse document prepared by DCPO during the planning process and outlines any reuse restrictions that must be adhered to. DCPO then follows the above steps 10 through 12 of the Real Property Disposition Process.

In the case of the Metropolitan State Hospital disposition, DCPO is still meeting with the three advisory groups, or Reuse Task Forces, but has begun to draft disposition legislation. Chapter Four documents the steps in the disposition process that have been completed to date and presents the reuse options that have been discussed.
Chapter Four

Metropolitan State Hospital: Case Study

The Metropolitan State Hospital disposition process provides a rich case study for learning about inter-local decision making and conflict resolution. When the Hospital was closed down by the Massachusetts Department of Mental Health in the fall of 1991, the State began to plan for its reuse. The Massachusetts Division of Capital Planning and Operations (DCPO), which handles property reuse planning and disposition, decided to convene an advisory committee made up of community members in order to gain community consensus regarding the reuse of the property. The Metropolitan State Hospital reuse planning has been complicated because the property straddles three communities, each with a different governmental structure and set of needs and resources. The State of Massachusetts, which currently owns the property, also has its own needs and resources. These differences have led to conflict over how best to reuse the property. This case study will explore why conflicts have arisen and document how the three communities and the State have dealt with their conflicts.

Brief History of the Metropolitan State Hospital

The property known as the Metropolitan State Hospital is located nine miles northwest of Boston, Massachusetts. The property consists of 346 acres, which
straddle the Towns of Belmont and Lexington, and the City of Waltham. (See Map #1) In the 1920s, the State of Massachusetts took the property by eminent domain in order to build a state mental health hospital that would be accessible to the Boston metropolitan area and would ease the caseload at Boston State Hospital. The Metropolitan State Hospital was built in 1930 and, by the 1950s, housed almost 2,000 patients.³⁹

The next few decades saw Metropolitan State Hospital decline in census and physical condition, due to the state's tacit policy of deinstitutionalization. In 1985, Governor Dukakis tried to slow the deterioration of the state hospitals by proposing multiple renovation projects in his *Special Message on Mental Health*. By 1990, most of the renovation projects were only in the design stages and were put on hold when Governor Weld was elected. In 1991, under Governor Weld, the Special Commission on Consolidation of Health and Human Services Institutional Facilities published *Actions for Quality Care*. This plan called for the closure of several state hospitals, including Metropolitan State Hospital and the adjacent Gaebler Children's Center. At the time of the report, Metropolitan State Hospital was undergoing a phase down from 400 patients to 120 patients, and its census was 260. One reason for the closure of the Hospital was its deteriorated physical condition.

power plant are original and need significant repairs/rebuilding. Estimates to rebuild the newer portion of the campus for 120 institutional beds and 80 transitional beds approaches $17 million dollars. These funds would be more appropriately invested in community programs and other state facilities.\(^{40}\)

Another reason for closure was the desire to save money by placing patients in facilities that qualified for federal reimbursements. "The annual net state per patient cost at Metropolitan State Hospital is $98,500. Providing the necessary services in an appropriate setting will result in a savings of $12.93 million dollars annually, a 5 year savings of $65 million dollars."\(^{41}\) The plan then called for the 260 patients at Metropolitan State Hospital to be transferred to other care settings. Fifty percent would be moved to other state hospitals, 35% to community residences, 10% to general hospitals, and the remainder to either nursing homes or Mental Retardation Schools.\(^{42}\) The Metropolitan State Hospital was closed in the fall of 1991 and declared surplus by the Department of Mental Health in the fall of 1992.

The Gaebler Children's Center, which is adjacent to the Metropolitan State Hospital, was closed by the Department of Mental Health in the fall of 1992. Gaebler was built in the early 1950s, and, at its peak, provided care for 155 children.\(^{43}\) Gaebler was closed down primarily because of the costs involved in obtaining national

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\(^{41}\) Ibid.

\(^{42}\) Ibid.

\(^{43}\) Letter to Eileen Elias, Massachusetts Department of Mental Health Commissioner from Joan Mikula, Assistant Commissioner, Child/Adolescent Services. Boston, 2 April 1992.
accreditation by the Joint Commission on the Accreditation of Healthcare Organizations. Governor Weld's *Actions for Quality Care* explains the reasons for closure:

-- An infusion of $4 million is needed for renovations to become Medicaid reimbursable.
-- The current site is not cost-effective if the configuration includes fewer inpatient beds.
-- The cost of the superstructure required for a certified hospital (eg. professional committees, medical records) increases the per diem rate.
-- Gaebler, being a state institution and isolated from the community, has a stigmatizing effect upon children and families who go there to receive services.  

The Department of Mental Health transferred its funding for children’s services to private psychiatric hospitals, community mental health centers, and residential programs. Once the Gaebler Children’s Center was closed, the Massachusetts Division of Capital Planning and Operations (DCPO) added the Gaebler property to the Metropolitan State Hospital property, in order to develop a cohesive reuse plan for both sites.

**The Initial Planning Process**

Metropolitan State Hospital contains one of the last large undeveloped open spaces located within the Route 128 belt. The property is adjacent to institutional properties, conservation land, and residential neighborhoods. Nearby are the McLean Hospital and Middlesex Hospital. The property straddles three communities, with 9.5% of the acreage in the Town of Belmont, 25.5% in the Town of Lexington, and

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44 *Actions for Quality Care: Appendix: Department of Mental Health Recommendations* (Boston: Executive Office of Health and Human Services, 1992), Appendix 7, p. 2.
65% in the City of Waltham. Undeveloped open space constitutes 80% of the area, or 270 acres, with the remaining 75 acres consisting of several hospital buildings and surrounding grounds. (See Map #2) When Metropolitan State Hospital closed, DCPO and the three communities realized that they had a wonderful resource to reuse.

The portions of Met State within each community are very different. The 9.5% located in the Town of Belmont is undevelopable because it comprises wetlands and steep slopes. The 25.5% located in the Town of Lexington contains the main hospital buildings and the majority of reusable floor area. The 65% located in the City of Waltham contains the Gaebler Children’s Center building, seven small campus buildings, a large front lawn, Mackerel Hill (with scenic vistas), and wetlands. The Belmont portion is zoned "Single Family Residential D", the Lexington portion is zoned "One-Family Dwelling", and the Waltham portion is zoned "Conservation/Recreation." The three communities are likely to change their zoning depending on the reuse options chosen.

Since Belmont and Lexington are Towns and Waltham is a City, their forms of government are also very different. The Town of Belmont has a three-member Board of Selectmen and a Town Administrator. The Selectmen have most of the administrative power of the Town. The Town Administrator has some administrative power but less than a Town or City Manager. The Town of Lexington has a five-member Board of Selectmen and a Town Manager. Both Belmont’s Town Administrator and Lexington’s Town Manager are responsible for the daily operations of the Town. Both Towns operate with an annual Town Meeting, made up of citizen
representatives. The Town Meeting members have the legislative power to pass bylaws. In contrast, the City of Waltham has a 15-member City Council and a Mayor. The Mayor has significant administrative power, combining the roles of the Board of Selectmen and Town Manager. These governmental forms represent distinct modes of democracy and distinct levels of perceived accountability to their citizens.

One of DCPO's initial steps in the reuse planning process was to ask the Boards of Selectmen from the Towns of Belmont and Lexington and the Mayor of the City of Waltham to each appoint a Reuse Task Force for the Metropolitan State Hospital (hereafter referred to as Met State). The purpose of creating the Task Forces was to develop a forum for discussion of reuse options for Met State. Since the property will not continue to be used as a mental health hospital, DCPO must obtain legislative approval of the Met State disposition. DCPO feels that the only way to obtain legislative approval is to obtain community approval. Creating the Task Forces allows representatives from the three communities and DCPO to work together to define a mutually acceptable reuse for Met State.

The three Task Forces are both similar and different in many ways. Each has five to ten voting members and one chairperson. Each Task Force also has representatives from its community's Conservation Commission and Planning Board or Planning Department as members. The personalities and styles of the Task Force members, however, are quite distinct. Each Task Force member has a different personal background affecting the reasons he or she is interested in the future of Met State and affecting the values that he or she brings to the Met State meetings. For
example, Anita Hume, a member of the Belmont Task Force and former Task Force chairwoman, is a member of the Belmont Cemetery Planning and Development Committee. At the beginning of the Met State planning process, Hume supported putting a cemetery on a portion of the Met State site. Marie Daly, a Waltham Task Force member, co-founded the Beaver Brook Watershed Coalition, which advocates for the environmental protection and preservation of the Watershed. Since Met State comprises part of the Watershed, Daly opposed the cemetery proposal.

The Task Forces contacted the Metropolitan Area Planning Council (MAPC), a regional planning agency, in the spring of 1992 to ask for data and technical assistance in determining the best land use options for Met State. DCPO already had access to technical planning data through its consultants, and the Task Force members wanted a consultant of their own, who would work with all three Task Forces. Joan Blaustein, a Land Resources Planner from MAPC, became responsible for attending meetings with the Task Forces. Joan helped gather market data for several reuse options, arrange Task Force meetings, and prepare minutes from the meetings. Because of the large amount of staff time deemed necessary for the Met State process, Joan applied for the State-funded Municipal Incentive Grant to help the Task Forces pay for her services. In the grant application, Joan stated that she would use the funding to study municipal re-use options for the property.

A Project Manager from DCPO's Office of Real Estate Management, Lorrie Louder, began meeting with the three Task Forces in the summer of 1992. The Project Manager and the Task Force members soon realized that their goals for reuse
of the property were quite different. DCPO wanted to maximize revenues from the sale of the site. Governor Weld had just promised to save money by closing the state hospitals down and promised to raise over $100 million in revenue from the sale of these prime real estate properties. Given the Administration's policy goal, DCPO asked its consultant, Penobscott Group, to determine the reuse of the Met State property that would generate the most revenues. The consultant's report recommended over one million square feet of office space. When DCPO presented that recommendation to the three communities, their response was extremely negative.

The three Task Forces do not believe that maximizing revenues should be the primary goal in reusing the property. The Task Forces want to tailor a reuse that will serve the needs of the three communities. In fact, the Task Forces felt that DCPO was trying to complete the reuse planning process as quickly as possible in order to minimize community input and guarantee that the property would be reused by the highest paying developer. In November 1992, the DCPO Project Manager, Lorrie Louder, presented the Task Forces with a marketing brochure that DCPO had developed for Met State to solicit interest from developers. The Task Forces thought that DCPO was acting prematurely, since the state and local polling processes required for property disposition had not been completed yet. Louder stated that DCPO wants to see an economic return on the site, but with a use that is consistent with the communities' desires. Louder was not well received by the Task Force members, not simply because she represented DCPO's interests, but also because of her personal style. In the view of a number of those interviewed, Louder did not consider the Task
Force members' interests to have equal standing with DCPO's interests, and, therefore, she treated the Task Force members condescendingly.

Also in November 1992, a Met State Working Group was created at the suggestion of DCPO. The purpose of the Working Group was to form a group of workable size to help shape the Met State reuse options. The Working Group met frequently in between the larger tri-community Met State meetings. Since attendance at the tri-community meetings had been averaging 30 people, the DCPO Project Manager felt that the smaller Working Group would make the meetings more productive. The Working Group was made up of the DCPO Project Manager, Joan Blaustein of MAPC, Dan Driscoll of the Metropolitan District Commission (MDC), the Task Force chairmen from Lexington and Waltham, the Town Administrator of Belmont, and one staff person from each community. The municipal Working Group members were expected to represent the views of their communities' Task Forces.

Lorrie Louder, the first DCPO Project Manager, left DCPO when the Working Group was created. Carol Gladstone, the Director of DCPO's Office of Real Estate Management replaced Louder for one meeting, and was succeeded by John Civilinski, the new Director of the Office of Real Estate Management. John Civilinski asked David Dixon, a consultant from Goody Clancy & Associates, to assist DCPO in improving its relationship with the three communities and in responding to the technical planning issues as they emerged. In March 1993, John Civilinski appointed Mika Brewer to be the Project Manager. Mika Brewer and David Dixon have since represented DCPO at Met State meetings. By tacit agreement among the Task Force
members and DCPO, Brewer and Dixon have led most of the Working Group and tri-
Task Force meetings and have been responsible for drafting the Met State Reuse Plan.

Both inside and outside of DCPO’s reuse planning process, citizens from the
Met State communities have been very active in trying to influence the reuse options
being considered. One of the first concerns raised was the possible impacts of the
reuse options on the sensitive environmental habitats and wetlands located at Met State
that are part of the Beaver Brook Watershed. In the spring of 1992, Marie Daly, a
Met State abutter who later became a Waltham Task Force member, formed the
Beaver Brook Watershed Coalition with John Andrews of Citizens for Lexington
Conservation and Nancy Childs, a naturalist at Habitat Institute in Belmont who later
became a Belmont Task Force member. The Coalition mapped the wetlands and other
sensitive areas at Met State. The Coalition also conducted tours of the Met State
property and gave slide shows to community groups to educate citizens and public
officials about the importance of preserving the undeveloped land. Most importantly,
the Coalition succeeded in gaining the interest of the Metropolitan District Commission
(MDC), which owns and operates over 16,000 acres of parks and reservations in the
metropolitan Boston area. The Coalition proposed that MDC try to acquire a portion
of Met State for a reservation during the state polling step of the DCPO disposition
process. MDC eventually agreed to the Coalition’s proposal, and Dan Driscoll, an
MDC Senior Planner, began attending Met State meetings.

The second issue was the historic value of the buildings and courtyards at Met
State. In the fall of 1992, Candace Jenkins, a historic preservation consultant and
Belmont Task Force member, informed the other Task Force members that rehabilitating and preserving the main campus buildings could be less costly than tearing down the buildings, as DCPO wanted to do. DCPO felt that razing the buildings would make Met State more attractive to developers. Candace also served as a consultant to the Massachusetts Historical Commission, which nominated 15 state hospital campuses, including Met State, to the National Historic Register. The Met State nomination was accepted in January 1994. Being listed on the National and State Registers means that the historical and architectural significance of Met State must be considered for any project in which federal or state money is involved. The State will be investing several million dollars at Met State to prepare the site for reuse.

The third issue was the traffic impacts that would be generated by high density reuses at Met State. The main entrance to Met State is from Trapelo Road in Waltham, which currently experiences heavy traffic during morning and afternoon rush hours. Consistent with traffic impact information gathered by DCPO’s consultant and the traffic engineers from the three communities, the Task Forces determined that the high density office complex originally suggested by DCPO would be totally unacceptable.

As a way of summarizing the concerns that emerged out of the preliminary Met State discussions, the three Task Forces agreed on four common goals:

Goal 1: Preserve and protect the natural resources of the site as an ecological preserve open to the public

Goal 2: Redevelop the site with a mix of publicly beneficial uses and revenue producing uses which meet the following performance criteria: -Generate relatively low traffic levels
- Preserve the feeling of openness and visual quality of the site from adjacent roads
- Minimize adverse impacts on surrounding neighborhoods
- Reflect locally identified needs and priorities
- Not adversely affect the protected open spaces
- If feasible, rehabilitate the existing buildings and protect historic landscapes

Goal 3: Consider the site as a whole, without regard to municipal boundaries

Goal 4: Restore use of the site as early as possible giving due regard to all environmental protection laws and fiscal constraints

Goal 4 was set because Met State is on the Massachusetts Department of Environmental Protection 21E Site List as a Confirmed Disposal Site. "[T]here is evidence of subsurface contamination from leaking fuel tanks, pollution of a tributary to Beaver Brook, improper storage of oily wastes and asbestos health hazards, all within the power plant." 46

DCPO also developed its own goals for the planning process:

Goal 1: Achieve consensus plan for redevelopment of property

Goal 2: Enact legislation authorizing disposition consistent with consensus plan

Goal 3: Revise local zoning to allow uses and density identified in the consensus plan

DCPO realizes that by achieving Goal 1, achieving Goal 2 is made easier. DCPO also has six goals for redevelopment:

Goal 1: Redevelopment plan which is financially feasible (self funding), and which, at minimum, generates sufficient revenue for the state to cover costs of site

45 Metropolitan Area Planning Council, Re-Use Recommendations for Metropolitan State Hospital; DRAFT (June, 1993), p. 6.

preparation necessary to allow redevelopment to occur (eg, environmental remediation, demolition and/or building stabilization, road and utility work)

Goal 2: Preservation of important natural resources

Goal 3: Support uses which encourage long term economic health of region (jobs and economic activity, housing)

Goal 4: Increase local tax base, local tax revenue

Goal 5: Provide benefits to the clients of the Department of Mental Health

Goal 6: Redevelopment plan which can happen in a timely fashion, to minimize holding costs 47

These six goals show a significant change in DCPO's willingness to meet the needs of the three communities. This change in attitude stems from the realization that DCPO's primary goal is to pass disposition legislation, not to maximize state revenues. In order to pass legislation, DCPO must obtain community support.

The Working Group

In November 1992, MAPC was awarded the State Municipal Incentive Grant. Joan Blaustein's first task was to develop a list of desired potential uses for Met State. Joan suggested that each municipality nominate a few uses, and that the Working Group select three uses from the nominations to be studied under the grant. The Belmont Task Force nominated preservation of open space, housing that would meet regional needs, and a cemetery, which was anticipated to be inappropriate for the site. The Lexington Task Force nominated preservation of wetlands and open space, mixed ownership and rental housing for mixed income households, and private/public

educational or agricultural uses. The Waltham Task Force nominated housing for first-time homebuyers, Bentley College expansion, senior housing/assisted care, recreational use, and a golf course.48

The Working Group met for one year, trying to narrow the number of reuse options being considered. The Group's progress was impeded since most of the community Working Group members did not, or were not able to, represent all the interests of their Task Force members. The Working Group members also had different styles for communicating issues between the Working Group and the Task Forces. Some Working Group members thought that their role should be just to convey information back and forth. Others thought that they should speak for their Task Force members. During this time, the three Task Forces met together infrequently at public meetings, at which the Working Group members would speak as a panel to the other Task Force members. The public meetings were an attempt to present the Working Group's progress to the Task Force members and the public and to obtain their feedback.

Both Working Group and Task Force members expressed their frustration regarding this stage of the planning process. Several Working Group members were frustrated that the Working Group was not able to make substantive decisions, since the community Working Group members could not represent the interests of the Task Forces. Within each Task Force there were differing viewpoints about the reuse

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48 Joan Blaustein, Minutes of the Metropolitan State Hospital Meeting, Belmont, MA, 8 December 1992.
issues, making it difficult for the community Working Group members to commit to specific proposals. Several Task Force members were frustrated because of the perception that decisions were being made at Working Group meetings without their input. This perception was reinforced by newspaper articles touting that deals were being made between the Task Force chairmen and DCPO.

**The Fact Finding Groups**

In an effort to end the frustration and misunderstandings, DCPO suggested that the three Task Forces meet together more often to try to get consensus on the reuse issues in the political arena of the tri-community public meetings. More importantly, one of the Working Group members suggested that joint committees be created around the issues that were causing conflict. The Working Group members formed three Fact Finding groups, made up of Task Force members and staff from each community. The goal of the Fact Finding groups was to develop objective information that all the diverse interests could agree upon as a basis for decision making. It was difficult, however, for the Working Group and Task Force members to clearly articulate the duties of the Fact Finding groups. For example, the traffic Fact Finding group was initially going to determine the traffic impacts from a range of reuse options. Instead the group tried to determined whether the uses already described in the draft reuse plan would have workable traffic impacts, and concluded that the impacts would, or could, be mitigated. A few Working Group members, however, wanted the traffic group to complete its initial objective of determining the traffic impacts of a range of options. Belmont’s planning consultant, for example, wanted to be able to provide
data to the Belmont Task Force members to justify the preclusion of particular reuses. Nevertheless, the traffic group never obtained data for the reuse impacts.

The second group was to address the alternatives for protecting the front lawn of Met State along Trapelo Road and for providing recreation uses, such as a golf course. Instead, the group spent the majority of its time creating conditions for the proposed golf course to make it as environmentally benign as possible. The golf course idea was first proposed as an 18-hole course by the Waltham Task Force chairman in December 1992. After preliminary mapping of the site determined the extent of the wetland area, the 18-hole golf course was removed from the list of reuse options since it would not fit in the developable area. In the summer of 1993, the golf course idea resurfaced. This time, the Waltham Task Force chairman proposed a nine-hole public golf course, since the Task Force had received calls from Waltham citizens asking for a golf course and since the Mayor of Waltham strongly desired a golf course. DCPO hired a golf course designer who said that a nine-hole course could fit on the site. Given that fact, the Waltham Task Force chairman applied pressure on the other Working Group members to study the golf course further. Most likely, this pressure changed the focus of the golf course Fact Finding group.

The third group addressed the community housing needs that should be met in the Met State developable area. While all three communities have different housing needs, the housing Fact Finding group has been able to meet its objectives more easily than the other two groups. This is due in part to the fact that nearly all of the housing units will be in Lexington, and that housing as a reuse option is supported by all three
The housing Fact Finding group also addressed the needs of the mentally ill. The Alliance for the Mentally Ill (AMI), a non-profit advocacy group, and the Massachusetts Department of Mental Health both expressed a desire to designate a portion of the housing units for the mentally ill. AMI wants either 10% of all the units to be supported apartments randomly situated throughout the development and 10% of the proceeds from sale to be placed into a housing trust fund for DMH, or a larger housing trust fund, if fewer units can be supported. AMI also wants the cemetery on the site preserved as it contains the remains of former Hospital patients.49

The Fact Finding group decided to conduct further study on the specific housing types that could be provided at Met State and the feasibility of developing special needs housing.

The Subcommittees

As the Fact Finding groups continued gathering data, their roles gradually shifted. The original golf course and housing Fact Finding groups were reconfigured as policy making Subcommittees. The traffic Fact Finding group was disbanded, since several Task Force members felt that the traffic data had reached a sufficient level of

49 Alliance for the Mentally Ill of Massachusetts, "Reuse of Metropolitan State Hospital Property Located in Belmont, Lexington and Waltham," 9 March 1994.
A third Subcommittee was created to meet with Dan Driscoll, the Senior Planner from the Metropolitan District Commission (MDC), to refine the proposal for a Met State reservation. Like the Fact Finding groups, the Subcommittees are composed of Task Force members from all three communities.

The reservation Subcommittee has been learning how MDC will operate the MDC reservation, and has provided feedback to Dan explaining the interests of the Task Force members. The salient issue throughout the discussion of the MDC reservation has been the ability of MDC to provide sufficient maintenance for the reservation, given MDC's recent budget cutbacks. As a way to protect against the funding uncertainty, the Waltham Task Force chairman proposed that a portion of the operating revenue from the golf course be used to maintain the reservation. The reservation Subcommittee has been discussing the possibility of creating a permanent reservation group to coordinate the transfer of money from the golf course to the reservation. Several Waltham Task Force members and MDC, however, see a permanent reservation group as a possible threat to their control over their portions of the property.

Creating opportunities for synergy among the reuse options has been difficult throughout the process. The adversarial nature of many of the Met State meetings has precluded free exchange among Task Force members. Complex issues have been simplified by DCPO and the Task Force members to try to prevent attacks on the details of a proposal and to try to gain consensus more quickly. This simplification has frustrated Task Force members who would like to discuss the details in order to
ensure that the reuse document is clearly interpreted by those who will use it. Efforts at simplification have not helped the process proceed more quickly. In fact, previous areas of consensus have been renegotiated to allow the Task Force members to adequately voice their concerns and to deepen the level of detail discussed. Despite these problems, the Task Force members and DCPO appear to have reached closure on their list of desired reuse options.

Next Steps

DCPO is currently drafting disposition legislation for Met State which will: create an MDC reservation; allow the City of Waltham the opportunity to create a public golf course; allow DCPO to draft two Requests for Proposals, one for housing developers for the buildable area in Lexington and one for institutional users or developers for the Gaebler Children’s Center; and create a trust fund for the Department of Mental Health for a portion of the State revenues from the sale of the site. DCPO will present the legislation to the three Task Forces sometime in May 1994. Once Task Force approval is obtained, DCPO will submit the legislation to the Governor’s office for filing. Two-thirds of the legislature must approve the bill before it is passed. The State Representatives for the three communities have said that if their constituents support the legislation, they will vote for the legislation. DCPO and the Task Forces believe that it is likely that the bill will pass if it has the support of the Belmont, Lexington, and Waltham Representatives.
Chapter Five

Lessons from the Metropolitan State Hospital
Reuse Planning Process

Analysis of the Met State Reuse Planning Process

The Massachusetts Division of Capital Planning and Operations (DCPO) initiated community involvement in the Met State reuse planning process by asking the governing bodies from the three communities to each appoint a Met State Reuse Task Force. The current DCPO Project Manager for Met State, Mika Brewer, admits that, at that time, DCPO had little experience setting up community forums for gathering information and gaining consensus on property reuse. When Governor Weld closed down several state hospitals in 1991, DCPO was expected to plan the large-scale dispositions and negotiate with the communities to determine the properties' best reuses. DCPO had to craft a new disposition procedure for the state hospitals because of their large size and the significance of any change in their use. In fact, no state hospital disposition procedure is the same. The procedures vary depending on the property characteristics. For example, DCPO set up only one Reuse Task Force for the Danvers State Hospital planning process, even though the Hospital straddles two communities. Unlike Met State, all the Danvers State Hospital buildings and 90% of the developable land are in one community. Therefore, setting up only one Reuse Task Force seemed sensible to DCPO.
Each Met State Reuse Task Force has been expected both to represent its own community’s interests and to think regionally about the impacts of proposed reuse options. This dual role has caused conflict both within and among the Task Forces. The three Task Forces were able to set common goals and present a united front to DCPO at the beginning of the planning process, when faced with DCPO's threat of high density office development. When DCPO eased up on its demands for revenue from the site, the Task Forces were forced to examine their individual interests, and they discovered gaps in their views. The Task Force members then had to face the most challenging aspect of group decision making: working proactively to create acceptable reuse options, rather than simply reacting to DCPO proposals.

The Met State Task Forces, which are each made up of residents from the same community, and the Beaver Brook Watershed Coalition, which was formed by residents with common environmental interests, resemble the affinity groups that are formed in the Ecologue workshops, described in Chapter One. Unfortunately, the Met State Task Forces did not have a chance to brainstorm their views and interests, as required by the Ecologue process. Instead, the Working Group was created shortly after the planning process began, and the Group took on the responsibility of determining three reuse options without having the Task Force members first establish their broader issues of concern. The rush to develop reuse options was driven in part by the state Municipal Incentive Grant awarded to MAPC. Rather than asking the Working Group to brainstorm issues of concern on behalf of the Task Forces, Joan Blaustein of MAPC asked the Working Group to nominate reuse options. The
Working Group's assignment was too narrow and preempted an initial creative process. The Task Force members were not able to explore and legitimize their visions for Met State.

Another challenge faced by the Working Group members was accurately communicating the concerns of their respective Task Force members to the Working Group and convincing the other Working Group members of their ability to do so. Given the complexity and diversity of interests within each community, the expectation that the individual Working Group members could and would represent them was inappropriate. In addition, the format for the public tri-community meetings did not facilitate an equal sharing of information among the Working Group members, the other Task Force members, and the public. The public meetings should have been an opportunity for community members to play a greater role in shaping the issues. Instead, the meetings were used by the Working Group members to present their views and allow the residents to react to the proposals.

A critical turning point in the process came when the Task Force members decided to create the three Fact Finding groups, and later the three policy making Subcommittees. All six groups were formed around particular issues, made up of members from all three Task Forces. The groups resemble the topical task forces created in the second phase of the Ecologue process. The groups have helped to demystify the issues and put them in tangible terms so that the reuse options may be judged on their merits. Since the subcommittee membership cuts across community lines, all three Task Forces have shared in the authorship of the subcommittee reports.
This shared responsibility has helped the Task Forces to work cooperatively together and create value from Met State rather than claim it.

Although the Met State process has operated as an unassisted negotiation, the process has not met the criteria described in Chapter One for an unassisted negotiation or for group decision making. Namely, the number of issues and parties have not been small in number, the channels of communication have not been sufficient for creative exchange of ideas, and no one has been responsible for protecting individuals from personal attack. Also, meeting minutes have not been taken, and the primary written record of the process, the Met State Reuse Plan, has been drafted by the DCPO Project Manager, rather than by a neutral party. These problems have led to frustration, duplication of previous efforts, and misunderstandings, which point to the need for a neutral person to manage the process.

The only neutral person in the Met State process was Joan Blaustein of MAPC. The Task Force members and the DCPO Project Manager have all said that Blaustein's role helped the process run more smoothly. Blaustein played a helpful role by organizing meetings and agendas and providing input from a regional perspective. Unfortunately, the work Blaustein was completing to satisfy the State Municipal Incentive Grant requirements became almost irrelevant to the Task Force members as their needs changed. Since the DCPO Project Manager was drafting the Met State Reuse Plan, and DCPO's consultants were providing reuse option data, Blaustein's grant products were no longer needed.
Since Blaustein was the only neutral party in the Met State process, it would have been beneficial to the Task Force members if she had managed the Met State process. As process manager, Blaustein could have made sure that all interest groups were represented at meetings. The interests of the mental health community and Massachusetts tax payers, for example, were never directly represented at Met State meetings. The Department of Mental Health and the Alliance for the Mentally Ill have only been represented through their published statements and through DCPO. The interests of Massachusetts tax payers have been indirectly represented by DCPO and State Representatives and Senators. Blaustein, however, did not take on the process manager role. She stopped attending meetings and taking minutes when the Municipal Incentive Grant funding ran out. No person has been solely responsible for planning meetings and preparing agendas, and no one has taken meeting minutes since Blaustein left the process.

**Recommendations for Similar Processes**

When setting up a decision making process for interlocal issues, an initial analysis must be conducted to determine the communities and interest groups that should be involved. Based on that analysis, groups should be formed to brainstorm the different facets of the task at hand. No matter what type of group is formed to make decisions, the purpose of that group must be clearly defined and redefined as necessary. Taking these steps will help to ensure that no interests are ignored. When interests are ignored, or not fully legitimized, at the initial stages of the process, those interests will resurface and slow the progress of the group.
A decision making group should contain representatives from all the possible interest groups. In the case of regional decision making, at least one person from each community must be involved. When the communities and interest groups involved are very different from each other, it is unwise to form only one group. With one group made up of members with opposing interests, the members will not feel comfortable freely exchanging ideas. In addition, only a few representatives of each of the community interest groups can be members of the decision making group in order to keep its size manageable. One group is also undesirable if the interest groups fear that their representatives will be coopted by "groupthink" or will not have an equal voice. The members of the communities and interest groups will want the security of having their own group in which they can strategize. The interest groups should be able to meet separately until the issues are framed and some common goals are established. Once mutual interests are discovered, then committees should be created by issue, rather than by community or special interest affiliation.

As the communities decide upon a group structure, they should agree to have someone from outside the group manage the process. The planning models described in Chapter One support this notion. The process manager should ensure that all the interest groups are represented throughout the process. The process manager should understand the political and legal context in which the process is operating, so that s/he can remind the group of the outcomes of their decisions. Given the objective stance of the process manager, s/he should be able to see the relationships between different issues and keep track of the effects of decisions in one area on another area.
The process manager should be cognizant of the fact that an interlocal planning process does not operate in a vacuum. Neighboring communities share a long history and have established relationships. While a particular planning process is occurring, the same communities may be working together on several totally separate issues. Those issues, however, are interrelated since they all affect the communities' relationships. If the process manager can bring this knowledge to bear, the process will be fairer and more efficient than one without a process manager.

There are several sources available to communities for obtaining a process manager. Consultants, local universities, and other community organizations are all sources of professional managers. Regional planning agencies can be a particularly good source of managers because their regional status usually ensures the manager's neutrality regarding the local planning issues.

The process manager will have different levels of involvement in the content of the process, depending upon the needs of the group. If the group decides that they need in-depth assistance in crafting proposals and resolving conflicts, the group could hire a facilitator or mediator to serve as their process manager. As explained in Chapter One, facilitators have less involvement in the substance of the issues than do mediators. Facilitators simply administer the process and maintain open lines of communication among the group members. Mediators are expected to meet privately with the group members and invent proposals. Massachusetts has a mediation service which is a good source of facilitator and mediator referrals.

The Massachusetts Mediation Service (directed by David O'Connor) is under the jurisdiction of the Executive Office for Administration and Finance. A 12-
member Board provides advice to a two-member staff. The MMS has already mediated statewide disputes concerning hazardous waste disposal, the clean-up of a Superfund site, and long-term health care insurance regulation.\textsuperscript{50}

No matter what route is taken in crafting a planning process, it is very important for the group to have a written record of each meeting and to document the results of their efforts. While the goal of planning is to develop agreement on intentions for action, not just to complete a report, a written record serves as a common basis for interpreting the intent of the planning group. The process manager should be responsible for producing the written records to prevent any perception of bias. Providing a clear explanation of intent is crucial when control of the process is handed over to the public officials responsible for implementing the final proposals.

\textsuperscript{50}Lawrence E. Susskind, "NIDR’s State Office of Mediation Experiment," \textit{Negotiation Journal}, October 1986, p. 324.
Appendix

Belmont Met State Reuse Task Force Members
Voting
Douglas Reynolds, Chair
Ralph Child, Vice Chair
Richard Betts (Planning Board)
Nancy Childs (Beaver Brook Watershed Coalition)
John Dalton
Arthur Heron (Fair Housing Committee)
William Holmes (Housing Authority)
Anita Hume (Acting Chair, Cemetery Planning and Development Committee)
Candace Jenkins (Consultant to the Massachusetts Historical Commission)
John Murphy (Conservation Commission)

Non-Voting
Thomas Gatzunis, Town Engineer
Philip Herr, Planning Consultant
Melvin Kleckner, Town Administrator

Lexington Met State Reuse Task Force Members
Voting
Leo McSweeney, Chair (Member of Lexington Board of Selectmen)
Joyce Miller (Chair of Conservation Commission)
Natalie Riffin
David Williams

Non-Voting
Dick Canale (Planning Board)
Jackie Davidson (Planning Board)
Shirley Frawley

Waltham Met State Reuse Task Force Members
John Snedeker, Chair (Director of Public Works, former Commissioner of Massachusetts Metropolitan District Commission)
John Bradley (Chair of Conservation Commission)
Gloria Champion (Conservation Commission)
Marie Daly (President of Beaver Brook Watershed Coalition)
Michael Squillante (City Councillor)
Edward Tarallo (City Councillor)
Ronald Vokey (Planning Director)
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Snedeker, John, Chairman Waltham Met State Reuse Task Force, Waltham, MA. Interview, 6 April 1994.

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