

THE ARCHITECTURE OF THE UNWANTED:
CRISIS IN THE IMPLEMENTATION OF THE COMMUNITY-SCALE INSTITUTION
Case Study: Mental Health Facilities in Massachusetts

by

Christopher Pilkington B.A. Yale University 1977
 Ed.M. Harvard University 1979

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS OF THE DEGREE OF
MASTER OF CITY PLANNING

at the

MASSACHUSETTS INSTITUTE OF TECHNOLOGY

June 1985

© Christopher Pilkington

The author hereby grants M.I.T. permission to reproduce and to distribute copies of this thesis document in whole or in part.

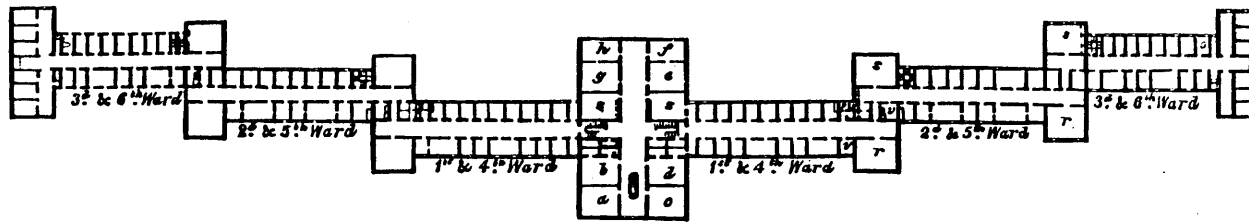
Signature of Author _____
Department of Urban Studies and Planning
May, 1985

Certified by _____
Tunney F. Lee
Thesis Supervisor

Accepted by _____
Phillip L. Clay
Head, Departmental Committee on Graduate Studies

MASSACHUSETTS INSTITUTE
OF TECHNOLOGY

JUL 12 1985 Rotch



THE ARCHITECTURE OF THE UNWANTED:

CRISIS IN THE IMPLEMENTATION OF THE COMMUNITY-SCALE INSTITUTION

CASE STUDY: MENTAL HEALTH FACILITIES IN MASSACHUSETTS



CHRIS PILKINGTON

SPRING, 1985

ABSTRACT

Throughout history, social and economic forces combined to establish large, isolated public institutions as the traditional form of treatment for society's unwanted. Fueled by breakthroughs in medicine and social services and a change in ideas about treatment, recent reformers have taken on the massive agenda of re-scaling the asylum and reintegrating its population within the community--an agenda which has only had mixed success. Among other obstacles, segmentation in the public budgeting and implementation process, and confusion as to the architectural goals of the new generation of institutional facilities needed to effect this change have reduced the capacity of reformers to overcome the still-strong forces to segregate, distance and warehouse the unwanted. The asylums of the 19th century remain very much alive, and the network of new community-scale institutions still very much unfinished.

Focusing on Massachusetts, the author reviews the history of public institutional treatment of the mentally ill and the reform movements which attempted change. Recommendations for a more effective approach to the public implementation process are presented.

Thesis advisor: Tunney F. Lee

Readers: Gary A. Hack
Donald A. Schön

ACKNOWLEDGEMENTS

Tunney Lee, Don Schön and Gary Hack were of great help in challenging and testing ideas, and making sure they were clearly expressed before they made the final draft. Many thanks to them, the Division of Capital Planning and Operations/Campus Planning team and all of the practitioners who took the time to tell the stories that made the history come alive!

C.P.

CONTENTS

INTRODUCTION 3

1 THE BIRTH OF THE ASYLUM AND THE ARCHITECTURE OF ITS REFORM 7

2 UNDERSTANDING THE FAILURE OF REFORM 57

3 UNDOING THE ASYLUM: SOME EXPERIMENTS IN COMMUNITY SCALE 65

4 CONFLICT IN INTENTIONS: BUILDING THE COMMUNITY-SCALE INSTITUTION
IN A HOSTILE ENVIRONMENT 89

CONCLUSION 115

BIBLIOGRAPHY 121

INTRODUCTION

Like most other states, Massachusetts has an extensive but aging regional network of institutional facilities. Created as a way of solving a problem, they are now themselves part of a problem which resists undoing. America's reliance on massive institutions began with the state-run almshouse, the asylum, and the prison. All were located at a distance from the city--both as a means of pushing away the unwanted but also ostensibly of "helping" them. All became crowded and guilty of custodial and inhumane care. However, once built, they took on a life of their own and have proved to be dinosaurs which resist extinction.

Periodic waves of reform movements in medicine and the social science had different ideas about treatment of the unwanted. These ideas had their consequences in the architectural design of institutions and their spatial distance from society. The asylum itself had been a reform, and later reformers would change or add to it--changes which have survived as the "layers" of institutions which are visible today.

Mid-20th century successes in medicine and service-delivery technologies and a new generation of humanistic ideals combined to create a movement to radically undo the traditional asylum: to reconfigure, humanize or disperse it. The unwanted, it was thought, could be humanely treated only if reintegrated into society. Among their several goals, recent reformers hoped to undo the institution by returning many of the unwanted back to their home communities. For those who would still need institutional care, reforms aimed to bring smaller-scale institutions closer to the community and to the social ties which had been left behind. Where institutions were already distant from society but could not be abandoned, they too would be re-scaled to become more "homelike" and more like a microcosm of the community.

None of these ideas were new; they were just more forceful in a time of great social change. I have called the goals of these reforms and the facilities they envisioned the "community-scale" institution.

As with other reform movements in history, attempts at creating community-scale institutions have met with only mixed success. The reasons are many. As institutions, the asylums have a peculiar resiliency: they simply won't go away. In addition, confusion about the goals and definition of "community-based" and "normalized" persist. Reform plans have been costly and only partially implemented--failing to accomplish their goals of replacing the asylum. Lastly, the economic and social forces which act to "push away" the unwanted have changed little--with the new community-scale facilities still unable to get close to the community they intend to serve.

Massachusetts is at an enormously difficult time. Dozens of huge, aging institutions have only been partially vacated. Among the facilities which are still used, many fall far short of acceptable standards of quality. The asylum's replacement--a complex network of public community-based facilities, partnership arrangements with private facilities, and supportive residential settings in the community--has only been partially implemented. For those public community-scale facilities which need to be built, the public agencies responsible for doing so remain ill-fit to meet the challenge.

One may ask whether the "community-scale" institution for society's historically unwanted is possible. History tells us that it is--but not without a fight.

The "layers" of facilities which survive are a legacy of reforms and ideas, and tells us much about society which built them. They are also a reminder of reforms which didn't work. But most

importantly they're a lesson about the forces which drive society to institutionalize, forces which have diluted even the most exuberant reforms in midstream. Looking at these layers may be the best place to start.

This essay begins with the history of ideas about the unwanted and the architecture they produced. I then draw some conclusions about the forces of institutionalization and look closer at the failure of a few experiments in community-scale facilities. Lastly, I review some modern organizational obstacles and make recommendations for overcoming failure in implementation.

THE BIRTH OF THE ASYLUM AND THE ARCHITECTURE OF ITS REFORM

1

THE ORIGIN OF THE ASYLUM

EARLY SOLUTIONS

The human community has not always dealt with its deviant members through isolation, exile or confinement. Throughout the history of society it has been the rule rather than the exception to care for the sick, frail, and offensive within the family or village. Even today, one does not have to look far to find examples of sacrifice among society members who have accommodated for the comfort of the few. As such, commitment to the care of family and neighbors remains an important value for even the most modern of industrialized, urbanized societies.

Even so, it is safe to say that the treatment of the unwanted or "fringe" members of society is distinctly different among smaller, simpler and less dense communities than among societies characterized by dense urban settlements. When seen in the light of the history of asylums and institutions for the "unwanted" it becomes clear that the institution itself may be a response to urbanization and its complexity.

Colonial America. The "town fool" or town beggar who frequented the public spaces of the small New England town of Colonial days was no doubt "monitored" by the watchful eyes of shopkeepers and passersby who were familiar with his situation and his background. His behavior--although curious and perhaps shameful--could be shaped or kept in check by those who knew

him and possibly cared about his wellbeing, and he no doubt had many opportunities to enjoy participation in the day-to-day events of his community. The potential negative impact of his "deviance" could be tempered by such closeknit community supports, and by the efforts of the church and family. The economic burden of his care could also be lessened by simple conventions, such as the sale of his labor to the highest bidder, or the auctioning of his care and boarding to the lowest.

Although depicted in history books as quick to deliver severe and violent punishment to criminal and religious disagreeables, Colonial America's treatment of its "fringe" members seems better characterized by humane, informal acceptance at the community level. This type of "care" was perhaps easiest to maintain in a setting in which community members are well-known to each other, such as in rural or semi-urban settlements, and in settings which are relatively free of chronic poverty.

These conditions were quite common throughout America's Colonial period and have been cited as partly responsible for the slow popularity of asylums on the American continent.

European solutions. The response to the unwanted in urban settings is quite a different matter. While America colonies enjoyed their new and expansive terrain, Europe's older cities --having experienced centuries of crowding and poverty-- had long since developed a significant array of methods and institutions for coping with those persons who had become unwanted.

By the early 17th century poor economic conditions and accelerated migration to urban centers created a new class of persons in European cities. When almost one out of four inhabitants of Paris could be classified as beggars, the city's response became aggressive. In 1606,

a decree of Parlement ordered that the beggars of Paris

be whipped in the public square, branded on the shoulder, and driven out. To protect the capital against their return, an ordinance of 1607 established companies of archers at all the city gates.(1)

After experiencing similar problems with large numbers of beggars, criminals and disorderly persons, the City of London responded by establishing their first house of correction. Established in an old palace, in 1556 its effect was so popular that each county in England was instructed to establish one of its own.

Other countries in Europe soon followed this lead. The Dutch established their first tuchthuis or "house of discipline" in Amsterdam in 1598. The French, opening the Hopital general in Paris to both medical and non-medical cases in 1656, soon found themselves housing almost 6,000 persons, about one-percent of the entire population of Paris. Although massive, the hospital was considered a success, and plans were made to create similar confinement facilities in hundreds of locations throughout Europe. Such facilities would house, among others

felons, debauchers, libertines, blasphemers, lunatics, spendthrift fathers, prodigal sons, childbearing women, cripples and incurables, beggars, discarded infants, homeless juveniles and homeless old people.(2)

Although the British had custodial madhouses as early as the 1400's, the idea of a facility meant exclusively for lunatics was quite novel, and it was with anticipation and much admiration that London opened its new Bethlehem Hospital in 1676. Designed as an incarceration facility for what were perceived as queer and lowly creatures, "Bedlam" drew an enormous crowd of visitors--upper and lower-class citizens alike who came to see the occupants behave queerly in their chains and punishment devices. Although its conditions were crowded and squalid, by the time it closed its doors to the public in 1770, Bedlam had been admitting some 96,000 visitors annually and was partially supporting itself by receipts from the door. (3)

FROM ALMSHOUSE TO ASYLUM: THE ASYLUM AS REFORM

During the 17th and 18th centuries European cities continued to develop massive asylums to perform a charitable but minimally custodial function--reflecting a great pressure to alleviate the large numbers of poor, disabled and dependent who had accumulated in their crowded urban centers. The goal of such institutions was to get the "unwanted" off the street. Little attempt was made to separate the medically ill or indigent from the criminal, or to identify any cause of the person's misfortune.

As the American city grew in size and density, it too began to show an increasing number of needy persons. Responding in part to ethics and moral obligation and in part to public response, towns and philanthropic organizations of the late 17th century began to open almshouses which provided room and board to indigent citizens. The first American almshouse appeared in Boston in 1662, followed by several others in Massachusetts and other eastern cities and towns. Handicapped, mentally ill and vagrant persons were treated equilaterally as "paupers", with no formalized distinction in care.(4)

The public almshouse--whether formally established as a town facility or informally run by a church group--remained the dominant form of care for America's nonviolent "unwanted" throughout the 18th and much of the 19th century. First found in the town center, they soon grew large and began to appear as "poorfarms" or workfarms where urban vagrants, the retarded and the insane alike could be sent for room and board in exchange for labor. (5)

Although the need for a separate facility for the medically needy, the insane, the "feeble-minded" and other special groups was recognized in Boston as early as 1729 (6), such facilities were not forthcoming. It took another 70 years and active advocacy on the part of private philanthropic and charitable organizations to establish specialized institutions for the disadvantaged. By the beginning of the 19th century, several

private and quasi-public institutions were established in the Boston area, including the Boston Female Asylum for Orphans (1800), the Boston Dispensary (1801), the Massachusetts General Hospital's McLean Asylum (1811) and the New England Asylum for the Blind (1829, now the Perkins School).(7)

But although the alternative to the almshouse offered specialized treatment to the lunatic, his presence was no more welcome than his vagrant contemporaries. Like the burgeoning Boston almshouses before them, most of Boston's lunatic and special treatment facilities were located far from the downtown--at the fringe of a Boston neighborhood, or in the nearby countryside.

State's role. By the early 1800's, almshouses were already taking a substantial portion of the municipal budget of larger towns. Conditions were variable but generally inhumane, and reformers and charitable organizations joined with the towns to impose significant pressure on the state to take the responsibility for almshouses and asylums. The towns were unhappy at having to care for recent immigrants and newcomers to the town, many of whom spoke strange languages, carried new diseases, and showed little ability to earn a living. In addition, in a trend that reflects a problem which is still serious today, private institutions like McLean Hospital--which had been originally established to serve all citizens and had been somewhat successful in relieving the demand on local almshouses--began to serve only those who were able to pay for their care. Reformers were unhappy that the indigent insane were unjustly kept in poorhouses (at best) or in jails, where they were consistently mistreated and punished for their afflictions. (8)

In 1829, Horace Mann, spokesman for a growing group of advocates for the humane treatment of the insane, chaired a state legislative committee to investigate

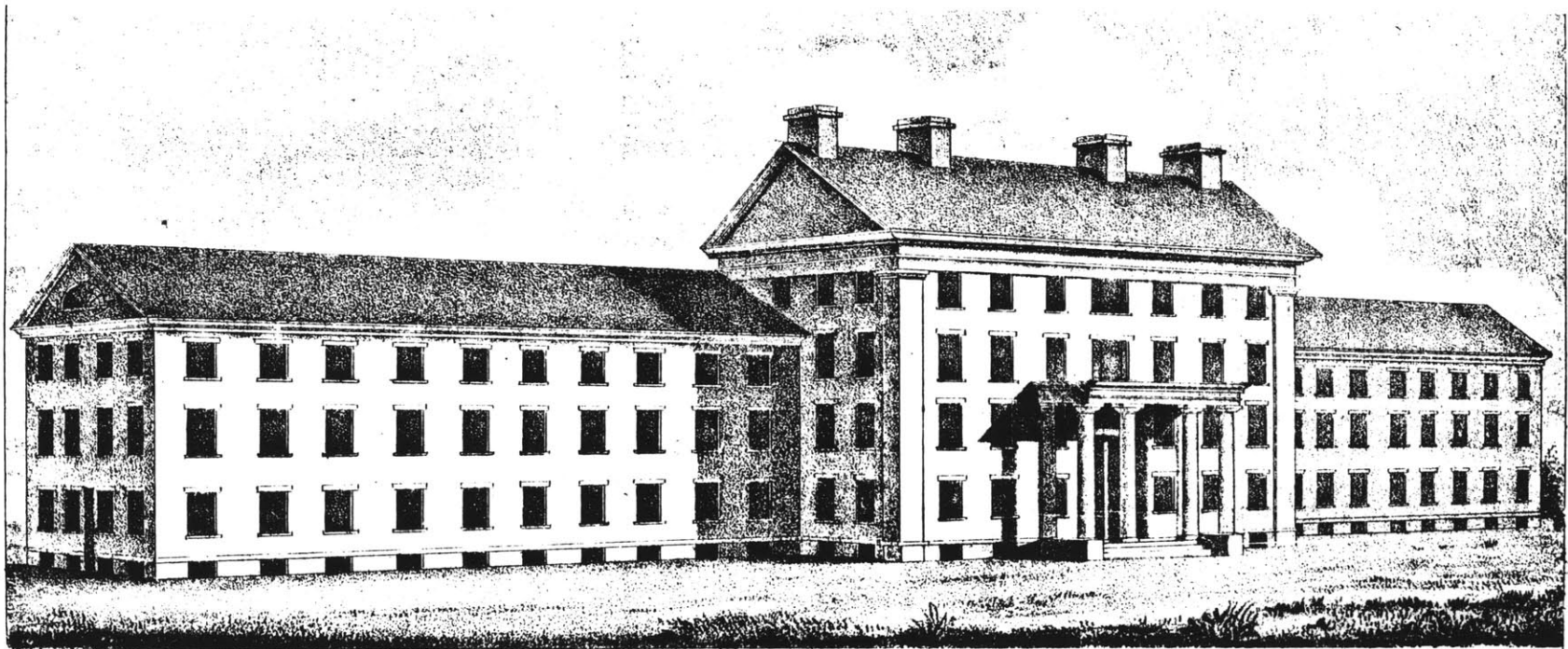
the practicality and expediency of erecting or procuring, at the expense of the Commonwealth,

an asylum for the safe-keeping of lunatics and persons furiously mad. (9)

After an assessment of statewide statistics on the number of insane persons, the legislature voted to construct a hospital for 120 insane persons in rural Worcester.

The Worcester Hospital for the Insane was completed in 1832, and marked the first participation of the state in what would become a series of public asylums and asylum-like facilities, including several more insane hospitals, three large almshouses, a "dipsomaniac" hospital, three reform schools, three sanatoria, and three schools for "idiot and feeble minded". (10)

Original Worcester
Lunatic Hospital; 1832.



Frederick's Lithog. Boston

LUNATIC HOSPITAL.
WORCESTER, MASS.

THE 19th CENTURY ASYLUM

MORAL TREATMENT

By the beginning of the 19th century, society not only viewed the asylum as a way to remove "unwanted" individuals from the public eye, but also believed that these individuals were treatable, curable, and perhaps even capable of returning to society. Inherent in this notion of curability is the belief that insanity, among other modern problems, had a cause.

Unready for any clear understanding of medical or psychosocial causes, the theorist of that time believed that insanity and troubles of the mind stemmed from moral depravity or lack of a developed moral sense. Society's depravity evolved from the inherent deviance of human nature. Both were contained by discipline, punishment and education in moral values.

The complex, confusing and rapidly changing character of the urban environment was felt to be a cause of the individual's personal disorder--the moral confusion of the city contributing to the individual's depravity. Cities were seen as dirty if not toxic, crowded and anonymous--destructive to individuals whose moral sense was not strong.

Putting aside the Weltanschauung of the 19th century, and looking from our own perspective, many of these theoretical observations were not far from accurate. Cities were crowding, and the new economic complexity and social stratification of the coming industrial revolution no doubt had a severe new effect on the American psyche. As communities became more dense, anonymity also grew. Dependent individuals became more easily separated from the familiar supports of his or her community. The number of persons who were not linked to supportive family or friends, or whom family and friends could not afford to support no doubt grew dramatically. The public institution was a last resort for this growing number of marginal citizens.

ON ISOLATION FOR THE INSANE:

"It is now a well-settled principle, that, to treat the insane with the highest degree of success, the surroundings of the patient should be entirely changed so that he shall see no face nor other object familiar to him in the previous stage of his disease."

- American psychiatrist Isaac Ray, 1863
(Greenblatt, 1955)

The city caused deviance; but the city was also the center of society. The "unwanted" were visible in the city, in full view of the largest concentration of population. Society needed a way to "solve" both problems.

Hence the promise of a "moral treatment" fused with society's growing need to "push away" some of its growing population of "unwanted" to create the country asylum.

What better place to provide asylum from the perils of urban chaos than the quiet countryside, and what better way to provide shelter for the disordered mind than to design an ordered, disciplined environment? Ideally, the sick would be quickly removed from their home environment. The asylum could provide protection, rest, and isolation from the city, while undesireables were kept out from under society's heels. The work of practitioners like European physician Phillipe Pinel supported these assumptions. Claiming successful cures through a regimen of sleep, labor, meals, moral instruction and recreation, and the avoidance of punitive or mechanical punishments, Pinel recommended a structured environment in a rural setting.(11)

MOMENTUM

It was under these therapeutic assumptions that Massachusetts embarked on an experiment in the opening of the Worcester State Hospital. The state had taken the responsibility of direct care-giver from the locality, and entered a new role of paternal benevolence.(12)

Support for the new institutions was strong. Within six years of Worcester's opening, Boston Lunatic Hospital was established (1839). Soon afterwards in 1848, the legislature funded the State Reform School in Westborough (eventually the Lyman School) and the School for Idiotic and Feeble-Minded Youth (now the Fernald School). Three years later the Taunton State Hospital for the Insane was founded, followed by three regional almshouses.

Further growth of the facilities was steady, with energetic reformers like Dorothea Dix staging multi-state campaigns and delivering eloquent and emotional speeches to state legislative committees on the inhumane character of local almshouses and the necessity for new facilities.

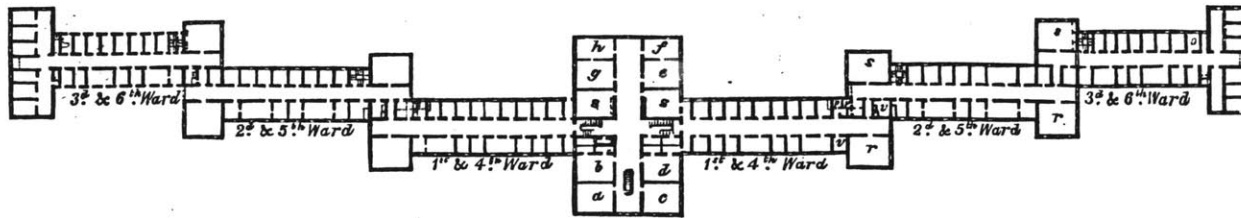
The momentum toward creating large institutions in rural settings had been established, and it did not waver for over a century. A partial chronological list of development (below) shows the rapidity of growth in the number of larger institutions.(13)

TREATMENT THROUGH ARCHITECTURE

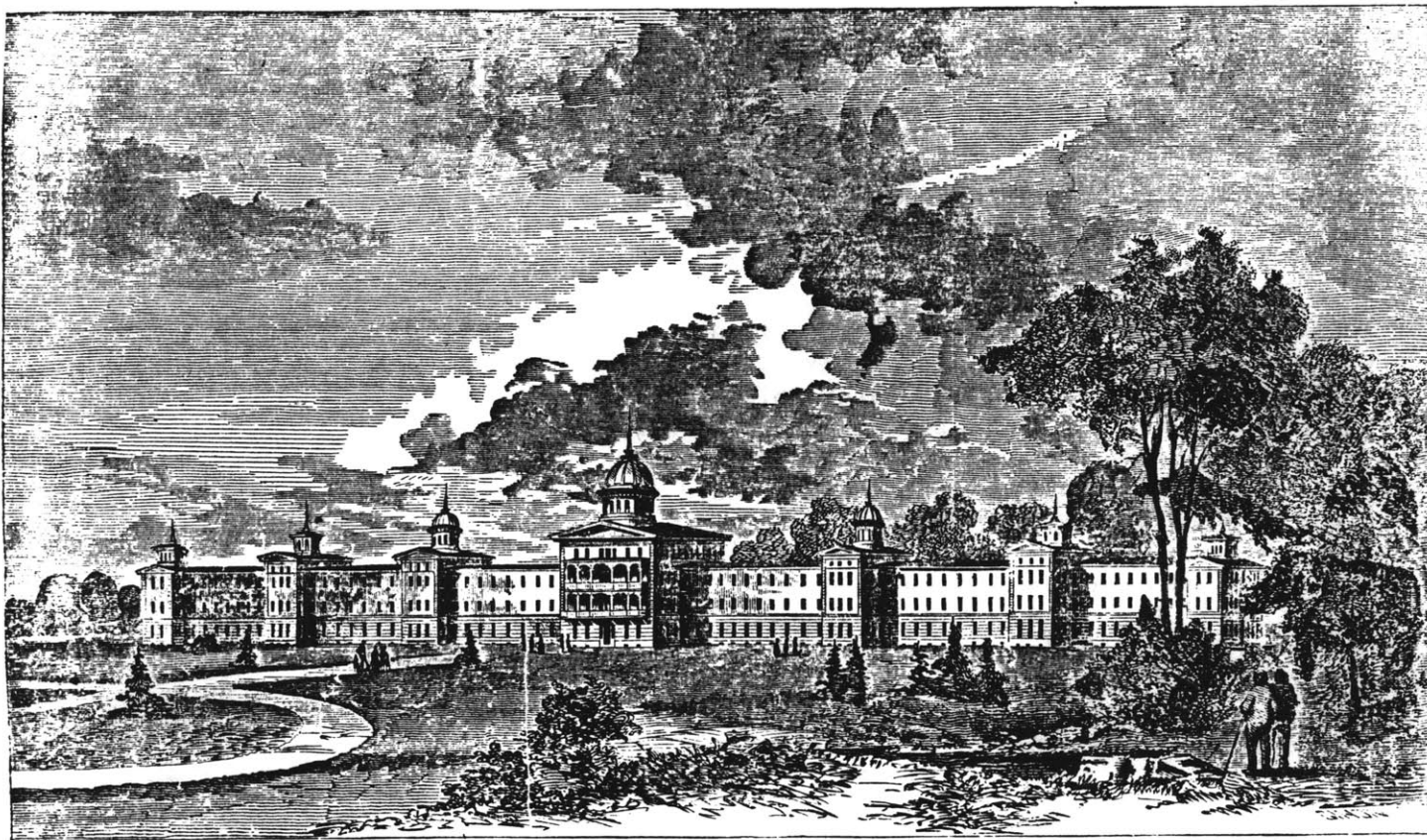
The "moral treatment" required the proper setting--one which provided order and discipline while allowing for health and rest. The promise of a New Asylum attracted the freshest of ideas about institutional design, with the architectural program closely focused on therapy and order.

At first, at least, asylum design did not have to focus on mass custodial care: it was not until after the first wards opened that momentum began and the demand for new wards bloomed. But from the start, designs for the state asylums seemed ready to accommodate successive additions and multiple sets of new wards--as if their makers were aware that the institutions would indeed grow. Here a close-up view of a Kirkbride ward.

Ironically, the design which accommodated a readiness for large volumes of users, coincided with the therapeutic call for orderliness and centrism, producing a facility with many (expandable) dormitory wings and a strong central core. Hence, the designs of the first asylums were driven by both therapeutic rationale and a capacity for the orderly organization of design elements.



PLAN OF SECOND AND THIRD STORIES OF WINGS, AND SECOND STORY OF CENTRE BUILDING.



STATE HOSPITAL FOR THE INSANE FOR 250 PATIENTS.

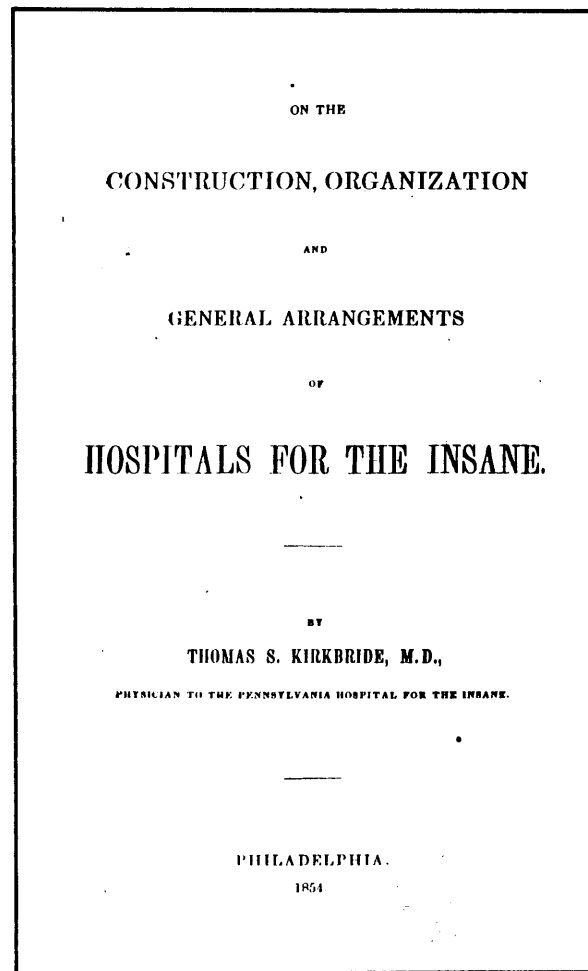
The Kirkbride Plan. Although fluent in the tenets of contemporary European treatment, the 19th century conceivers of the American asylum were limited in what they could learn from European institutional architecture. Many of the European institutions involved reuse of older estates, monasteries or prisons and provided a lesson which did not fit the American opportunity.(14)

In 1847, Thomas Story Kirkbride, Superintendent of the Pennsylvania Hospital for the Insane--one of the country's first (1752) and most admired asylums--published his views on asylum design in On the Construction, Organization and General Arrangements of Hospitals for the Insane, with some Remarks on Insanity and its Treatment.

Kirkbride's translation of moral treatment into design showed an overwhelming theme of symmetry and centrism. The heart of the asylum was the Superintendent, the Administrative core and the shared dining room.

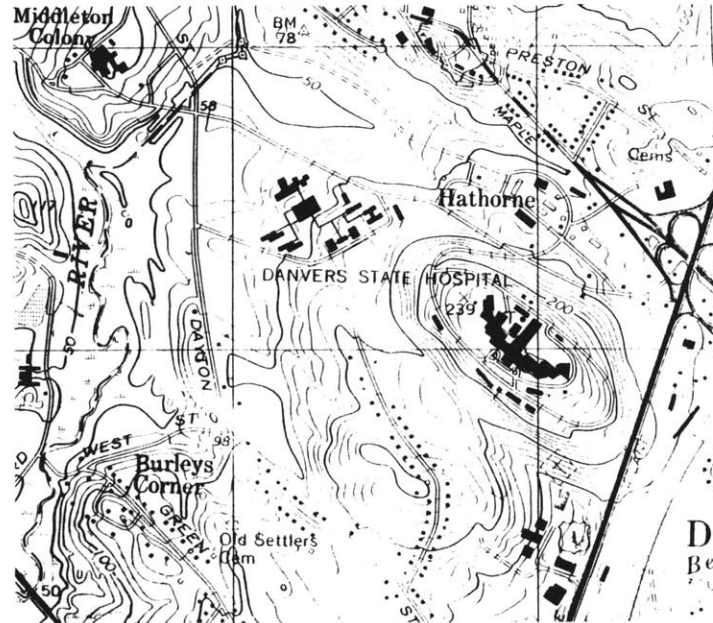
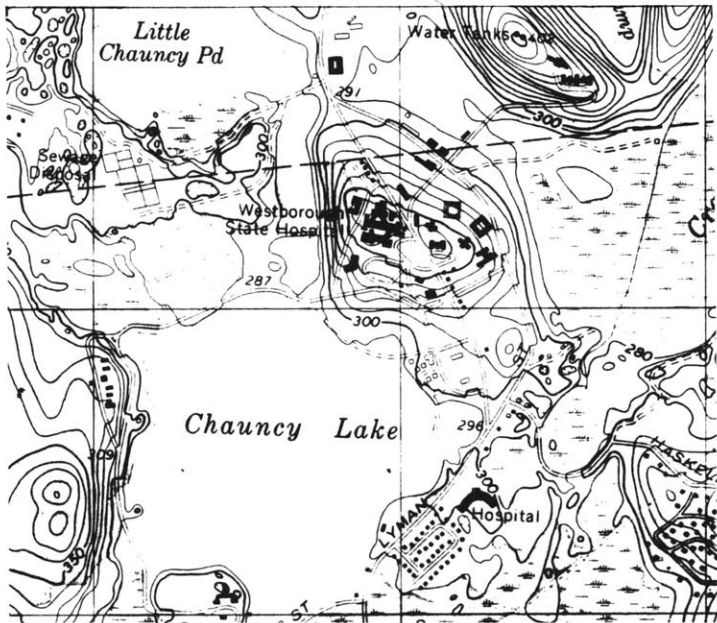
That the asylum was seen as inner-directed--a world unto itself--was evident in its very layout. Kirkbride recommended a linear scheme of wards, radiating from a central core of congregate facilities, in which patients were arranged hierarchically according to the degree of their insanity. The most "excitable" patients were located at the outer fringe. Those who were more cooperative and required less supervision were located closer to the heart of the facility, where they could benefit from the freedom to use the hospital's common facilities. Ironically, the healthier you were, the "deeper" you were located within the asylum--closer to the sane core, the main entrance, and the parental oversight of the Superintendent and his family.

To effect therapeutic isolation, Kirkbride specified that the asylums be located in the country, far from the dirty air of the city, on sites of no less than 100 acres. He specified high quality construction, including fireproof masonry and slate or metal roofing. Maximum size of the asylum was set at 250 beds, arranged in eight wards and segregated by sex.



Three years after the publication of Dr. Kirkbride's guidebook, Massachusetts opened the first of four asylums closely resembling the superintendent's model. That same year, the 13-member Association of Medical Superintendents of American Institutions for the Insane (AMSAMI) recorded its "well matured" views on the construction of asylums. Its 1876 reiteration of these rules included the advice that every asylum "should be located in the country, not within less than two miles of a large town and easily accessible at all times".(15)

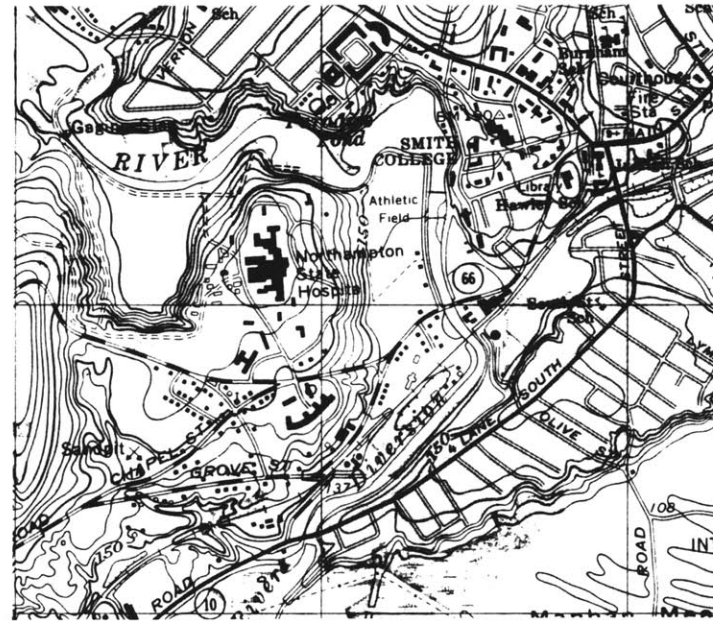
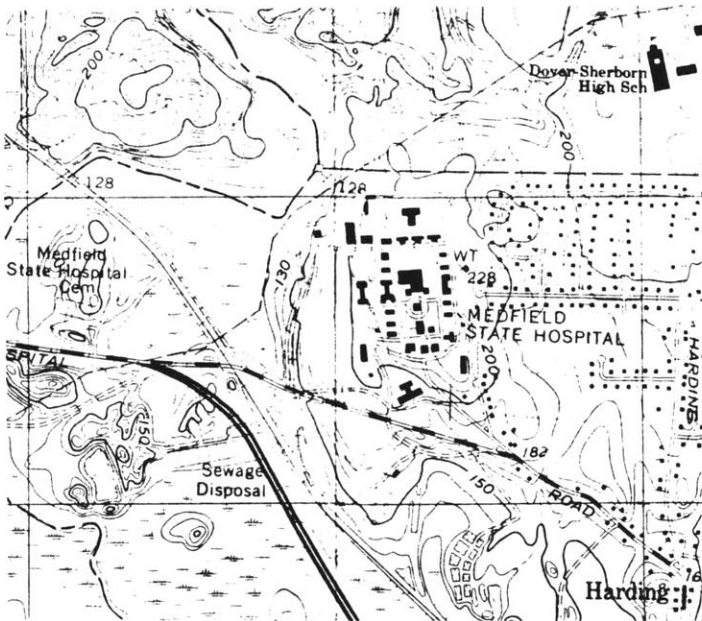
Taunton State Hospital for the Insane, Massachusetts' first Kirkbride asylum, was designed in Renaissance Revival style by Elbridge Boyden of Worcester, Massachusetts. This three story red brick building is noted for its cast iron Corinthian pilasters and iron cornice, Baroque-domed end-pavillions, and curved, glazed second-story walkways which connect these pavillions to the central wards. (15a) With the addition of new wings, the main building had reached a volume of over 330,000 square feet by 1894. Today, like its sister facilities, it still stands, although substantially deteriorated and almost totally vacant.



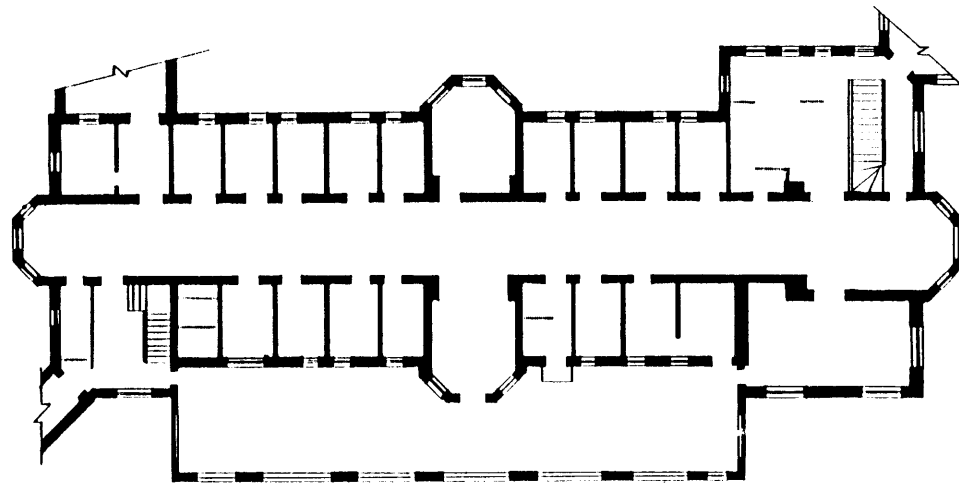
State planners chose rural hilltops and quality farmland as sites for asylums.

Illustrated here, four of the state's eight large mental hospitals.

Asylum neighbors usually consist of other institutions, schools, hospitals, sewage disposal sites, borrow pits, and wetlands.



Typical ward wing in the Kirkbride plan, here illustrated from the Kirkbride Building at Danvers State Hospital, 1873. Repetitive design allowed for easy addition of new wings.



0 8 16 32

THE ASYLUM'S FIRST REFORMS

DETERIORATION

By the third quarter of the 19th century, the size of Massachusetts' asylums and the number of new facilities had grown enormously. The institutions of asylum, school for the feeble-minded and almshouse, which had been born in the spirit of humanitarianism, had become perilously large and overcrowded. They had become a magnet for a growing population of the unwanted.

As social historian Rothman observes, the pride of one generation had become the shame and embarrassment of another. Incarceration for treatment purposes, although a relatively novel idea, was already in danger of being discredited. Many asylums, although less than thirty or forty years old had degenerated from therapeutic hospitals to custodial madhouses.

Care of asylum residents was directly in the hands of the Superintendent, and generally out of the purview of the public. The quality of care was rarely publicly monitored, such that faults could be hidden and "cure" rates inflated. Conditions could easily get out of hand without public notice.

Official investigative committees discovered and condemned punitive "treatments" such as the "water crib", a coffin-like box which was slowly filled with water until control was invoked (16), or the "covered bed", which was

to all intents and purposes, a child's crib; it is large enough for an adult patient and is well ventilated: the cover fastens onto it by means of hinges and will lock on; the covered bed is a necessary restraint...to keep a patient in a horizontal position. (New York Senate Committee to investigate the Lunatic Asylum at Utica, Albany, 1984) (17)

As designed, the public asylums were open to all, and hence received a large share of the poor and recent immigrants. Rothman found that the 1890 census of the Worcester, Danvers and Northhampton asylums showed that each housed a population that was over 50% foreign born or second generation. New York's asylum on Blackwell's Island had 86% foreign born patients. In contrast, private institutions like McLean Hospital had far less (only 10% of McLean's population was foreign-born).(18)

The presence of such large numbers of non-English speakers and international newcomers further reduced the respect for the residents and allowed a conscionably lower level of care.

Functionally, the asylum itself was virtually run as a quasi-public institution, with its own budget subsidized in part by charities and the profits from its own industries. To establish an element of public supervision, a series of overseer bodies emerged. The first Boards of Visitors would conduct semi-annual reviews. Later, these overseers would report to the newly established state boards of charities, correction, or lunacy. Their reviews were not necessarily professional, and there is every indication that they took the Superintendent's word as truth.(19)

Expansion as solution. During the third quarter of the 19th century, challenges to the institution seemed to be responded to by building more institutional space and to providing a clearer distinction among needy populations. It is in this period that the three large state almshouses and two reformatories were built. In addition the asylum at Worcester was rebuilt and two new asylums constructed.



The new Worcester Lunatic
Hospital; 1870

THE ASYLUM IS CHALLENGED

By the late 1870's, reformers had begun to rethink the asylum and its goals.

The demand for humane treatment for those who were incarcerated became a vocal public concern. Congress' Declaration of Principles of 1870 demanded humanitarian treatment for the imprisoned. Experiments in the "reform" of criminals were lauded, such as the 1877 "model" Reformatory at Elmira, New York. (20)

The growth of the science of neurology and of medically-based treatment concepts were also influential in the growing criticism of the asylum. In the 1870's and 80's neurologists began to question the efficacy of current treatments and of the Superintendents' stewardship.

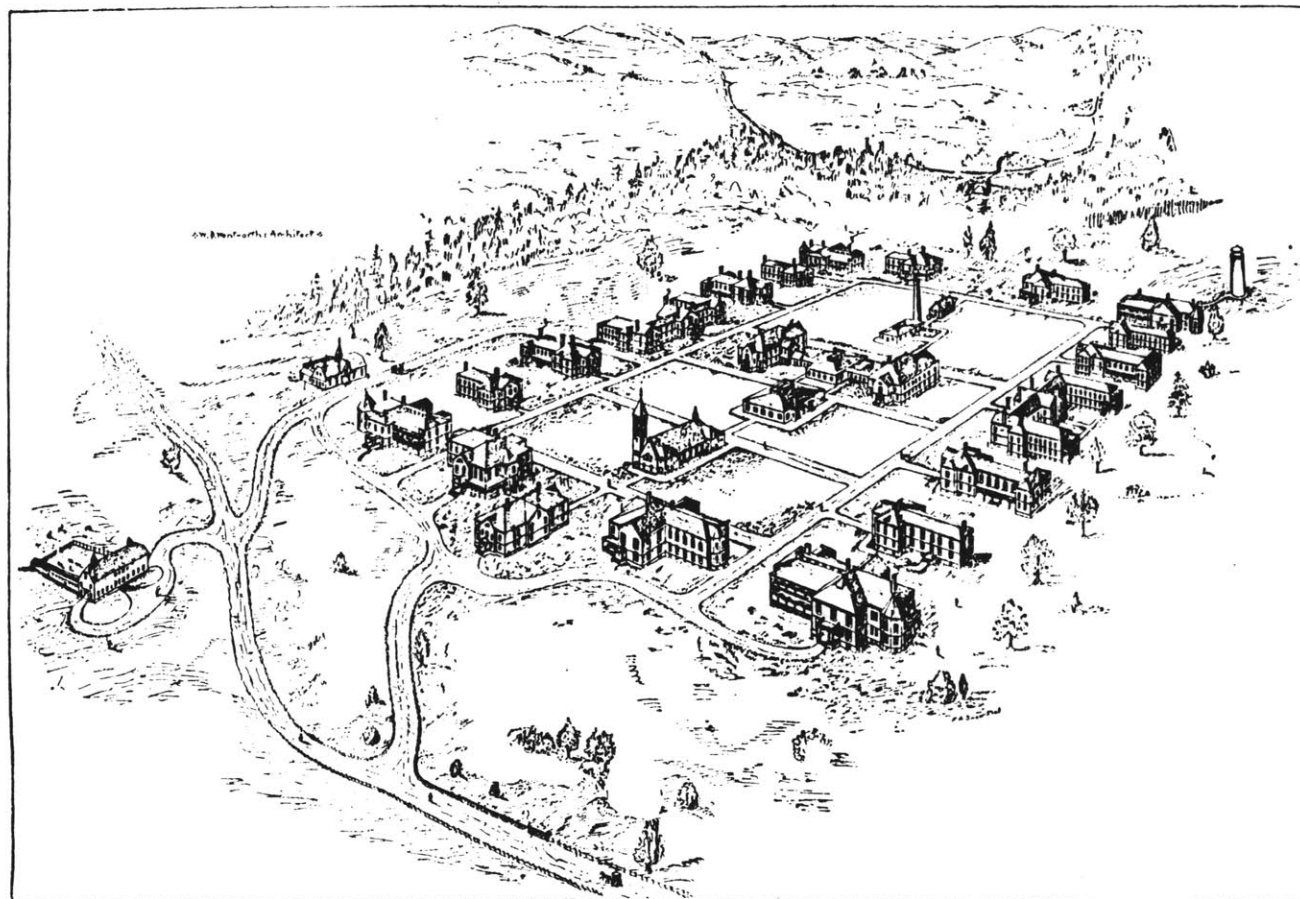
Even the concept of institutionalization was scrutinized, a preview of a reform movement which would gain an upper hand almost a century later. Rather than heal, institutionalization could stifle

...the passion for liberty which is in the human heart....
All the comforts which the insane person has in his captivity are but a miserable compensation for his entire loss of liberty...(in addition) the violent rupture of social and family ties is especially injurious....
(William A. Hammond, The Non-Asylum Treatment of the Insane, NY, 1879) (21)

The design response: early "medicalization" and the "campus" plan.

The asylum needed change, but although radical change was not forthcoming, several substantive changes in the asylum's design were gained as a result of these pressures for reform.

Led by the growing popularity of biological determinism and advances in biomedical analysis, neurologists had pressed for a



THE NEW "CAMPUS" PLAN Bird's-eye view of the Medfield Insane Asylum from the institution's Third Annual Report, 1898. Designed by Boston architect William Pitt Wentworth, the facility is located on a 300-acre farm in rural southeastern Massachusetts.

Although this was the state's eighth asylum, it was the first facility admittedly created for the chronic and "incurable" insane. The new "campus" design was a reform response to the immense multi-ward asylum of the day. Its design clearly reflects the wish to replicate the spatial configuration of the familiar New England town. Most of the asylum's residents would never see a real town again.

more important role at the state hospitals. Extensive mortuaries and laboratories for dissection and autopsies were added to existing asylums, as well as special sections for behavioral observation. (A visit to the Worcester State Hospital today will find the asylum's historic library filled with files upon files of nerve tissue sections preserved on glass slides). Popular treatment methods of the time, such as hydrotherapy, personal hygiene, and vocational training were also expanded and reflected in new additions to the already numerous inventory of asylum-affiliated buildings.

The schematic design of new asylums also showed a dramatic change at this time. In what may be construed as a response to the negative image of the large, single-building "madhouse", design of the three asylums built in the 1880's and 90's reflected a switch to a more decentralized or "campus" approach. Slow progress toward this design scheme can be seen in the Westborough Insane Hospital (1884), the Foxborough Hospital for Dipsomaniacs and Inebriates (1889), and--more clearly--in the Medfield Insane Asylum (1892). This latter institution was designed as a nearly symmetrical array of buildings organized around central green, with communal dining facilities and a chapel located at the center--an obvious attempt to replicate the community scheme of a New England town center but nevertheless an artificial community located far away from the nearest non-institutional settlement .

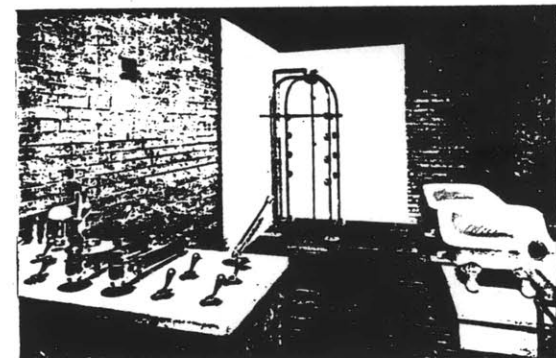


AFTER KIRKBRIDE Like all of its fellow institutions, the Westboro Insane Hospital functioned as a self-sufficient farm.

Built in 1884 on a 600-acre farm, Westboro was the first departure from the radial Kirkbride plan. It was also the first Massachusetts asylum to provide a congregate dining hall--encouraging patients to eat in a "hotel" environment. The experiment was a success and appeared in later designs.

Emphasizing rest, massage, hydrotherapy (showers and tub baths) and diet, Westboro sported the highest "recovery" rate in the state by the turn of the century.

Illustration from Second Annual Report, 1886.



DOUCHE ROOM, BARUCH SYSTEM.

THE NEW SHAPE OF THE ASYLUM

NEW TECHNOLOGY

Although slightly attendant to reform, the institution had done little by the turn of the century to improve its actual ability to heal. It remained a facility with custodial care as its primary focus. Two new technologies seemed to drive the call for reform, one old and one new, and the effects of both left their traces in the physical structure of the institution.

The Medical Model. The debate between the therapeutic benefit of the "restful asylum"--then the "traditional" model for treatment--and the medical approach to treatment was a consistent and forceful one.

But although a strong movement, the new protagonists of a medical regimen had not fully developed a substantive therapeutic alternative. The isolated asylums had given society a generous amount of free time to ignore the problems of mental illness and retardation, and few treatment alternatives had been examined.(22)

Like the earlier proponents of the new science of neurology, physicians at the turn of the century were at a loss for alternatives. Rothman cites a speech to asylum superintendents by neurologist S.W. Mitchell in which the physician

...had little to substitute for the asylum beyond a general charge to superintendents to behave like doctors. He closed his speech with a sketch of his "ideal hospital" which was not very different in organization and structure from the designs that medical superintendents themselves had been offering for fifty years: "It is near to a city... vine covered...(has) farm and vegetable garden."
(speech to the 50th Annual Meeting of Medical Superintendents) (23)

The force behind the medical argument was singular: the medical hospitals had proved successful, so why couldn't the "monastery of the mad" be reshaped into a curative psychiatric hospital?

The superintendents defended their role by citing that insane hospitals were very difficult to manage--requiring a sophistication of management if a clean and healthy environment was to be proffered, that asylums would ultimately be called on to deal with the most violent and destructive of individuals, and that neither superintendents nor their neurologist critics were likely to administer a cure for insanity.

"AT SOME DISTANCE"

Owen Copp, Superintendent of the Pennsylvania Hospital for the Insane addressed a convention of his fellow medical superintendents in 1916 calling for a comprehensive mental hygiene effort which included prevention, community outpatient care and aftercare, chronic custodial care for long-term clients, and state hospital care for infirm and dangerous patients. Low-level custodial care could be performed in restful "colonies" while more problematic patients were to be cared for in state hospitals located "at some distance in the country". (Rothman, 1981)

Both farm "colonies" and asylums survive today.

But the reformers' confidence in the hope for a medical cure could not be shaken, and would join with another growing force of that era to demand a reformulation of institutional care.

The advent of casework and mental hygiene. The turn of the century brought with it a new era of social reform and several new sciences for approaching social problems.

In Europe, psychiatry and psychology had blossomed since Freud's landmark publication of The Interpretation of Dreams(1900). The individual was beginning to be seen as both unique and predictable--a complex bundle of psychological forces which interacted in both rational and irrational ways.

In America, behavioral and social psychology and the new social sciences had begun to revolutionize social attitudes about deviance and illness. A sophisticated model of man as a product of biology and society was born, and many approaches for social intervention were developed. Settlement houses, outpatient clinics and probation officers began to treat the problem individual within his milieu, while medicine focused more on the etiological approach to illness, on public health and on prevention.

For the first time, therapy could be systematically conducted while the individual remained in his or her own community. The "friendly visitor" had become the trained social worker, and many other "helping" roles became professionalized and publically funded.

Institutionalization had a long history of failure, and the prospect of circumventing it through diagnostic testing and preventative counseling was enthusiastically welcomed. If those with incident-related and acute psychological problems could be distinguished and treated separately from those who experienced long-term chronic illnesses, a more effective curative program could be administered.

Among other organizations, the National Committee on Mental Hygiene was formed in early 1900's by Adolf Meyer and associates to disseminate information on the causes and prevention of mental illness and to advocate for the reshaping of the custodial asylums.

Meyer--widely considered the "father of mental hygiene"--and others rallied for the creation of a "remedial rather than custodial" hospital environment--a facility which could finally offer true medical treatment and structured social counseling rather than just serve the function of rest and isolation.

This alternative took the shape of the "psychopathic hospital".

DETERIORATION IN CARE

Clifford Beers, in his 1907 autobiography, A Mind That Found Itself, recounts the first-person experience of an asylum resident and his impressions about asylum care and punishment.

He would often hear "the dull thud of blows" on an inmate, "the cries for mercy until there was no breath left the man with which he could beg even for his life."

whole duty to their closely confined charges consisted in delivering three meals a day. Between meals he was a rash patient who interfered with their leisure."

Yet Beers offered recommendations which he hoped would improve the nation's hospitals for the insane, with the final goal of creating "the most perfect hospital system in the world". (adapted from Rothman, 1981)

THE PSYCHOPATHIC HOSPITAL

Confidence in the medical model, social work and the social sciences, and America's new interest in mental hygiene combined to create a new institution designed to redefine the aging asylum.

Progress in these new areas provided definitive proof that some mental illness could be cured. What was needed was a specialized hospital and a method of screening for acute, curable cases. Acute cases would be directed to the hospital, chronic and incurable cases to the less specialized asylum.

Unlike earlier reform movements, more than just a new wing was proposed.

Early diagnosis and speedy removal to special hospital for the insane are of paramount importance in nearly all acute psychoses...This object can be attained only through the establishment of psychiatric clinics in all our larger cities.(24)

New outpatient and admissions clinics would conduct the diagnosis and referral of cases and provide a reference point for a new layer of treatment: aftercare and social work. The clinics would be located either at the hospital or as a satellite in the community.

If possible, existing asylums would be converted to Psychopathic Hospitals. Since most of these were isolated in distant rural settings, new hospitals would be built close to the community.

We should never dream of placing a general hospital for acute disorders in some remote region of the country....Why deal differently with acute disorders of the brain? (25)

The new psychopathic hospital would be convenient. It would be designed with the community's mental hygiene in mind. And it would provide for medical treatment and medical research in a professional, non-custodial environment.

CLOSER TO THE COMMUNITY

"The special role of the psychopathic hospital, its close affiliation with the general hospital, the absence of the large accumulation of chronic patients make it easier for a patient to accept the suggestion of admission to a psychopathic hospital than...to a large hospital for mental disorders....The family accepts more readily admission to a psychopathic hospital; (and) should the patient have to go later to the state hospital for continued treatment, the relatives feel that the step has been taken after due consideration and diagnosis."

-C.M. Campbell in
"The Work of the Psychopathic Hospital", First International Congress on Mental Hygiene, 1930
(Rothman, 1981, p329)

These were the reformers' forceful promises and intentions. But the execution of the intentions was slow, sporadic and minimally successful. The reform would take three general architectural forms: the psychopathic hospital was added to the existing asylum, new asylums were built and both new and old asylums were retermed "state hospital", a new name for an old idea. Although meant to be located closer to the community and capable of more intimate treatment, the psychopathic hospital, did neither. As with earlier reforms the reformers failed in their ultimate promise: the asylum persisted, and the unwanted remained isolated in an institutional environment.

THE STATE HOSPITAL

The story of Boston State Hospital demonstrates the transition from asylum to state hospital and the failure of its reform.

Originally opened in South Boston in 1839 as the Boston Lunatic Hospital (later, the "Boston Insane Hospital"), this city-run facility soon became overcrowded and custodial, and efforts were made to contract-out patients to the state's new rural asylums. By the 1880's it was clear that Boston needed a metropolitan asylum, and plans were made for a new facility at the newly acquired Austin and Pierce farms in suburban Dorchester.

From its first phase of construction in 1898, the new asylum took the shape of a sex-segregated "campus" plan as had been the reform custom of the day--a negative response to the multi-ward asylums that had grown elsewhere in the earlier part of the 19th century. A second-stage plan emerged by 1899, calling for a "metropolitan hospital" which could care for "all the insane of Boston".

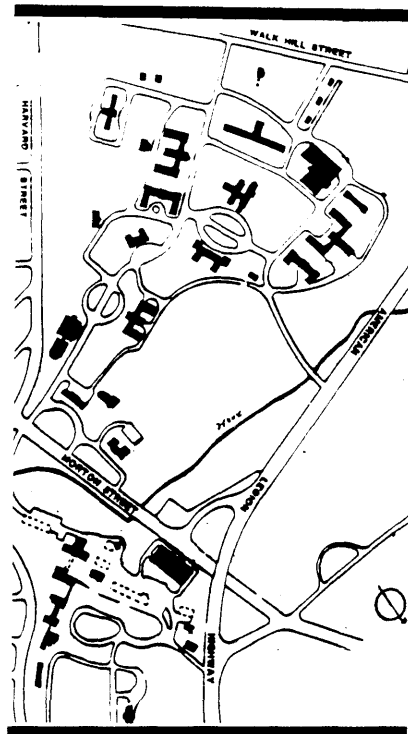
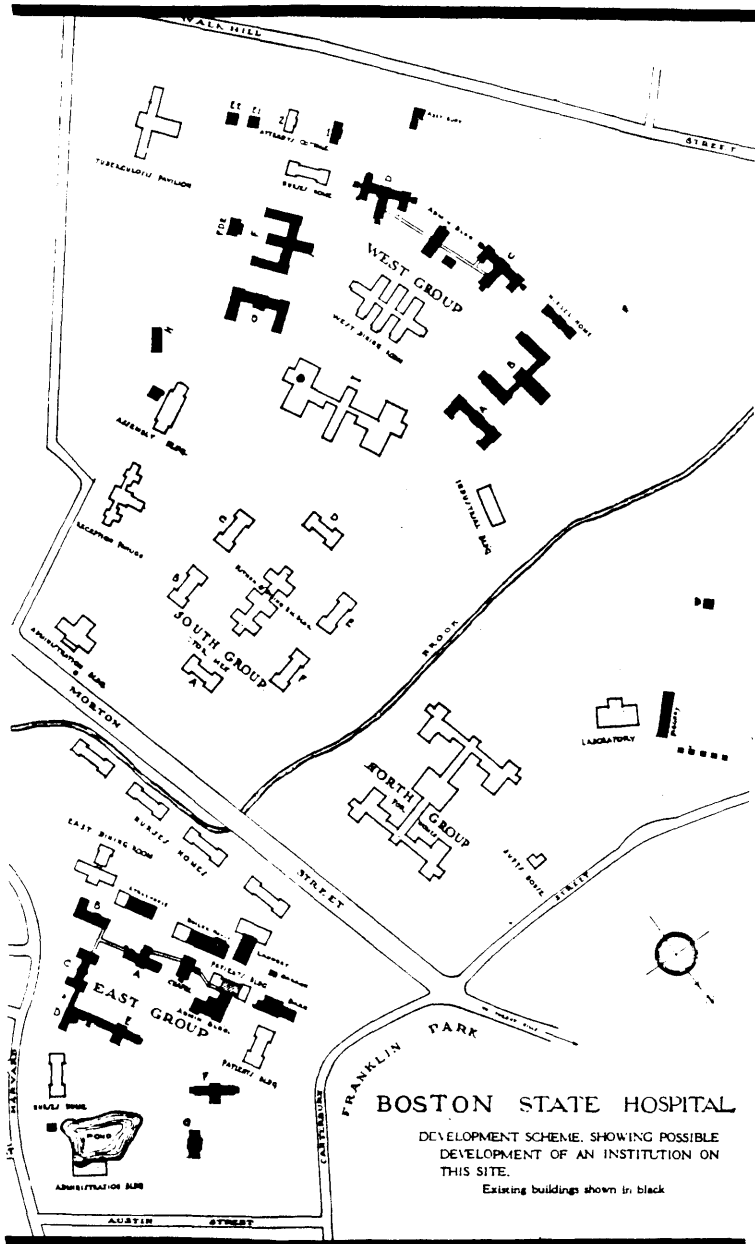
The present location is eminently suitable. Sufficient land for a model metropolitan hospital can be acquired, and it has been shown by the City Engineer and a landscape gardner that this land is

available for building sites, for exercise grounds, for patients and for tillage. In order to begin the work of developing a metropolitan hospital, the trustees have asked for an appropriation of \$353,000 for buildings and land. (Second Annual Report, Board of Trustees, 1899) (26)

Advocates hoped that this would be the first step toward a "hospital" facility of great scale. About 1,700 insane had been identified by city officials. The maximum model for asylum size time had been increased from Kirkbride's original 200, to 600 by AMSAII in 1866. But administrators now pushed for a volume which was far greater. By 1913, the Trustees related that

...it is now believed by some good authorities that 5,000 patients can be cared for under one management in one institution, provided that there are buildings enough on a sufficiently large territory to maintain a suitable classification. (Fifth Annual Report, 1913)(27)

Despite this drive for bigness, state authorities never let the Dorchester asylum get that large. The State Board of Insanity had taken control of the asylum by 1908 and renamed it Boston State Hospital. State planners maintained that 2,000 patients was any hospital's optimal maximum.(28) Instead of major expansion, a new type of facility would be built according to the latest calls for reform. Boston State would become a true hospital; it would receive a new "psychopathic" hospital.



Far left: Boston State Hospital and plans for its expansion, as illustrated in the administrator's 11th Annual Report, 1919.

"Campus" plan came at the height of turn-of-the-century reforms. Adoption of the new medical model is evident in the number of nurses' residences and the "Tuberculosis Pavillion". Later, a new "hospital" building accommodated new surgical techniques and tissue research.

Most of the buildings proposed in the 1919 plan were never built.

Left: existing site plan.

With a \$600,000 appropriation from the state Legislature "for the purpose of erecting a hospital for the observation and first care of mental disease in the city proper" (29), Boston State soon had a new layer of care. Boston Psychopathic Hospital was built a few miles from the asylum, along a part of Olmstead's "Emerald Necklace" park but in an area which was closer to the downtown and adjacent to several growing, prestigious hospitals. Opening in 1912, it was designed as multipurpose facility which could "receive all classes of mental patients for first care, examination and observation". It was to be a diagnostic entry-point to all mental hygiene care, focusing on cure and prevention. "Incipient, acute and curable insanity" cases were to be accommodated within the Hospital's small inpatient ward, while chronic cases were to be referred directly to the Boston State Hospital.(30)

LANGUAGE CHANGES

The language used to refer to the unwanted and the institutions created for them tells us much about the perceived causes of their afflictions. Changes in language demonstrated an evolution from naturalism and superstition to a medical and sociological model.

"Lunatic" was the term which arrived on the American continent from Europe in the 17th and 18th centuries. The Massachusetts State Board of Lunacy evolved into the State Board of Insanity in 1899, later replaced by "Mental Diseases" in 1916.

Similarly the "Lunatic Asylum" of the late 19th century became the "Asylum for the Insane" or "State Hospital for the Insane" around 1900, and later the "Hospital for Mental Diseases" or just plain "State Hospital" (1920's).

"Mental Hygiene" and "Mental Health" had been around for more than half a century before Boston Psychopathic Hospital got the name of Massachusetts Mental Health Center in 1956, a change that probably would have been eventually necessary if that institution were to apply for federal "mental health" monies during the mental health movement of the 1960's and 1970's.

Designed as a first-class medical facility, Boston Psychopathic would also provide clinical research and teaching opportunities, as well as give "free consultation to the poor and such medical treatment as would...promote the home care of mental patients"(31). Site selection had been made based on its proximity to the community and to the medical schools and teaching hospitals which allowed it to "be accessible not only to those engaged in teaching nervous and mental diseases but to students and other engaged in special research work."(32)

Early reports indicated that hospital administrators were convinced that the model was working. Its opening had anticipated "an earlier and more intelligent method of treatment which will reduce hospital admissions by cure or prevention" (33)--treating only acute clients and referring the chronic and incurable to Boston State.

According to one modern historian, changes in the commitment laws were the major force behind the breakdown of Boston Psychopathic's efficacy. (34) Both acute and chronic cases could be immediately committed and hence Boston Psychopathic's wards became full of chronic cases of unwanted persons who were essentially being funneled toward the custodial wards and long-term treatment of Boston State Hospital.



Massachusetts Mental Health Center; 1912

What had begun as the front door to the asylum, where the curable sick could be cured and the incurable allowed to pass within, had evolved into an intensive treatment and case management center whose largest preoccupation must be discharging and preventing admission.

Whether regulatory changes or the mere fact that any residential institution--whether hospital model or not--will attract the entire population of unwanted, institutionalizable persons cannot be determined; but Boston Psychopathic (now Massachusetts Mental Health Center) continues to fight this trend today. (35)(36)

CHRONOLOGY OF TREATMENT AND CARE

- 1800's Rest, diet, occupational therapy, hydrotherapy and massage. Medications consisted of quinine, opium, iron and cod liver oil among others. "Water treatment" consisted of tub baths and showers. Dr. Simon Baruch's popular system (1895) included high-pressure spray from hot and cold water hoses. Some static electricity use, 1897. Restraint not uncommon.
- 1910 "Pack" or tight wrapping of the body between wet sheets. Restraint and seclusion, already controversial, became a public policy issue. Chains and mail camisoles were mostly gone, but other devices were not uncommon. As late as 1897, "many persons regard non-restraint in lunatic hospitals as a fad of enthusiasts" (Danvers Insane Asylum head, Dr. Page, 1897 Annual Report). By 1910, the Mass. Board of Insanity's Dr. Owen Copp was proud to announce that restraint had been reduced 50% in the state and 85% at Boston State alone in that year. (Briggs, 1910)
- At the date of this writing, the issue is far from resolved.
- 1920 Occupational, drug and hydrotherapies have a revival. Malaria fever used as a treatment.
- 1930 Insulin used to produce hypoglycemic coma; metrazol to produce convulsions.
- 1935 Pre-frontal lobotomy, leucotomy introduced in America. Of over 500 lobotomies performed at Boston Psychopathic Hospital (Mass Mental) in 1930'S and 1940'S, 35-40% allowed eventual release to the community. (Greenblatt et al, 1955)
- 1943 Electroshock popularized
- 1955 Psychotropic medications, antidepressants

MORE MEDICINE

Reforms for the medicalization and professionalization of institutional care remained a strong force throughout the middle of this century. All state asylums became State Hospitals and were granted additions which more closely followed a hospital model in design and orientation. Taunton State Hospital for example, the first of the state's large "Kirkbride plan" asylums, gained a new "hospital" complex which more than doubled its capacity for chronic care. Similarly, the facility for the mentally retarded became a State School and its educational components emphasized.

The community-based "psychopathic hospital" model--the model which had created the Massachusetts Mental Health Center--was never fully implemented. In fact, no new freestanding, community-scale hospitals of its kind were built. Instead, the psychopathic hospital model succumbed to the push for isolation and took on the form of a hospital addition to the traditionally isolated asylum.

The next large asylum which was built was Metropolitan State Hospital, designed to reduce the demand for room at Boston State Hospital and to provide an institution which was more convenient to the metropolitan Boston area. Its design would fuse the psychopathic hospital and the asylum on one isolated site, ostensibly continuing the now-standard "hospital" model of care for all of the insane.

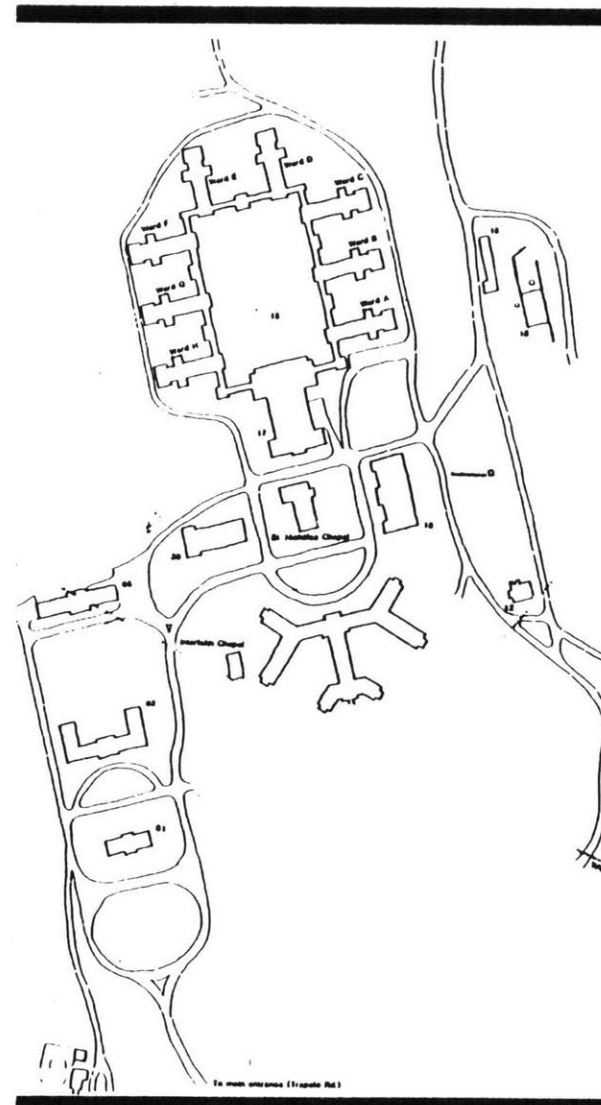
The institutions must be such that may be looked upon by the community not merely as a place to which the insane may be sent for final disposition, but as hospitals where the development of mental diseases may be prevented and where recoveries may be expected...This should be the principle object of the state hospital of the future.

Dr. James May, Head of Boston State Hospital
Mental Diseases: A Public Health Problem Boston, 1922

(37)

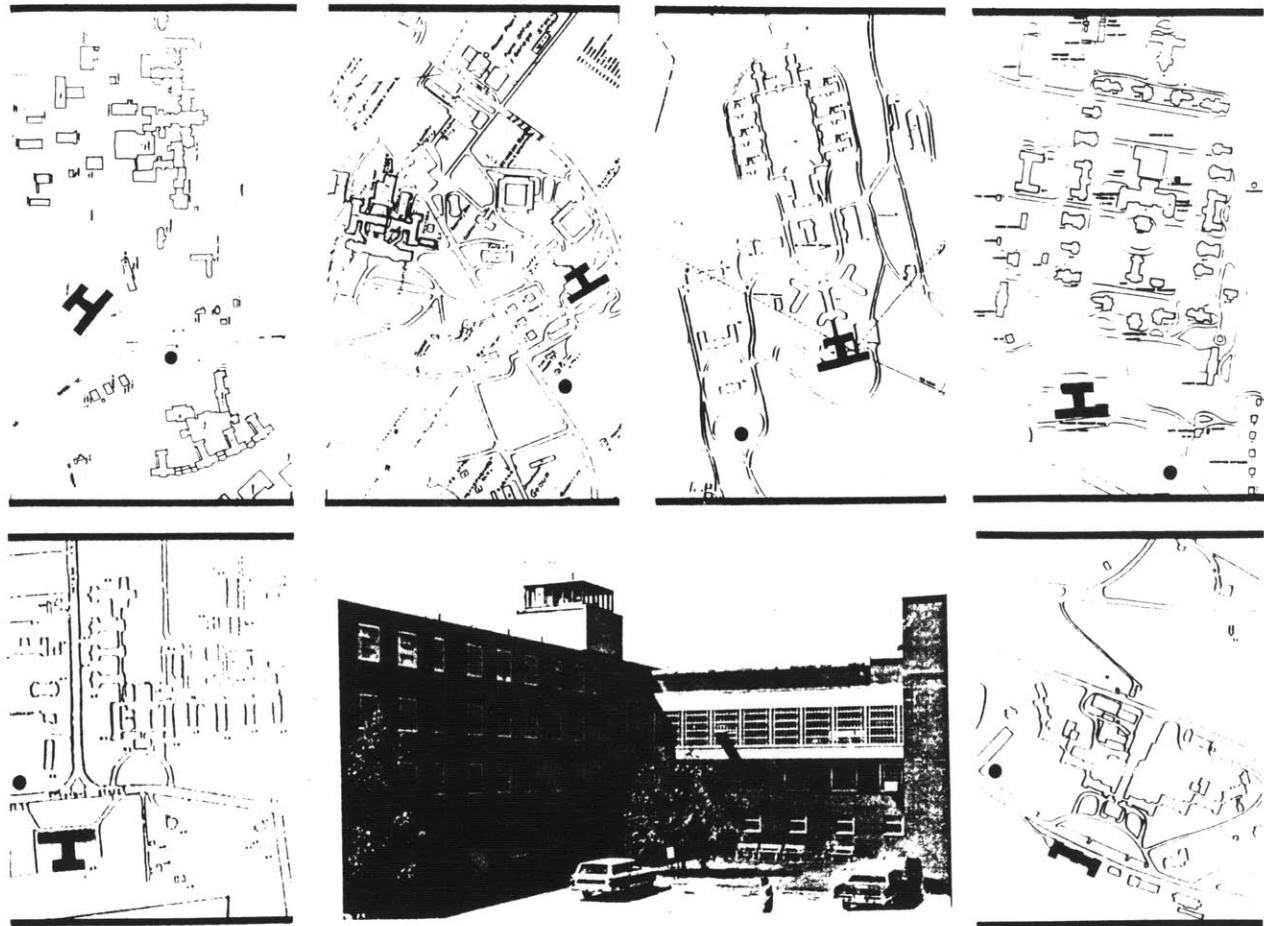
The new State Hospital was built in 1930 on lovely grounds encompassing several large hills about seven miles west of Boston. It has an impressive administrative building, a hospital building, and staff dormitories, all situated in an attractive campus plan.

But in a design format which took a step backward from the most recent "campus" plans toward the original single-building model, Metropolitan State also contained a massive interconnected multi-ward structure which eventually housed almost 2,000 persons. The asylum had returned.



Left: "Front door" and "back door" at Metropolitan State Hospital; above: site plan; 1930.

After Metropolitan State and several medical additions to existing asylums in the 1930's, a second wave of medical buildings in the 1950's attempted to introduce an even stricter medical model to the asylum campus. A cookie-cutter approach was taken and several identical or near-identical structures were added to several of the asylum grounds. All were extremely institutional-looking, with barred windows and interior tiles. All were placed at the "front door" to the asylum sites, in an attempt to make them easy to find.



DEINSTITUTIONALIZATION: THE FINAL REFORM?

THE RATIONALE

Two world wars and an economic depression took much of the punch out of asylum reform in the early 20th century. Although consistently upgraded with new "medical" facilities in an ongoing attempt to provide "treatment" to society's unwanted, the institutions grew and grew. Massachusetts' population of mentally ill inpatients alone had reached the unimaginable figure of 23,000 during the 1950s and showed no sign of decreasing on its own. The state schools for the mentally retarded, substantially overcrowded at 1,200-2,200 residents each, were no better. Institutional care remained largely custodial and the physical plant continued to deteriorate as the state got more and more behind in appropriations for needed maintenance.

Three forces provided the preconditions for a concerted attempt at finally undoing the asylum. The first two were premises --assumptions about what was possible. Firstly, reformers believed that "mainstreaming" was possible: many of the unwanted could live in society without institutionalization. Secondly, where institutions were necessary, community-scale architecture was possible: institutional facilities could be closer to the community in both shape and location. The third precondition was an attitude of outrage that had become widespread among reformers and conservatives alike: inhumanity in the treatment of the "unwanted" would no longer be tolerated.

These assumptions and premises combined with a postwar economic boom to produce the greatest institutional change since the asylum itself was created.

"Mainstreaming". Institutional care was no longer necessary for many of the mentally ill, mentally retarded and other traditionally "unwanted" individuals. It had become increasingly possible through effective case-management and social work, behavioral skill training, and psychotropic medications to remain or return to one's family and community. Caseworkers could work to prevent institutionalization as well as track recent discharges. Psychologists had learned much about testing, diagnosis and treatment during the war years and could now apply this knowledge to the public at large. For the first time, medical treatments such as prefrontal lobotomies, shock treatment, and anti-depressant and psychotropic medications allowed for many of the "cured" to return home.

According to theory, once in the community, a professionalized health care delivery system would supervise one's progress. With this system in place, only those who were severely disabled, seriously deviant or medically needy would require institutionalization.

The Community-scale institution. Postwar America had confidence that architecture could heal. Just as urban renewal programs sought to erase "urban blight" and replace it with clean new structures which would in themselves better the disadvantaged, architecture could help cure social ills as well. It needed only to be well-designed and well-located.

Facilities such as psychiatric clinics, counseling centers and settlement houses had had some success with bringing institutional and professional care on a day or short-term basis closer to the community. According to reformers, if new clinics could standardize this care, much institutionalization could be prevented. To accomplish this, there needed to be a network of accessible and inviting clinics.

Based on limited experimentation, reformers felt that residential care could also be more fruitful and less custodial if provided on a smaller, non-institutional scale and in an environment which was non-threatening, "homey", and conducive to "reality testing". Informal institutions like boarding houses and foster homes had been successful and provided a model which the state might be able to replicate.

Public outrage. The Great Society had arrived. Inhuman conditions at the institutions would not be tolerated by a society which had also declared a "war" on poverty, substandard housing, crime and social illness. Several longstanding advocacy coalitions began to find sympathetic ears among politicians and laymen alike, and media attention added to public awareness as filmmakers and journalists pointed their cameras and pens at America's domestic atrocities.

During the Eisenhower presidency, the institutionalized mentally ill population reached 560,000 nationwide. Overcrowding had led to a deterioration in care which shocked the unfamiliar observer. Use of restraint and radical somatic therapies became more heavy-handed as overworked staff sought a way to control an increasingly unmanageable population.

Conditions at the state institutions for the retarded were no better. In 1952, a Special Commission on Mental Retardation was created by the Massachusetts legislature to investigate the quality of services provided to the state's training school residents. By 1964, Commission members were still appalled at the intolerable living conditions and inadequacies of the facilities at the state's four institutions. Commission documents reported that overcrowding had reached 20% in at least two of the schools, staff shortages left up to 100 children at a time supervised by one night attendant, and most of the more modern buildings were at least 30 years old and suffering from long-deferred maintenance. The price tag for remedial capital investment alone was estimated at \$27 million.

Influenced by President John F. Kennedy's 1961 demand for "...a comprehensive and coordinated attack on the problem of mental retardation" and the recommendations of his Panel on Mental Retardation, the 88th Congress enacted the "Maternal and Child Health and Mental Retardation Planning Amendments of 1963" (P.L. 88-156), urging states to look at what had been found to be a nationwide problem and providing grants to develop statewide plans for changes in care.(38) Similar developments among mental health advocates led to the publication of Action for Mental Health in 1961 by the federal Joint Commission on Mental Health.

By 1966, Massachusetts' Mental Retardation Planning Project admitted that the state schools were largely custodial. In response, it established a ten year plan which called for the decentralization of existing institutions into small residential subunits. A year earlier, a similar body--the state's Mental Health Planning project--called for the implementation of community mental health services and the upgrading and phase-out of the state hospitals.

But without major capital expenditure, progress could not be made. Between 1972 and 1973, parents, guardians and advocates for the state school residents brought five class action suits against the state for failing to provide care and treatment which met minimal constitutional requirements. A 1976 suit by Northampton State Hospital advocates charged the state with similar negligence.

In response to these suits, the Commonwealth of Massachusetts entered into consent decrees which required it to provide capital and program improvements toward the goal of providing appropriate care in the "least restrictive" setting.

THE NEW ARCHITECTURE

By 1976, implementation of the new architecture for the unwanted was officially underway. The improvements took four shapes: (I) rehabilitation and down-scaling of the large institutions; (II) community-scale inpatient facilities in the form of community mental health centers; (III) convenient clinics and outpatient facilities; and (IV) "normalized", community-based residential settings.

Rebuilding and "rescaling" the institution (I)

By 1966, reform plans for a new type of institution had begun to evolve. With the help of new federal seed funds, Massachusetts' statewide planners drafted an innovative 10-year policy plan and began to take a new look at the role of the state school and the asylum.

In its 1966 report, the Massachusetts Mental Retardation Planning Project had outlined the new "social development" approach to mental retardation care.

...The essential problem of the state residential school for the retarded is that care is provided on a nonindividualized basis. An overlarge mass production system provides medical care, custody and security, but not small group and individual relations essential for stimulating and reinforcing social growth potential.(39)

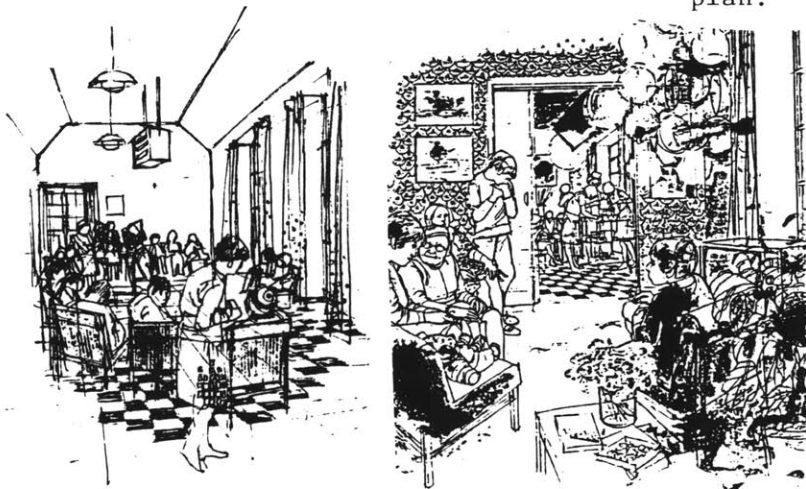
Influenced by Goffman and other contemporary social theorists, the planners admitted that increasing the staff-client ratio could not guarantee an answer. "Pertinent social science findings" clearly indicated that institutions "cannot provide individual care unless they are broken up into smaller units" where staff could work intimately with residents.(40)

The state schools could not realistically be totally abandoned--the state had invested too much in them already. And although community-based residential accommodations were in the planning stage, these would not be adequate for the near future. As is asked in the state's 1966 ten-year plan,

How can large complex residential centers be converted into smaller semiautonomous communities to provide the inherent benefits of more individualized approaches to residents?(41)

The answer to that question began with dividing residents with medical needs from non-medical residents. The planners then outlined a new system of staffing for new "functional units" of residential care. Mental health planners soon followed suit, introducing similar plans for scaling-down the state hospitals into smaller administrative if not physical units.

The new decentralized institutional plan called for conversion of underutilized farm buildings, nurseries and dormitories for these purposes. The state schools, built largely on the "campus" plan originally and located in rural settings with many buildings, were thought to be relatively adaptable to this plan, but not without extensive capital modifications. Typically however, although extensive plans for staffing and program costs were drawn up, no realistic capital costs were estimated in this plan.



"Re-scaling" of a large institutional space into a more "homelike" setting. Great Britain, 1972. (from King Edward's Hospital Fund)

As mentioned, the consent decrees provided the impetus to put the down-scaling plans into action. But a second force was also at work in instigating insitutional improvement.

The emerging availability of federal reimbursement monies provided a rude awakening about facility quality: facilities would have to meet federal standards for both architecture and program if the cost of their operations were to be made eligible for reimbursement.

Title XIX (referring to the section of the Social Security Act of 1963 which created the Medicaid program) would reimburse about half of the care of institutional-level persons in "certified" facilities. It would also cofinance the capital costs of upgrading these facilities--adding an enormous incentive for the state to invest in improvements.

Federal standards for care of the mentally ill and retarded had recently improved--creating several levels of care for which reimbursement was available. One level was called the Intermediate Care Facility (ICF), a specialty variation which specifically targetted the mentally retarded or disabled person. The "ICF/MR" was designed to serve small groups of disabled persons in "homelike" settings, training them--where possible--in independence skills to improve their chances of returning to a more normalized, non-institutional setting. The building and programs codes were strict, but here was a humane design for a facility--approximating "community-scale". Even more importantly, the federal government was willing to pay for it.

Thus the state was sent into a rush for certification and for meeting the schedules agreed to in the consent decrees--objectives which would alleviate both financial and legal pressures. Its goal remained a least-restrictive, more "normalized" environment for all of its institutionalized clients.

Throughout the late 1970's and early 1980's a series of action-oriented masterplans and comprehensive implementation strategies were hastily prepared. Implementation of these is still underway. What is still not clear is the optimal size of the institution itself, a topic which will be discussed in full later.

HOMELIKE

The trend toward "normalized" institutional settings was not limited to mental health facilities, as seen in this design program for a secure treatment facility for adolescents.

"Although security is a special requirement, the underlying purpose of the Department of Youth Services is to return youths to their communities as useful citizens. Therefore, the architecture and furnishings should be as "homelike" as possible, avoiding such institutional devices as barred windows and hard glossy surfaces.

A normal environment includes contact with family and friends. A facility should be located so as to be reasonably accessible to the residents' home community and should provide for supervised visits in a comfortable setting.

("Building Program for Secure Treatment Facilities", Sturgis and Basu, for Department of Youth Services, 1981)

Reflecting modern standards, the program for this facility called for an optimal grouping of 8-15 "clients". To accomplish both privacy and community-scale, designers recommended that the residential part of the structure should be physically separated or at the edge of the facility, administrative space facing the street, and outdoor recreation behind--away from public view.

Community inpatient and outpatient care: the community mental health center (II and III)

With the passage of the federal Community Mental Health Center Act (P.L. 88-164) in 1963 and the Massachusetts mental health reform acts of 1966 (Chapter 735) and 1970 (Chapter 123), Massachusetts was on its way toward developing a network of facilities which would provide an alternative to (and replacement for) the state hospitals.

According to National Institutes of Mental Health (NIMH) guidelines, community mental health centers were to serve catchment areas of 75,000 to 200,000 persons and would provide a range of core services. NIMH would provide starter grants for planning, construction and operation.

Although "community-based" by definition, performance criteria for siting the centers were never fully articulated. At its inception, the concept of the mental health center never wandered far from the medical model. Rather, it was seen as adding a preventative or "hygiene" component to existing hospital-based mental care. Even the site for the community mental health center (CMHC) was visualized as proximal to the hospital.

In his message to Congress proposing the program, President Kennedy stated that "ideally, the center could be located at an appropriate community general hospital, many of which already have psychiatric units. In such instances, additional services and facilities could be added--either all at once or in several stages--to fill out the comprehensive program". (42)

The actual legislation, when passed, contained no specific requirements for location or organizational structure, but rather stressed that the centers provide a comprehensive program which contained, inpatient care, partial hospitalization, outpatient care, emergency services, and consultation and education.

After several applications of the CMHC model to general hospital settings throughout the nation, a variety of other applications followed, including centers at state and county mental hospitals, private psychiatric hospitals, and outpatient clinics, and new construction of "freestanding" centers (with the help of federal P.L.88-164 grants). (43)

Massachusetts' experience was unique. It already had a strong "back-up" of hospital beds, hence its community mental health centers were best placed "out there" in the community for maximum exposure to the population centers that needed them most.

Of the six centers built in Massachusetts, four were nevertheless sited adjacent to hospitals--less by design and more by convenience, since the hospitals were willing to dispense with land for this purpose, and the "institutional" part of town was the least objectionable location from the town's point of view.

Among the four centers which were built outside of the City of Boston, all share similar problems of scale and institutional identity. Three of these also share problems of accessibility, having been built far from the center of town, from public transportation, and from dense residential communities.

The major failure of the centers was that too few were built. In addition to the six centers which were built in Massachusetts, many more were funded as outpatient-only facilities in existing shared or rental space. Because so few new public community-based inpatient beds were created, if the community mental health centers were to effectively replace state hospital and state school care, there would need to be no "holes" in the new network of non-institutional and home-based support programs. But holes in the network were inevitable and the community support programs couldn't keep pace. Instead, the state was caught operating two systems and two sets of institutions, not benefitting from the costs which were to be saved by "phasing out" the asylums --a crisis that it is very much in the middle of today.

THE NEW NETWORK

"Indications are that 75 percent of the acutely mentally ill who receive intensive treatment in community facilities will not require costly institutionalization. Long-term costly hospitalization of the mentally ill should be avoided, not only for the sake of the economy, but also in the best interest of the patient. Whenever possible, the patient should be treated and short-term psychiatric services...day and night hospitals, halfway houses, and other rehabilitation facilities."

-Joint Commission on Mental Illness and Health, National Advisory Mental Health Council; Hospital Management, April, 1963, p.61

"Normalized residential care (IV)

The last form of physical institutional reform undertaken by the deinstitutionalization reformers is the "group home", "community residence" and other supportive, semisupervised living situations set in normal residential environments. The idea was to establish "normalized" living situations in normal residential communities in which clients could live with dignity while learning more about living independently.

THE 19th CENTURY GROUP HOME

Reformer Dr. William Hammond demanded the support of a group home model in which physicians or other professionals took needy patients into their homes.

"I am decidedly of the opinion that there are no lunatics no matter how dangerous or troublesome who would not be better cared for under the family system than within the walls of any lunatic asylum., and it is a great satisfaction to percieve that this sytem is being gradually developed in this country."

In the absence of this care, and where more asylums had to be built,

"they should be constructed after a different system from that which prevails. An aggregation of small homes, each one not containing more than a half a dozen patients, would be the best plan...."

Hammond admitted that the implementation of such cottage-care at the existing asylums would be difficult due to their rural and isolated settings and the lack of interested personnel (although the new railroad lines connecting city and country might make a crucial difference).

Hammond's reforms were only experimentally implemented but his views and those of sympathetic reformers were instrumental in the creation of the "campus" asylum plans. (-"The Non-Asylum Treatment of the Insane" 1879 pp.16-18)

State housing planners devised a range of housing models which could accommodate clients with various degrees of independence skills. Rather than construct or purchase these residences in residential communities, the state would primarily rely on contracting with vendor organizations who could procure adequate housing and provide for staff.

Although adequate for the minimally disabled, the intensive facility needed by the more severely disabled could not be reliably supplied by vendors. The state would finance these and other group homes with its own capital funds. An innovative state housing grant program had also been created in 1976, which provided additional funds for local housing authorities to build appropriate housing (Chapt.689). In addition, Federal Title XIX regulations allowed for the cofinancing of specialized "intermediate care facilities" which served severely disabled individuals who were capable of "self-preservation" (ICF/B's).

The design of nearly all new state-funded and state-built residential facilities was exquisite--largely meeting both pertinent life-safety standards as well as standards of comfort, "homeyness" and practicality. (The Executive Office of Communities and Development competently oversees construction of the housing authority grant projects; the Division of Capital Planning and Operations oversees the research and design for the Intermediate Care Facilities. The latter's design is also reviewed by the Departments of Mental and Public Health.)

But serious problems plagued the community-based housing effort from the start. Firstly, community programs were expensive. Economy of scale had been lost in the switch to small eight-person residences. In addition, housing in Massachusetts was already a tight and competitive market, so most new residences had a difficult time finding existing rental space and had to be sited in new construction, major rehabilitation, or whatever type of existing housing could be afforded. As a partial consequence, residential "slots" were slow in the development and have consistently fallen short of need. For those slots which are available, they are distributed less on a priority basis for the most needy individuals but more according to the demands of a consent decree schedule or to the "easier", less supervision-intensive clients.

Vendors could not be easily monitored, and often offered substandard living arrangements to the clients in their charge.

Where adequate resources have been available, the largest problem of the community-scale residences has been siting. Few families are convinced that a community residence for deinstitutionalized persons located next door would be an asset rather than a liability. Most neighborhoods and town officials appeared ready and willing to fight controversial sitings at every opportunity. And where community acceptance wasn't an issue, the unavailability and high cost of land was.

In light of the history of attempts at community-scale reform, the net result of siting problems for the group homes was to be expected: many were placed in substandard or isolated areas or on the grounds of the asylums and state schools.

The demand for a "normalized" environment had an early following in Europe and Great Britain. Here an illustration and excerpt from Room for Improvement: a better environment for the Mentally Handicapped (King Edward's Hospital Fund, 1972).



Position matters

If you want to set up a home for the mentally handicapped in an ordinary street, whether it's run by the local authority or the health service, there's almost sure to be a protest of some kind. You may wish to explain to the neighbours how very ordinary the mentally handicapped can be, but you won't be helped in your mission if the proposed home looks like a mini-hospital or mini-institution. If it is clumsily sited, say, alongside a fire station or clinic or public weigh-bridge, or wherever there happens to be a spare bit of local authority land, this won't help either. The home needs to be visually integrated into a residential area wherever possible: a house in a street of houses.



Taunton State Hospital
for the Insane;
begun 1851



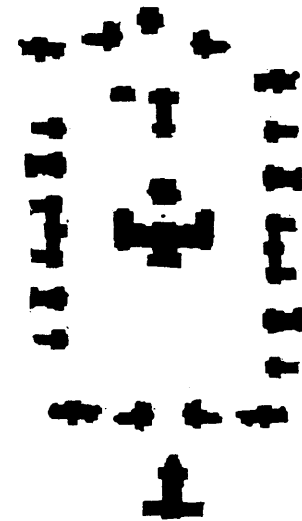
Lunatic Hospital at
Northampton;
begun 1855



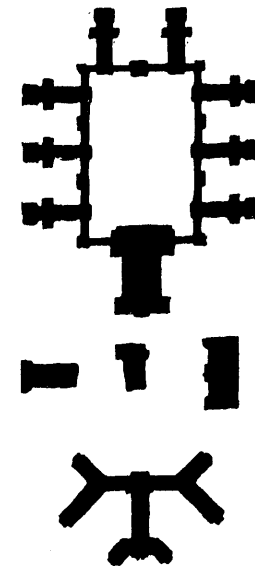
Worcester Lunatic
Hospital;
begun 1870



State Lunatic
Hospital at Danvers;
c.1873



Medfield Insane
Asylum;
c.1892



Metropolitan State
Hospital;
1930

 CHRONOLOGY OF LARGE INSTITUTIONS IN MASSACUSETTS

DATE	ORIGINAL NAME
1830	Worcester Insane Asylum (demolished)
1839	Boston Lunatic Hospital (demolished)
1848	State Reform School School for Idiotic and Feeble-Minded Youth
1851	Taunton State Hospital for the Insane
1852	State Almshouse at Bridgewater State Almshouse at Monson State Almshouse at Tewksbury
1854	Lancaster Industrial School for Girls
1855	Lunatic Hospital at Northampton
1859	Nautical Reform Scool (Mass. Maritime)
1870	Worcester Lunatic Hospital
1873	State Lunatic Hospital at Danvers
1884	Westborough Insane Hospital Lyman School for Boys
1887	Walter E. Fernald State School
1889	Hospital for Dipsomaniacs and Inebriates at Foxborough
1892	Medfield Insane Asylum
1895	Rutland State Sanatorium (demolished) Boston State Hospital
1899	Templeton Colony
1902	Worcester Farm Colony Grafton State Hospital Colony for Insane at Gardner
1904	School and Home for Crippled and Deformed Children (Mass. Hospital School)
1906	Wrentham State School
1907	Lakeville State Sanatorium North Reading State Sanatorium Westfield State Sanatorium
1908	Industrial School for Boys (MCI Shirley)
1922	Belchertown State School
1930	Metropolitan State Hospital

TALE OF TWO COTTAGES

By the late 1840's, Dr. Thomas Story Kirkbride, master designer of the multi-ward asylum, had become concerned with providing quarters for two special groups who shunned the asylum's wards--the wealthy and the intemperate. His recommendations called for semi-private cottages to be located on the spacious asylum's grounds. Their sites would be situated such that one could "have pleasant views from them, and sufficiently near the main building to admit, without inconvenience, the constant and varied supervision, which is of the utmost importance, and which can never with safety be neglected in any part of an Institution for the Insane."

By 1980, institutional reformers had experimented with a number of alternatives to the asylum ward, including the "campus" plan and the cottage--this time no longer reserved for the wealthy or "paying" client. Looking like a single-family home but meeting the institutional building codes, "community-based" institutions like the Group Home were designed to "blend-in" to residential neighborhoods.

Difficulty in acquiring or affording sites in residential neighborhoods, and preference for proximity to core services has influenced the siting of many Group Homes on institution grounds. Like the cottage of the Kirkbride era they only partially turn their back on the institution they sought to avoid.

Excerpts from Dr. Thomas S. Kirkbride's Remarks on Cottages for Certain Classes of Patients in Connection with Insane Hospitals (N.Y. Lunatic Asylum at Utica, 1851).

There seems to be no good reason why persons possessing ample fortunes, and accustomed to all the comforts and luxuries which wealth can procure, should not, when insane, continue to enjoy as many of them, as are not likely to prove injurious. Those who have the ability and the inclination to pay for them, should be able to find, when their minds become diseased, in connection with some of our institutions, large and airy apartments, handsomely furnished, with provision for ample attendance—private tables—separation from other invalids—with means for enjoying the visits of friends, without interfering with the comfort of others.

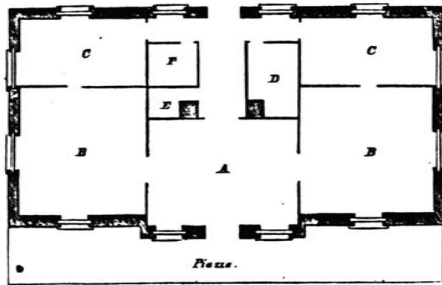
1851

1983

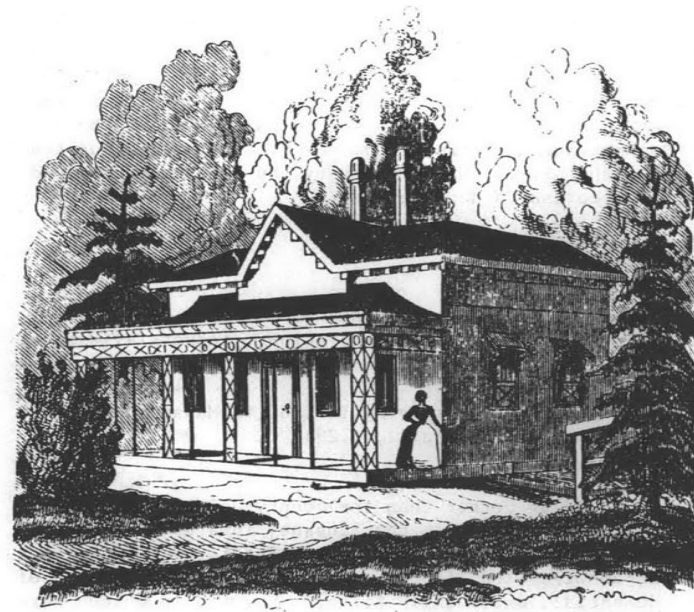
One of the most effectual plans to meet the views and requirements of these different classes would consist in the erection of a limited number of Cottages, on the grounds of our large institutions, connected with the main building only by a covered way, and while distant enough for privacy, not so much so, as to deprive them of the many advantages, resulting from proximity.

A few such Cottages, in connection with those institutions that receive wealthy patients, especially those near our large cities, would rarely be without occupants who would be glad to pay liberally for such accommodations, and who, with them, would be under as little restraint, and subjected to as few annoyances as they would be anywhere.

Illustration of Intermediate Care Facility for the Mentally Retarded (Type A), a group home for several severely disabled persons. One of three main models chosen for their ability to meet institutional building codes in a pleasant home-like design. ICF's are frequently sited at the perimeter of the institution's grounds, preferably in proximity to nearby residential neighborhoods.

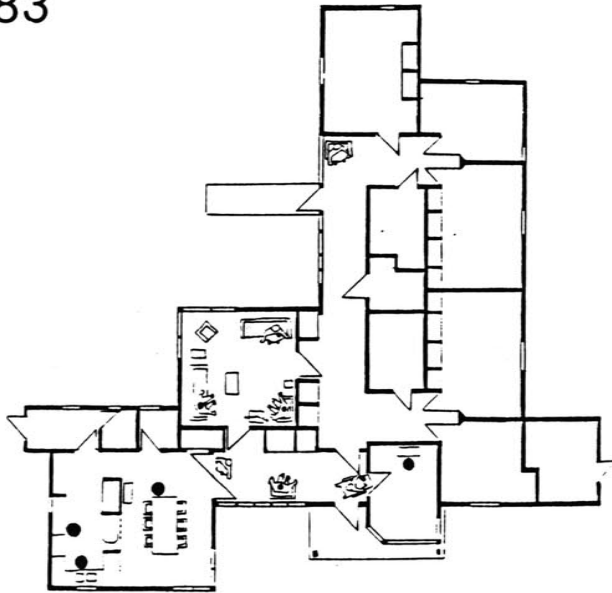


PATIENTS' COTTAGE.
Pennsylvania Hospital for the Insane.



1851

1983



SCALE 0 2 4



NOTES: Chapter One

Research sources for this section were comprised primarily of the rich and detailed accounts of progressive reform movements by David J. Rothman and a review of Commonwealth of Massachusetts Archives at the State House Library by the author and architectural historian Candace Jenkins.

1. Yi-fu Tuan, p.188
2. *ibid*, p.193
3. Reed in Yi-fu Tuan, p.195
4. Rothman cites the breakdown of the "boundaries" of colonial society; this heightened by immigration, industrialization, improved transportation and the rise of the rationalist Enlightenment.
5. Over 200 almshouses were surviving in 1860 in Massachusetts (in Mental Health Crossroads..., p.29)
6. *ibid*, p.29
7. Jenkins, 1984
8. The asylum would be better than the county almshouse, where "...the treatment accorded to the [insane] inmates is scarcely better than that which be given the sane paupers..." Conditions included excrement-soiled floors, a woman "in a state of turbulent dementia...exceedingly filthy", a ward in which were found, "indiscriminately huddled together, paupers, children, vagrant and insane, all in a state of extreme disorder". (New York State Commission on Lunacy, 1889) in Rothman, 1980 pp.29-30
9. Sanborn in Jenkins, 1984 p.39
10. Soon thereafter, state law required separation of insane from criminals in local jailhouses.
11. Jenkins, 1984 p.8
12. This responsibility was not complete until 1904 however, when the state abandoned its methods of assessing a per capita fee on the town for its indigent patients and assumed full and direct responsibility.
13. adapted from Jenkins, 1984
14. Rothman, 1971 p.139
15. AMSII Propositions and Resolutions Philadelphia: Collins, 1878 p.7 Mass Archives
16. Lansing, Kansas Penitentiary Investigation, 1909 (in Rothman, 1980 p.20)
17. *ibid* p.23
18. *ibid* p.23-4
19. *ibid*
20. *ibid*
21. *ibid* p.38
22. *ibid* p.297
23. *ibid*
24. Frederick Peterson in the "Meyer Papers", 1899 (in Rothman, 1980 p.309-310)
25. *ibid* p.312
26. in Jenkins, 1984 and Mass. Archives
27. *ibid*

28. *ibid*

Throughout the U.S., overcrowding remained a crucial issue.

In 1905, the rated capacity matched the number of patients in the institutions: 8,552. Then, year by year, the degree of overcrowding increased. In 1910 there were 10,364 patients for 9,627 places (8 percent overcrowding)...by 1939, 20,623 patients for 17,538 places (18 percent overcrowding).(Rothman, 1980 p.352)

Institutions like Boston Psychopathic which could send its overflow patients on to the state hospital remained relatively uncrowded.

Psychopathic Hospitals also had outpatient clinics, but the volume was tremendous and often allowed only diagnosis. According to its 1921 Annual Report, after dispensing with those psychotic patients who were referred directly to the state hospital, the clinic at Boston Psychopathic was left with "one thousand and fifty hours with which to examine and treat 779 patients, which allows us about one hour and twenty minutes to each patient per year." (Rothman, p.370)

29. *ibid*

30. The University of Michigan at Ann Arbor had opened the first in 1909. Other new models included "Pavillion F" of the Albany General Hospital, Albany, New York, and the Psychiatric Institute of New York. A German version was often cited as the model to be emulated.

31. Massachusetts Board of Insanity Annual Report 1910, (in Rothman, 1980 p.325)

32. First Annual Report 1909, (in Jenkins, 1984)

A tour of Boston Psychopathic at the time included:

"An operating suite, examining rooms and limited ward space were found on the first floor of the rear wing. The second and third floors served primarily as wards for acute male and female patients respectively. The fourth floor had a solarium and a partially covered roof garden while hydriatic treatment facilities were located in the basement. A medical library was located in the front of the building on the second floor with laboratories on either side. The third floor held the assembly hall, flanked by nurses dormitories which could be converted to ward space when needed. (An) observatiuon ward dominated the fourth floor." (Jenkins, 1984)

33. E. E. Southard, first director (in Jenkins, 1984)

Across the nation a similar pattern was developing. Clinics were set up to do preventative work, to serve children who lived at home with their families, or to provide supervision of patients who had been released on a "parole" basis. New York required each asylum to have an aftercare clinic in 1913. However, budget restraints in most states kept their number few. By 1935,

62 Of 127 state hospitals were administering outpatient clinics; and while it is true that most of the clinics were located off the institution's grounds, in a local hospital or school building, still they met only intermittently. Almost 60 percent were open only once a month or less, and a mere 6 percent met twice a week or more. (Rothman, 1980 p.367; based on National Committee for Mental Hygiene Survey.)

In the 1930's the Massachusetts Division of Mental Hygiene administered a network of clinics within Boston. Clinics were not created elsewhere and many of the Boston clinics folded.

First designed as temporary programs which would encourage the state hospital to institute a permanent relationship with their surrounding districts, the clinics proved unable to function on the skeletal funds and staff that the core institution could spare. There was a growing awareness that clinics would need their own targeted funding and staff.

34. Rothman posits this idea (1980)

35. For extensive discussion of Mass. Mental, see Gudeman and Shore, 1984

36. In 1909, enactment of Massachusetts Chapter 395 allowed for a "temporary commitment" for observation and treatment of up to seven (and later, ten) days without a court order. Temporary commitment to the psychopathic clinic thus became a quick route into the mental hospital. Detailed in Rothman, 1980.

37. *ibid* p.322

38. see bibliography entry

39. p.58 of the "Ten Year Plan"

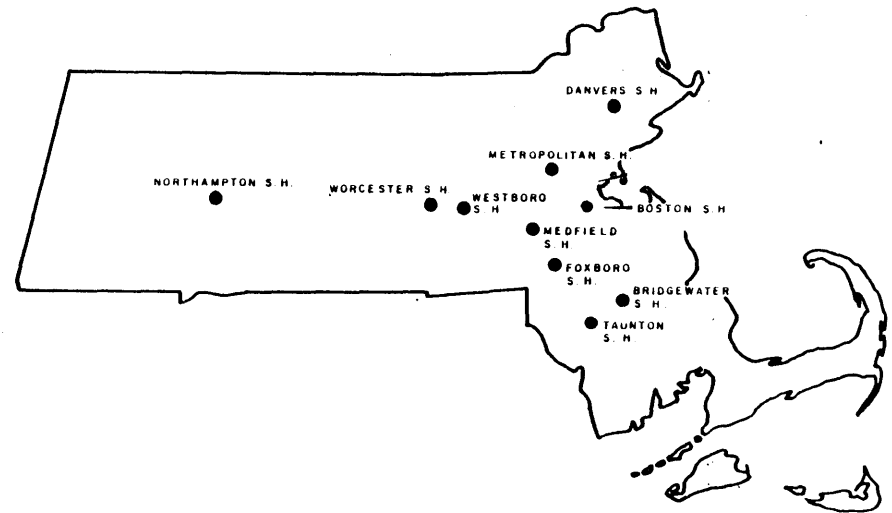
40. *ibid*

41. *ibid* p.59

42. Thompson, et al 1984 p.1107

43. *ibid*

Regional State Hospital system.



UNDERSTANDING THE FAILURE OF REFORM

2

The history of the asylum and the architecture of its reform offer us important lessons about the forces and attitudes which shape the way we treat our "unwanted".

History tells the story of a dynamic tension between the forces toward institutionalization and the intentions of reformers ---a tension which is evident in the architecture of institutions as they evolved and as they exist today.

The asylum itself had been a reform against inhumane treatment, but it also solved the problem of ridding society of its unwanted. Once created, the asylum performed a function which was not easily undone and which persists today as a challenge to modern reformers.

Two forces work against reform to help the asylum endure. They were the same forces which created the asylum in the first place. Although difficult to name, their existence can be easily recognized along the dimensions of space and scale.

TWO FORCES

Our analysis of history has shown that society's ideas about and reactions to its unwanted are expressed along a spatial dimension, such that the way the unwanted are treated can be gauged as a matter of proximity.

From the time society first attempted an organized approach at coping with the problem of the unwanted, its response had been to push away. The unwanted were first segregated in institutions--pushed from the streets and into facilities that would contain them. Once segregated, the institutions themselves would be pushed away--their distant location exaggerating the isolation which the institution's walls had begun.

This urge to distance the unwanted is an ongoing force and one which is repeatedly instrumental in offsetting reformers' attempts to bring the institution and its residents closer to society.

Design of the asylum, and, more specifically, its Scale and internal configuration, also reflect society's ideas and attitudes about the unwanted. For example, our ideas about whether or not a mentally ill person benefits from a neutral and sterile environment, or from a familiar and fraternal environment determines the shape of the facility which is designed. Conversely, our indifference to what is or what is not "beneficial" determines our blindness to therapeutic design at all.

THE FORCES AT WORK IN HISTORY

Although extremely simplistic and elemental, the constructs of spatial distance and scale are useful tools for understanding the historic and current forces at work. Let us apply these constructs in a brief retrospective of the history covered thus far.

As mentioned, the first response to the growing numbers of unwanted persons in a rapidly urbanizing society was a spatial response. The unwanted were gathered together and pushed away. The asylum was set in a remote, rustic area--far from urban centers. Once established at a distance, it solved society's problem by both segregating and isolating its unwanted. Ironically, the intentions of institutionalization were at least partially driven by reform, for this new, distant setting was in itself intended as a cure.

The asylum served society well it seems, for the momentum toward institutionalization was massive. Few other methods were available for treating insanity, and more and more persons ar-

rived at the asylum door. The demand for the institution soon outstripped the available space, and the first asylums soon grew crowded as conditions deteriorated.

In response to this deterioration, the first institutional reforms were reforms of scale. Standards of the day tolerated bigness: it was felt that a therapeutic environment could be maintained in a facility of up to 250 persons, and later, 600 or more. As existing asylums reached these capacities new ones were built or new wings were added. Society could accept the institution's bigness and the proliferation of new facilities because they were located far away, out of the public eye. Bigness was even desirable: largeness afforded economies of scale and enabled the asylum to support itself through farming and industry--affording enormous cost savings to the public coffers. Largeness was also desirable from the point of view of the asylum's director and chief planner, the medical superintendent, who was concerned with the permanence of the semiautonomous institution and his role as its chief executive.

Hence the momentum toward institutionalization and the "reforms" of expansion combined to create a network of massive, isolated asylums--a trend which was further reinforced by its effectiveness in segregating the insane and the enormous cost savings it afforded.

Many later reforms also took the form of changes in scale, as new configurations of the asylum attempted to produce a more effective cure or more humane environment. The asylum's distance from public awareness allowed deterioration in conditions to go largely unnoticed and unchallenged, hence, conditions inevitably became crowded and the quality of care custodial if not inhumane. Reformers, focusing on the size and concept of the large, single-building asylum proposed changes. In these changes, the spatial proximity of the institution to the community was not at issue. That the asylum would remain distant and isolated was taken for granted.

Among these progressive reforms of scale, design and configuration were the following:

The "campus" plan altered the configuration of the entire institution, in this case bringing the configuration of the community itself--the New England town--within the walls of the institution. The scale of the new institution would not appear as a single large entity, but would be more of a collection of entities--much as a real community is an aggregation of individual residences, workplaces and open space. Medfield State Hospital was a good example: an isolated institution which looks like a town. But wards were wards, and the institution "walls" still surrounded the asylum. Its major goal of isolation and distance remained unchanged.

Application of early medical cures merely brought a different subfunction to the asylum, one which focused on teaching physicians about what made people deviant and on enabling patients to be "cured" by medicine. The institutions remained large and isolated, but now under the auspices of medicine. They needed new space for research and observation, and for separating new and existing residents by type of illness into separate wards. The asylums would be recast into "hospitals".

The "normalization" of the institutional environment which had been attempted by the early "campus" plans were carried one step further when reformers began to create more realistic "homelike" environments within institutional buildings (the campus schemes had left the ward interiors unchanged). Cottages and group homes grew up on asylum grounds. Wards were converted into scaled-down functional living units. Planners worked to create the "least restrictive setting" on a campus originally designed to control, restrict and discipline.

Reformers also focused on bringing the unwanted closer to their home communities--a task which required undoing the tendency to "push away". This was a reform along the spatial dimension with two directions for implementation. Reformers could bring the institution itself closer to the community. They could also bring the unwanted closer by preventing institutionalization in the first place or by "mainstreaming" the deinstitutionalized.

Some examples in history of reform along the spatial dimension are obvious:

Clinics and psychopathic hospitals by definition required proximity to the city. The goals of "prevention" "hygiene" and crisis intervention were acceptable and welcome, but these institutions created densities of the unwanted and were subject to the same strong forces of isolation as had been the asylums. Hence the new clinics and community mental health centers were located in the most far-away part of town or were piggy-backed onto medical or governmental institutions already imbedded in the community. In a sense, these latter institutions--less objectionable to the community and hence less subject to being pushed away--were used as a stepping stone for the mental health facilities seeking to penetrate the urban environment.

Were they successful? Although they did succeed in partially dispersing the asylum and in getting closer to the community, they could hardly be said to have reached their goal of reintegration.

The community-based residence and "intermediate care facility" are examples of institutions which reformers intended to "inject" back into the community. Institutional by function but ideally designed to "blend-in", group homes were intended to get close to the community the way larger facilities

couldn't.

Success has been spotty, as the forces of spatial distancing remain difficult to overcome. Public attitudes still insist that such facilities be distant, or, at least, "not in my back yard". Ironically, although one of the traditional methods of coping with this problem, the convenient siting of "community residences" on the asylum grounds remains one of the most controversial issues among reformers today.

VICIOUS CIRCLE

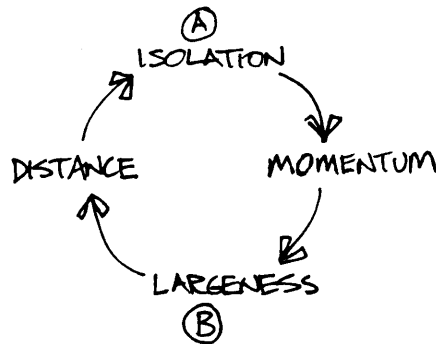
Stepping back, we can see that the forces of distancing and bigness of scale have historically aggravated each other in a closed cycle which renders the asylum even more resistant to reform.

In a simplified sequence:

A Responses to the unwanted which manifested themselves along the spatial dimension took the form of trends toward segregation, distance and isolation.

B Attitudes about care, (or basic indifference) combined with the reality of economies of scale to produce a response along the dimension of scale: "bigness". Demand for the asylum was massive, and asylums grew crowded. As conditions worsened, existing asylums were expanded and more were built. Distant from society, asylums could become large and many, and conditions could worsen without much notice.

A Distant Asylums "solved" a problem. They got the unwanted out of sight. Society postponed all attempts at alternative solutions to treatment, and hence became reliant on institutionalization as "the only way". This encouraged admissions--aggravating crowding and leading to expansion.



The asylums' massiveness and the poor conditions they became known for further fueled the desire to keep them as distant as possible--a desire which also effected the next generation of scaled-down institutions.

Institutional reformers stepped in throughout history to break this vicious circle--attempting to effect change by creating their own type of facility. The first reforms of expansion and medicalization built new structures which succumbed to the same forces of isolation and scale which shaped the original asylum. The new "hospital" complexes, such as the additions made at the Taunton asylum in the 1930's or the entire format of the Metropolitan State Hospital of 1930, were largely just an expansion or reiteration of the original asylum design and did little to undo the forces of distance and scale.

Not until the mid-20th century did reformers set about to radically alter the forces of institutionalization themselves and apply a more comprehensive strategy to break the vicious circle of distance and scale. But again, the attempt to disperse and rescale the asylum, and to reintegrate those who had been institutionalized fell victim to the same forces. Rather than successful reintegration, the asylum was indeed partially dispersed--only to essentially "re-form", albeit on a smaller scale.

A CLOSER LOOK

Although good tools for understanding a complex problem, the constructs of spatial distance and scale are not in themselves sufficient for the task of developing constructive alternatives to implementation. When examined in detail, the forces behind the failures in community-scale institutional reform are much more varied and enigmatic.

Putting names on all these component influences and pressures is difficult. Understanding their effect may be a more manageable goal. A look at more specific examples of these forces at work may make that task easier.

Four examples of community-scale reform provide a broad look at the forces which are elemental to its failure.

The story of Norfolk Prison Colony is one where the distance between institution and society is taken for granted. Rather, a community is artificially created within the institution. In the second example, reform takes a contradictory direction. Regional Observation Centers would remain institutional in design but attempt to get closer to the community which they served. In the third example, the reforms of scale and proximity combined in the master-planning for the state schools for the retarded: the institution was to be scaled-down to be made more community-like while community-scale cottages were to be built closer to the community. Lastly, the community mental health centers were to replace the asylums entirely, but succeeded only in adding another layer of institution--this time dispersed in an incomplete network which failed to undo the persistent asylum.

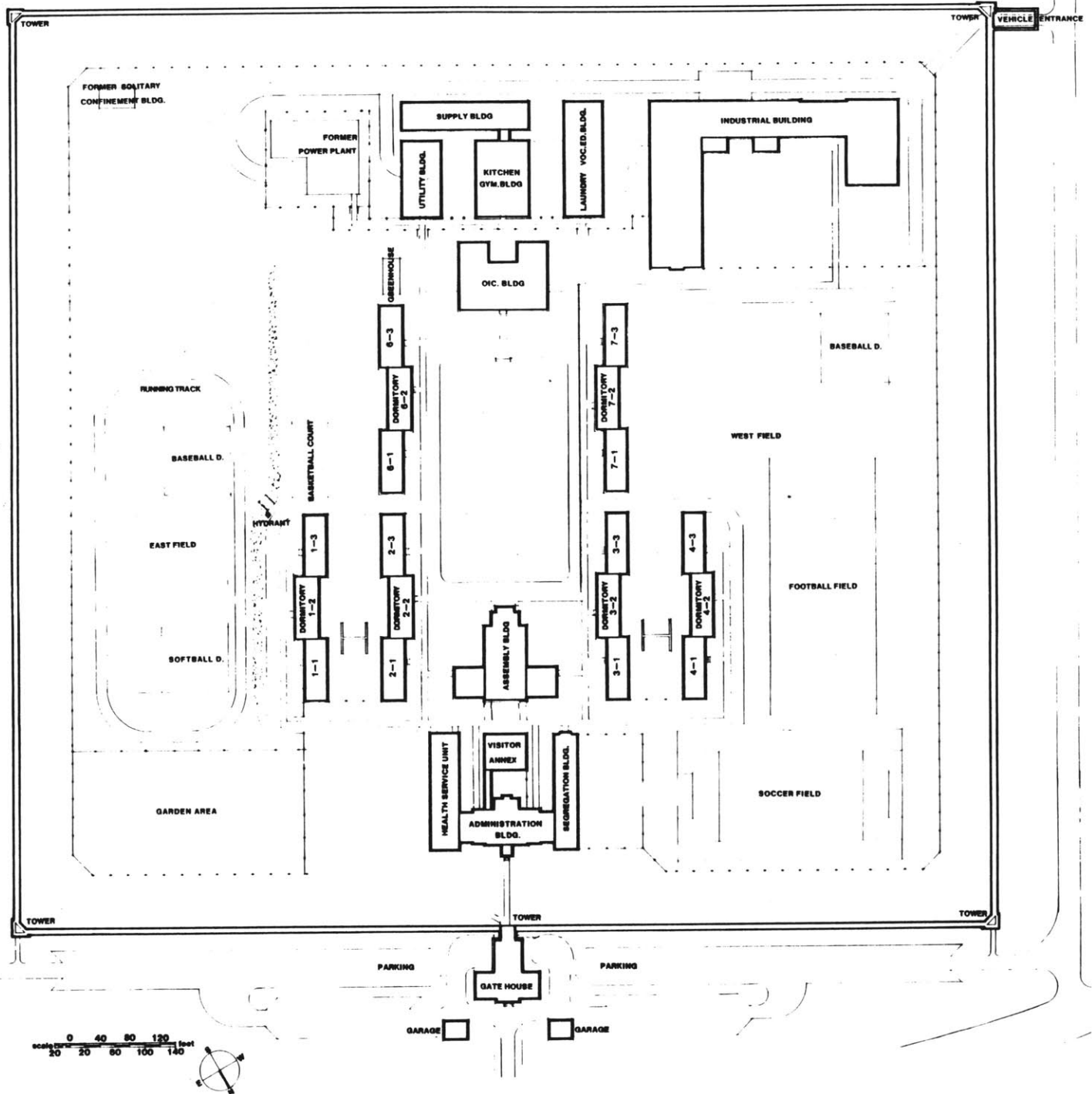
NORFOLK PRISON COLONY, 1927: THE COMMUNITY BEHIND THE WALL

While researching the history of Progressive reform in the treatment of criminals in the United States, social historian David J. Rothman discovered a running two-year diary of the events of the early years of Norfolk Prison Colony. Prepared by a prison official in the early 1930's, the diary not only provides an insider's account of the failure of an experiment in penal reform, but allows us to look at the architecture of the reformers and its performance in practice.(1)

NORFOLK

Existing site plan for Norfolk correctional facility, Norfolk, Mass.

The 1927 "colony" plan represented new ideas about rehabilitative penology. Originally designed with only one "jail" building for uncooperative or new prisoners (adjacent to the central office, lower center), Norfolk evolved into a traditional prison, with solitary confinement and an isolation "hole".



Funded by the state Legislature in 1927 to relieve the crowding at the 1805 Charlestown Prison, Norfolk Prison Colony was to reuse an older inebriate hospital and soldiers' home located in a rural setting about 25 miles from Boston. Harvard Business School-educated Howard Gill was placed in charge. As was the custom, prisoners from the ancient Charlestown prison were used for construction labor, spending almost two years erecting the perimeter wall and "the barriers and the building that would eventually imprison them". The positive behavior of the team of convicts who were building the wall taught Gill a lesson in the benefits of teamwork and goal-orientation--a lesson which reinforced his liberal notions about rehabilitative penology. Thus the idea of a "normalized" prison community which would encourage individualism and positive socialization found its expression in the new "colony" format. A few years later

...when recounting to a visiting architect the origins of the Norfolk experiment, (Gill) declared: "We did not come here with a plan all worked out as many people had imagined. The original idea was to build a bastille, but during the two years we lived down here with 150 inmates, clearing the land and building the wall, we began to get the idea of the Prison Colony."
(from the Norfolk Diary)(2)

State of the art prison design at that time consisted of a central administration building with radiating ward wings. The new colony design consisted of two and three-story dormitories arranged around a central quadrangle. Dorms contained single and multiple rooms and variable amount of locked and unlocked public space. A single "receiving" building was fitted in standard prison design to hold new or troublesome prisoners. Prisoners were hierchically placed in dormitories of varying security or the jail based on their behavior and progress toward rehabilitation.

Overall, the element of "punishment" was present but relatively

minimized and the feeling of freedom encouraged--that is, freedom to better oneself. Guards wore no uniforms and the strategy of "casework" was to be applied. The presence of the imposing and impregnable perimeter wall made possible "a fairly free community within the wall", but all served to create a constant reminder of incarceration.

By 1933, the colony was in full swing and the dream had become diluted by reality. Many of the clinical social work strategies had never been implemented, and the novelty of the new facility had worn off.

The era of the best spirit in the Oval came to a close when the wall was put into operation, and life became as a consequence more institutionalized. - Norfolk Colony official (from the Diary, 1933)(3)

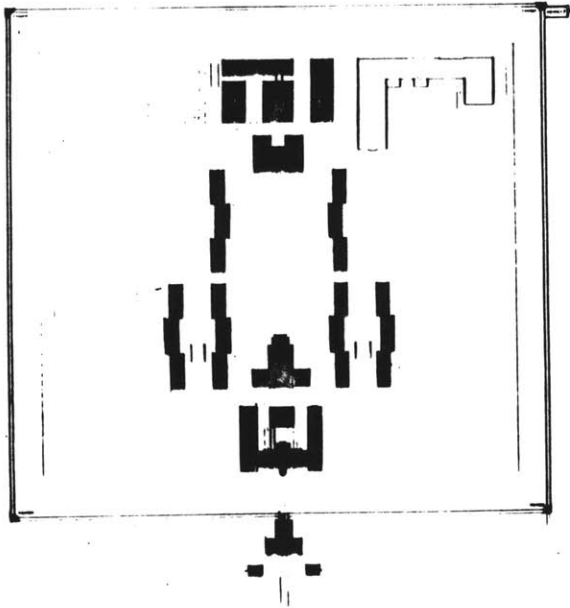
Disciplinary problems increased and the steel-celled jail building became the focus of increased punishment. Gill expressed his defeat in admitting that the community prison had little hope of success. The treatment model had failed.

In a comment which captures the irony of the hierarchy of dormitories being used for punishment rather than rehabilitation, Rothman observed that

(a)rchitecture was now determining treatment; men were being fitted to the facility, not the facility to the men; and rehabilitation was once again being coerced.

Far from the promise of the "colony" at its creation,

...Norfolk had become a full-fledged prison. One architectural change confirmed this. By January, 1934, the windows of 12 cells had been boarded up, the cells' plumbing stripped, and their beds removed. Norfolk had its hole.(4)



THE REGIONAL OBSERVATION CENTERS, 1967

THE SITE IS THE MESSAGE

In 1967, a Special Advisory Committee to the Governor was established for the purpose of providing a review of the laws and treatment programs for "mentally disordered criminal offenders and potential offenders". Then, as now, the State handled most of its mental health services for criminally and sexually dangerous persons at the Bridgewater State Hospital correctional facility in Southeastern Massachusetts, about 25 miles from Boston.

In its Long-Range Plan the Committee found that

The isolation of patients at Bridgewater from their communities of origin (two thirds come from greater Boston) render attempts at a community-oriented mental health program impractical. Modern treatment of such men can only be available close to their communities and what is required ideally is a good sized unit in the greater Boston area and a number of smaller units throughout the state where men who are not under criminal sentence can have flexible degrees of control exercised over them. With adequate provision for security in parts of certain institutions of the Department of Mental Health this could be accomplished and such programs integrated into the community mental health movement. (from Governor's Special Advisory Committee report: A Long-range Plan for Massachusetts, 1967)(5)

To establish this community-scaled network of medium/minimum security facilities, the Committee recommended construction of a 150-patient facility on the grounds of Boston State Hospital and six 40- to 60-patient regional facilities. Curiously, these community-scale institutions were also directed from the start to be located on the grounds of the state's six existing asylums.

The designer which was contracted to perform the architectural program and feasibility study for these facilities noted that

This study accepts, as a "given", that the observation centers will be located within the existing real property boundaries of the designated parent institution--either at their central sites or at "colony" sites under their control. It has not been found necessary to recommend any exception to this limitation.(6)

Obviously recognizing the push-pull nature of the unwanted facility, the study designer noted that

It has been suggested that the observation centers should be as remote as possible, even on a remote "colony" site of a host institution, so as to avoid the possibility of the community ascribing a "stigma" to the (host) state hospital due to the addition of more "dangerous" patients. Such a premise is considered to be secondary to other considerations by this study except to the extent that it is recommended that locations immediately adjacent to privately owned dwellings or school houses are to be avoided in order to reduce the likelihood of public opposition. (from Preliminary Study, 1969)(7)

A location at the edge of the state hospital campus was considered preferable, especially if not too close to public or industrial areas, but still within walking distance of the centralized services of the host institution.

None of the proposed facilities were constructed. The idea got to the planning stage and no further, but is still being considered--in another form--today. Why weren't the centers built? The bottom line was probably the enormous cost of seven new facilities, especially where one was minimally tolerable.

But the political popularity of seven new facilities for the criminally and sexually dangerous in seven cities and towns which were doing fine without such a facility was anything but strong. In addition, most of the potential asylum sites were no longer very distant from nearby settlements, as suburbanization had carried new residential development right up to the asylum perimeter. Few neighborhoods could be expected to let such facilities be built in their "backyards" without a fight. Hence the Regional Observation Centers plan quietly faded away.

THE STATE SCHOOLS UNDER THE GUN, 1976: REBUILDING AND UNDOING THE INSTITUTION AT THE SAME TIME

In 1976, the state was faced with an unusual planning task. It had spent years redefining its "training schools" for the retarded and transforming these into quality educational and "development" centers where its clients could benefit from an intensive regimen of skill-building and socialization. Through professional staffing and the implementation of the new "behavioral management" techniques it had sought to upgrade its institutions from custodial warehouses to comprehensive colleges capable of medical care, habilitation and vocational skill training.

Despite years of attempted improvements however, the programs and physical conditions of the five regional institutions had a long way to go.

At the same time, the pressure to create non-institutional, "homelike" settings had peaked. The state was under pressure from several court decrees to provide care in the "least restrictive" setting fitting the particular client (as identified in his or her individual service plan). Federal Title XIX (Medicaid) regulations created the same pressure for "least restrictive" settings by creating a reimbursable semi-institutional entity (the Intermediate Care Facility) characterized by decentralized units of "homelike" care.

Pressure to provide both institutional and non-institutional settings created a conflicting demand on limited resources. Both alternatives required an intensive capital investment. Rehabilitation of the core facilities at the state schools to the most minimal standards was estimated at that time to cost over \$45 million.(8) Constructing new intermediate care facilities, or rehabilitating existing campus buildings to meet this design proved no less expensive. Although intended for "less restrictive" non-medical care, the ICF was required to meet strict institutional codes--standards which were costly in new construction and often prohibitive in rehabilitation. The promise of ICF status however brought federal matching funds once the structure was operational.

Capital investment decisions for the state schools seemed to hinge on two important questions, the answers for which were based on the reformer's concept of and expectations for the future of mental health services to come:

What was the optimal size and design of the core institution?
How many clients would the state be able to successfully
"place" in the community?

Extensive investment in selected campus buildings could be made if the state knew which buildings it would need in the future. The improvements could be done well and would endure. Spreading a little investment over all facilities on the other hand would at best afford "limited compliance" with current standards but provide no long-term solution. Once the core institution could be defined, the key investment indicator would be the speed of deinstitutionalization:

As the optimal service model evolved, the core state school was envisioned as serving only severely disabled clients and providing intensive programming. Census at each regional facility was to be targetted at 200-300 students (except Wrentham's 600). Most current residents were expected to be served by community-based facilities, whether contracted or state-built.

The scale of expected deinstitutionalization and concomitant community placements was massive. Population figures for the state schools in 1975-6 were 320 at Hogan, 770 at Belchertown, 815 at Monson, 1083 at Furnald, 1250 at Dever, and 1284 at Wrentham. Nevertheless, Department of Mental Health planners set community-placement (deinstitutionalization) goals of up to 1250 individuals per year and set future census projections for the schools. It was upon these optimistic figures that renovations decisions were made.

Because the goals were unrealistic, so were the renovations decisions, and as with most of the large "core" institutions the state is left with a hodge-podge of adequate, inadequate and substandard buildings.

The new cottages: creating a "homelike" environment on the institution grounds.

The drive for a home-like, community-scale, Title XIX-compliant facility had an immediate effect on the shape of new construction for mentally retarded persons, but the final product often fell short of its intended goals. The case of the Furnald State School may be a good representative.

Built at the turn of the century on a wooded site in Waltham, about eight miles from Boston, Furnald was comprised of over thirty separate buildings organized in a loose campus design. Clients were served in administrative units of 60-200 individuals residing in separate "halls" or dormitories. Although the halls were large, institutional, and hardly "homelike", the campus had clearly been designed on a "decentralized" pattern from the start--attempting to replicate what might have been a village or small college on another scale. Although situated in a potentially attractive site, most dormitory buildings needed complete renovation and improvements in heating and ventilation, handicap access, circulation and program space.

With the pressure of a consent decree, Title XIX certification, and deinstitutionalization policies, the Department of Mental Health decided to renovate several halls, phase out others, and immediately build several separate ICF's for its current residents.

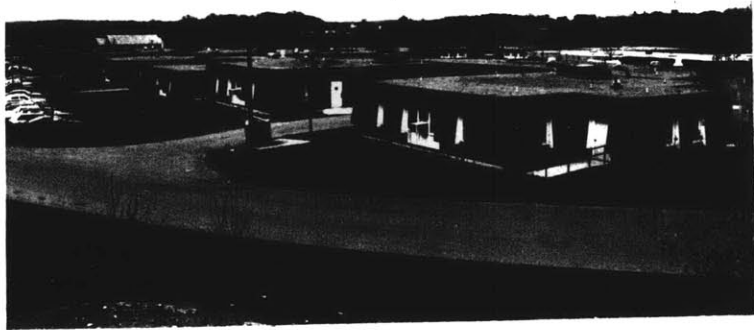
At a loss for a better or more available building site for its new community-scale residences than one in its own front yard, Furnald recieved eleven separate 16-client cottages--all designed to fit the new self-contained training model.

Although situated in a dense suburban city, Furnald's immediate surrounds are primarily institutional (a park, a school, a mental hospital and a federal document warehouse), hence any attempt to relate the new cottages to existing residential neighbors would have been minimal or tenuous. But the opportunities for clustering the cottages in a normalized pattern were also missed, and they were instead oriented toward their parent institution or toward some undefined "common space" intended to exist between them.

THE COMMUNITY MENTAL HEALTH CENTERS: ACCESSIBLE RESOURCES OR CONVENIENT ASYLUMS?

The social forces and reformers behind deinstitutionalization had a clear picture of the type of care that was to replace the "outmoded" and barbaric asylum model: decentralized, prevention-oriented care which was conducted in a loosely restrictive setting, close-to or within the individual's home community.

What hadn't been worked out however, were the specific models of mental health facilities which would accommodate the new service programs. At least one thing seemed to be clear: the community mental health center would be located "in" the community and not on the distant asylum's grounds.



Cottages at Furnald State School

Identity crisis. The implementors of the new regime of community-based care essentially focused on three main tasks: counseling and preventative mental hygiene for the general public, intensive short-term inpatient care for individuals in crisis, and management of the chronic mentally ill and mentally retarded through case-management and social work in community-based residential settings, private or public. Unlike the "psychopathic hospital" model which reformers had introduced half a century earlier, the medical component of care would take a back seat to case management and behavioral skills training. Medicine was primarily limited to the new field of psycho-pharmaceuticals.

From the start, the community mental health center had a crisis of identity. It would strive to serve the unwanted within the community that didn't want them. It would provide inpatient and non-institutional care. Implementation of this mixed set of objectives met with several prohibitive obstacles which seem predictable when viewed in retrospect.

First, in the face of more acute problems, hygiene and prevention predictably remained a low priority and were consistently underfunded. Secondly, public inpatient care had historically been executed only in large-scale institutional settings. That's what the state knew how to build and knew how to budget for. The difficulty in creating a small-scale inpatient facility which was both architecturally and financially sensitive was entirely underestimated. Lastly, the difficulty of deinstitutionalizing and reintegrating a chronic care population which numbered almost 20,000 was also entirely underestimated. Many of this population could be characterized as experiencing learned helplessness, a not unusual condition, especially for those who had spent their whole lives in the asylum. Even if supportive settings could be arranged in friendly communities, many would have to learn a totally new way to live.

Lindemann Mental Health Center,
Government Center, Boston.



In brief, a system which had over a hundred years experience in building, designing and budgeting for large institutions could hardly be tuned overnight to produce a Community Mental Health Center. New architectural design would be needed. Higher program costs could be expected as the asylum's economy of scale was lost and the state supported both the asylum and the center as the former was phased out. And the social attitudes which created the asylum in the first place--not the least of which being public hostility--needed to be substantially overcome.

The alternatives to asylums that reformers visualized were unclear. But the errors in their assumptions about undoing the asylum had a very real effect on the shape of the new public mental health facility and the efficacy with which it offered an alternative to the asylum. These difficulties in effecting a successful community-scale institution are evident when one takes a close look at the centers that were built, and can be summarized as errors in programmatic concept, siting, and basic architectural design.

PROGRAMMATIC CONCEPT

Background. By the late 1950's and early 1960's, program plans and standards for the new generation of community-based facilities had begun to surface. Based on early rates for the incidence of mental illness, the National Institutes of Mental Health had recommended that the community mental health center serve a "catchment area" of 75,000 to 200,000, and as mentioned previously, provide a range of services which included inpatient, outpatient and preventative care.

Massachusetts already had a regionalized system of institutional care. Each region had a mental hospital for its mentally ill and a state school for its retarded. The state hospitals had each been divided into into about five or six administrative units

corresponding to "areas" within each region. (About forty areas persist today.) Each area's "unit" within the institution had a somewhat fixed number of beds or "slots" in which it dealt with institutionalizable population from its area. Hence, out of 500 beds at the regional state hospital, five groups of 100 would be administered by five separate "area offices".

By the time the deinstitutionalization movement and planning for community mental health centers converged, it was conceived that a statewide network of centers and the community-based programs with which it linked would essentially replace the asylum. The center's ideal size could vary, but about 60 beds of inpatient care was ideal. (9)

Magic numbers. During this time, planning for the mental health centers contained a significant amount of magic with numbers.(10) In a typical scenario, Area A had about 90 individuals remaining in its unit at the regional state hospital after the first wave of discharges (original unit population may have been as high as several hundred). These remaining individuals were not the easiest of clients and represented a mixture of chronic, acute and others who had been steered to the asylum over the last decades. As the new mental health center for Area A came up for design, about 24 to 40 inpatient beds were specified.

What of the other 50% to 75% of the institutionalized population? Where would they go if not to the community mental health center?

The assumption that these persons would be reintegrated into the community via state or vendor-operated residential programs--was an assumption about the "absorbtion rate" for clients which would amount to broken promises and unfulfilled dreams.(11) Vendors had not much more of an easier time developing residential programs than the state did. And with both state and vendors, the operating budget for this work did not meet its original optimistic projections. In addition, the role of state-contracted

vendors had been overestimated in another way. Vendors preferred to treat the better clients (or "creampuffs") and in the absence of strong contract management on the part of the state, could subtly refuse to treat the well-known troubled clients. Hence the toughest clients would filter back to the facility which couldn't say no--the asylum or the public community mental health center.

With the failure of the numbers magic, only two things could happen: the mental health centers which were built would be subject to crowding, and the asylums--with their backlog of individuals waiting for community-placements--would remain relatively full.

Continuing the example above, of the 90 beds at the state hospital meant to be replaced by the 24 mental health center beds at the onset of planning 10-15 years ago, about 70 remain filled at Area A's unit at the state hospital. (12)

Financial planning and economy of scale. A mixed-use facility is not easy to budget for. The complexity of staffing, reimbursements, and subcontracting makes for a complex administrative function.

Inpatient care is expensive and requires budgeting which is extremely sensitive to economies of scale. Minimum coverages of professional staff make it necessary to have a surplus of staff in some instances--such as keeping two physicians on call when staff-client ratios call only for one and one-quarter. Also, running a 24-hour facility for persons with little capacity to care for themselves requires a staffing flexibility that can meet small crises or temporary staff absences.

For these and other reasons, community mental health centers cost more to run than was expected. The plan to close the state hospitals included replacement of each hospital by several local community mental health centers. Too few centers were built to

effectively take the load off the majority of the state hospitals. Hence the hospitals stayed open as the centers opened, proving a dual burden of operating costs for two sets of expensive facilities--a revolving cycle which further contributed to the shortage of funds for new construction.

SITING

Just as the success of the "mental health" part of the new "community mental health center" was defined by the success of the new and unusual mixture of inpatient and outpatient care, the "community" part of the new centers would depend on the closeness of the relationship between the center and its community.

The center's site--or how easily it could be reached by those in need--was clearly one of the most important criteria for success or failure; but as we shall see, it was the criterion which was most often compromised in the course of implementation.

A look at one center's journey from paper to plot plan may be helpful.

Quincy's story. In a typical scenario, local mental health planners, advocates, and sympathetic elected officials fought long and hard for a permanent home for a mental health program in their community. Since 1926, the South Shore Mental Health Center--first begun as a one-day-a-week service called the Quincy Habit Clinic--had been renting space in downtown Quincy (one of Boston's largest neighboring cities). Although accessible to the pedestrian and to the many rail, bus, and streetcar lines which passed through the downtown, affordable rental spaces were always too small or inadequate for the Center's growing purposes.

As the program's catchment area expanded and national mental health policies shifted toward the community model, advocates focused their efforts on acquiring a state bill to "provide for a Mental Health Center in Quincy".

In 1964 they were successful. By 1966, Quincy's Mayor had appointed a committee to select a site for the Center, and an eight acre site was selected later that year. Purchase was eventually authorized by the Legislature (by eminent domain if necessary) and purchase money appropriated in 1968--two years later.

The site was an auto salvage yard, located on a rocky promontory which overlooked one of the largest ship-building plants in the Northeast. Difficult site conditions (much fragmented ledge) and clear views of the rusty hulks of tankers being repaired at the shipyard guaranteed that no typical residential development would occur in that area in the near future. In addition, this site was located several miles from the town center along an aging county highway with little or no public transportation.

Although located in a generally dense area, Quincy Mental Health Center is generally inconvenient for much of its geographic "catchment area".

City officials had designated the area an urban renewal area, and sited the likelihood of a new community college, an electronics plant, and elderly housing being built nearby.

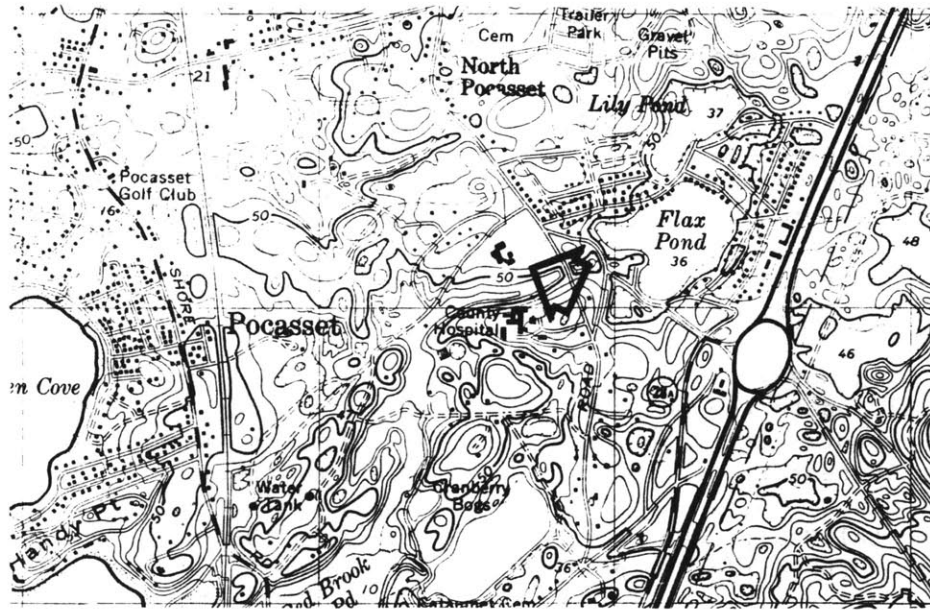
Among the site selection criteria used by the committee are the following items found in a 1969 report.

Easy Accessibility The site is at the geographic center of the nine towns served by the Center.

General Familiarity The site is adjacent to the General Dynamics Fore River Shipyard, a landmark on the Shoreline.

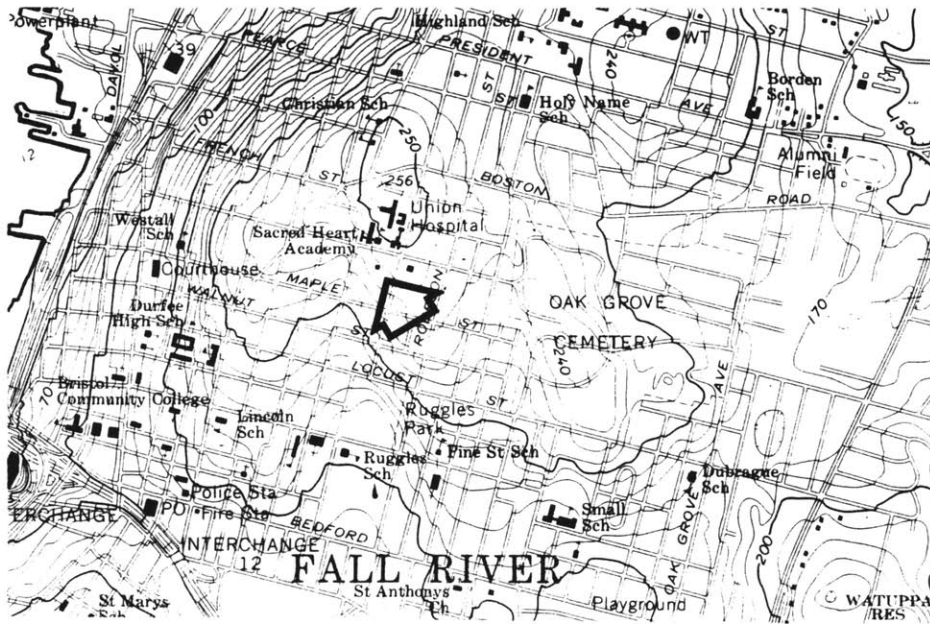
Convenience to Densely Populated Areas Located in Quincy, it would be most easily reached by the economically disadvantaged concentrated in that City §statistics sited¶.





Massachusetts' community mental health centers have frequently been sited adjacent to hospitals and other institutional facilities--far from residential neighborhoods, transportation and the center of town.

Pocasset Mental Health Center (left) is a common example. Fall River's Corrigan Mental Health Center is an exception (below left). It is well-located in residential downtown Fall River, with a public bus stopping at the front door.



SCALE 1:24,000



Convenience to a General Hospital The site is less than ten minutes away from the Quincy City Hospital.

Compatibility with Master Planning The area is an urban renewal area....(t)he Community College might be a major asset to the Mental Health Center's location.

(from South Shore Comprehensive C.M.H.C. Working Program, 1969)(13)

The planning assumptions of the time are clear: proximity to a hospital and to the poor was important. Proximity to a town center was not. As for the observations about "convenience" and "geographic center", the planner was clearly mistaken.

THREE COMMUNITY MENTAL HEALTH CENTERS

Both by design and by default, most community mental health centers are located adjacent to general hospitals. When asking for directions for each of these three centers, one is first asked a question like "Do you know how to get to the County Hospital? Well we're just around the corner..."

Pocasset Mental Health Center (1976) is located in one of the least dense areas of Cape Cod, several miles from a small town and from the nearest highway. Sited next to a golf course and set far back from its residential neighbors across the street, Pocasset gives every hint that it was designed to hide from view, albeit in a pleasant wooded setting. Its land was "one of the only available parcels" which the county could volunteer to the state.

Lowell's Harry C. Solomon Center (1959) is located adjacent to Lowell General Hospital on a wooded parcel across the Merrimac River from the city's downtown. It separates the Hospital from a residential neighborhood, and is built on land originally owned by the Hospital. Transportation is minimally adequate, and although located near a residential neighborhood, its proximity to the river and a

Quincy Mental Health Center opened its doors in 1984--twenty years after the official "go-ahead" for planning. One-fifth of that time was spent before the site could be legally purchased.

The Center's neighbors have changed. The elderly housing has been completed and long since occupied--separated by a large fence behind the Center's rear parking lot. And the auto salvage yard across the street which had once competed with the Center site's earlier owner has been doing better now that the competition is gone.

Common siting issues. In part due to the city's density, Boston's community mental health centers are all easy to reach by both private and public transportation, and by foot. None are located in residential neighborhoods. Rather, they are found in the business/government district (Lindeman), the hospital areas (Solomon-Carter-Fuller and Mass.Mental), or on State Hospital grounds (Dorchester).

Accessibility of centers outside of Boston are a different story. Most are located outside of the center of town and --at best-- on

the edge of the least dense of residential neighborhoods. Sites are often acquired from large general hospitals, the town or county. Hence like the asylums they sought to replace, the centers are frequently situated in the "institutional" part of town--clustered near hospitals, parks, schools and other institutional users.

DESIGN

Hospital or not? Community mental health centers were intended to serve both an inpatient and outpatient population. Some patients would be staying for months on end and might exhibit various degrees of medical and behavioral problems; others would come for a one-hour counseling session or would participate daily in a rehabilitative workshop.

Ward space had to be both "homey" and sterile, rehabilitative and hospital-like--serving a range of persons who were physically sound, medically ill, and behaviorally destructive. Office space had to accommodate medical records, the telephone-intensive social work professionals, and the general public who had come for a counseling appointment.

The difficulty in designing for such a dualistic program probably contributed to the non-response it got from the original facility designers.

The first internal designs were strictly institutional and indistinguishable from the state hospital wards from which the center residents would come. Beige masonry-tiled walls, gang baths and bare "lounges" which were merely enlarged corridors dominated the designs. The architect was basically designing a hospital with a few more offices, a few less equipment rooms, and a courtyard or

state forest put it at a considerable distance from the areas of greatest population.

Tucked between a dense residential neighborhood and a large general hospital on a Fall River hilltop, the John C. Corrigan Mental Health Center (1968) is one of the only public community mental health centers outside of Boston which looks and feels accessible to the community it was built for. One might say that it is so "tucked-into" the fabric of a residential neighborhood that it is hard for an outsider to locate.

As with most other mental health centers, it was built on land acquired from the neighboring private hospital and met a substantial amount of community opposition to its construction. Built without a parking lot in a neighborhood already crowded with cars, Corrigan's directors have been able to negotiate an alteration in the city bus routes which now brings a major bus line directly past the Center's entrance.

so for outdoor recreation. Perhaps there was no available alternative at the time or perhaps it was thought that the design was better more insitutional than less, for the institutional design would hold up better over time--a major concern for public construction.

But the "hospital" design for the Community mental health center backfired in many ways. Wards that were patterned after the sedate model of a general hospital were not prepared for a psychiatric population. For example, small security windows and a ventilation system designed for a non-smoking hospital ward were not prepared for a full complement of chain-smoking residents, thus creating an unbearable atmosphere during the active day hours. Office space had not been adequately planned or left flexible for expansion, so that the growing number of caseworkers were forced to double up in rooms designed as hospital examination rooms. Similar problems were numerous.

Less problematic for inpatients and staff, but extremely crucial for outpatients, neighbors and the community is the exterior image of the community mental health center. Those early centers which were driven by the hospital model on the inside could not look like anything but a hospital on the outside.

Security. Asylum wards had for the most part been locked. Patients were not free to come and go as they pleased unless located in special sections and unless independence and competence had been demonstrated. Massachusetts' first-generation community mental health centers--such as Lowell(1959) and Fall River(1968) were designed on the hospital model to reflect the asylum's secure wards. At least two of its second-generation centers were not (Quincy, 1982; Pocasset, 1976). They had attempted to provide a more "homey" setting--more like a college dormitory that had been fused with a suburban office building than an official state institution.

Nationwide, design for early community mental health centers showed little attention to non-institutional or "community-scale" approaches.

Right, the Charles F. Read "Zone" Center, Chicago, named in part after the nomenclature for the geographic region or "catchment area" it covered.

Right below, the hospital-based Winter Haven, Florida Community Mental Health Center.

(from the Journal of the American Hospital Association, 1968)

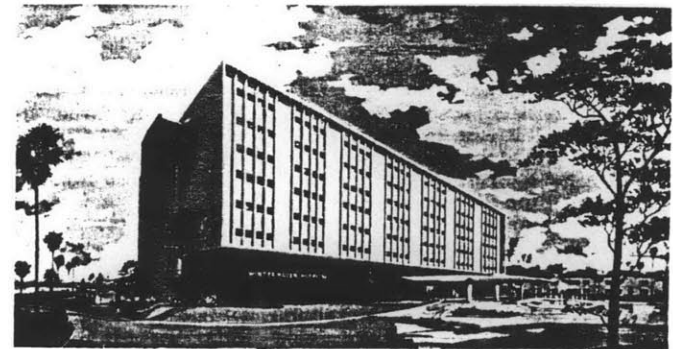
STATE-OPERATED
COMMUNITY
MENTAL HEALTH CENTER



OFFERS
FLEXIBLE
TREATMENT
PROGRAMS

Illinois' first state-operated community mental health center offers a variety of diagnostic and treatment services to children, adolescents, and adults. The center's demonstration clinical program works with both inpatients and outpatients, and an intermediate program involves the patient in a therapeutic community at the center during the day but allows him to return to his home at night.

FLORIDA
CENTER
STRESSES
OPENNESS,
CASUAL ATMOSPHERE



The program's assumption behind substituting a locked-ward asylum for an open-ward mental health center was a radical one. The reality was that despite the value of behavioral socialization training and milieu therapy, the client population who would use the center had become no less likely to wander or run away than their counterparts at the asylum--occurrences that had critical impact on neighbor relations and clinical liability.

Once built, the open-ward centers were handled in a variety of ways. One was "retrofitted" by staffers with locks and window barriers. Another remains unsecured, but is consequentially considered unfit as a referral site for court-involved clients or clients who need secure supervision.(14)

Divided function. Few American models exist for design of a facility in which living and working occur under one roof. Once past the hospital model which rendered the first community mental health centers looking like miniature asylums, designers of new centers strove to accommodate both functions. The final product shows the errors which could be expected when one tries to mix-and-match the best of several models but fails to design a working whole. Kitchens designed to institutional scale but lacking institution-size storage; "dorm" style ward rooms with no storage for a person's belongings; no privacy for staff or too much unsupervised private space for residents; confusion as to the "front door" of the residential part of the center and the boundary between clinical space and office space--all problems which have yet to be worked out in the next wave of facilities.

NOTES FOR CHAPTER THREE

1. Rothman, 1981
2. Rothman, 1980 p.382
3. ibid
4. Rothman, 1981 p.133-4
5. Governor's Special Advisory Committee Report:"A Long-Range Plan for Massachusetts" 1967
6. ibid
7. "Preliminary Study" Whitney, Atwood, Norcross Associates, 1969
8. Reference source: "Campus Futures: In the Balance"/Title XIX planning, Mass. Dept. of Mental Health, by Environmental Design Group, August, 1976
9. Interview with Fernando Duran, Director, H.C. Solomon CMHC
10. Example based on report by Margo Ellison, Director, Quincy CMHC
11. ibid
12. ibid
13. South Shore Comprehensive CMHC, Working Program, 1969
14. Based on interviews with Quincy and Pocasset CMHC directors

CONFLICT IN INTENTIONS : BUILDING THE COMMUNITY-SCALE INSTITUTION IN A HOSTILE ENVIRONMENT 4

THE DECISION TO INVEST

Massachusetts is caught in the midst of reform--a stalemate between the forces to institutionalize and the attempt to humanize environments for the unwanted. "Humanizing" has taken the form of efforts to normalize, down-scale and disperse institutional facilities, while continuing to reintegrate individuals into the community. These efforts can be generalized as the reforms of "community-scale".

Present reform philosophies have been around for twenty years and have shown little sign of substantially abating. But twenty years' effort at redefining the institution and building institutions which are community-scale have been only partially successful.

That the reform itself is "do-able" is highly contested. First, we have seen that the goals of reformers during the past twenty years were often poorly defined from the start. Many were happy just to undo the asylum, and had not set an image for alternative methods of care. In other cases, a general image of a new type of facility was clear, but the finer elements of its implementation were ignored, In both situations the performance of the final product fell far short of any reasonable definition of "community-scale".

Secondly, no one is quite sure of the economic and social costs of creating acceptable community-based environments for society's unwanted. There is some notion that the optimal "network" of facilities which has been called for would be very expensive when measured both in fiscal and social terms (high capital costs and social sacrifices, not to mention the possibility of decreased property values in the vicinity of the dispersed institu-

"In order to be worthy of the term "hospital", our state mental institutions, buildings and lands should be therapeutic centers instead of warehouse repositories for the mentally ill. They must improve the care and treatment of their patients and have well-trained and adequate staff teams providing for the dignified comfort of those who may always need hospitalization. those patients whose illness is brought under control should be properly prepared at such therapeutic centers for return to their communities where and when effective supportive services are in place, with a continuum of services between hospital and community.

"It would be feasible and economical to establish such therapeutic centers for patients needing inpatient care by using some of the many buildings standing empty or underutilized on state lands since the onrush of deinstitutionalization."
(--from "Alliance for the Mentally Ill Spearheads Campaign to Preserve State Lands and Residences for the Mentally Ill" A.M.I. flyer, 1984)

tions). There is also a hint that money could actually be saved, especially if local voluntary involvement was increased and the older asylums could be completely phased out.

Thirdly, whether or not reform itself is practical and beneficial to its target population is also contested. Many now believe that a core group of individuals cannot be reintegrated into society and that there will always be a place for the isolated asylum.

How does the modern public planner proceed to make a decision about investment in facilities? Are community-scale institutions worth future public investment? Are they do-able, feasible, beneficial? Is the reform movement worthy of a higher-profile drive at implementation?

Most critical to this decision about the feasibility of investment in additional community-scale reforms is an evaluation of their efficacy. But although the movement is over twenty years old, this evaluation remains, as we have seen, ironically impractical: most community-scale reforms have remained unfinished or poorly implemented and have had little opportunity to prove their effectiveness. In a sense, the "network" of community-scale communities has barely been given a chance. To evaluate it now is unfair and tells us little about what is possible. A better shot at evaluating this alternative system requires a more complete "first step".

The decision to invest in additional community-scale institutional facilities must ultimately be based on the assumption that, on the whole, these facilities will work--that they will successfully provide a high quality of care at reasonable social and economic cost.

This assumption is a safe one to make. This is especially the case not only because of the promising nature of this type of reform, but also because few alternatives present themselves. Traditional institutions can never be wholly relied upon because of their seemingly inevitable evolution toward crowding and

custodial care. Conversely, community-scale care has been shown to work (although not to the extent expected and not with all population groups). In addition, the decision to invest may not even be a matter of choice at all in the future, but may rather be a forced decision based on the demands of court suits filed by residents and their advocates and enforced by an assertive judicial system.

Once this assumption is made, the goal becomes one of developing a new set of tools which can counteract the forces which have diluted reform in the past, or which can steer these forces to the advantage of the reform itself.

LESSONS FROM HISTORY

How do we incorporate the lessons gleaned from history in shaping our new tools for implementing institutional reform?

We have identified the general forces of spatial distance and scale and observed how they became manifest in the institutional products of reform movements in both the 19th and 20th centuries. But these simple constructs are not enough. Although the same forces are still very much present, this simplified analysis does little to describe the complexity of oppositional forces facing institutional reformers today.

That the task of planning institutional facilities has become more complex over time is clear--creating a new and more persistent set of obstacles for planners in this century than those encountered in the last. For example, the creators of the 19th century asylum no doubt had faced similar issues in acquiring real estate as the state does today. But the built environment was much less dense and the amount of available land much more extensive. In addition, the asylum-builders had, by design, looked for sites which were distant from the city, and never fully confronted the reform-driven need to acquire real estate for the unwanted within urban settlements. Funding patterns were also fundamentally different, with asylum managers making direct appeals to the state legislature that they could

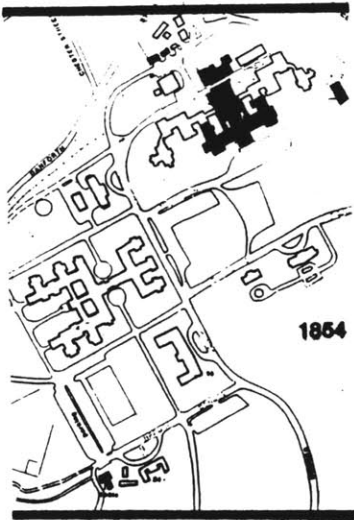
"solve the growing problem" if only additional monies were made available for expansion. Similarly, because the asylums were somewhat self-supportive (via their proceeds from farming and industry), the bigger and more autonomous the superintendent's empire, the better.

Great spurts of population growth seemed to correlate with an increased momentum of admissions to the asylum. The asylum grew crowded. Meanwhile, the urbanization and, later, suburbanization which had accompanied population growth decreased the availability of land and increased the oppositional pressure against large "unwanted" institutions. Hence by the time reformers got around to attempting a dispersal of the institution, real estate forces had become a much more crucial factor. Also, modernization brought with it a bureaucratization of the budget process and the end of the direct link between the asylum and the legislature, its ultimate source of funds. The asylum manager, previously the provider of the only known solution to the problem (keeper of "the only show in town"), must now compete with a broad range of social services and medical programs and a multiplicity of new special interest groups.

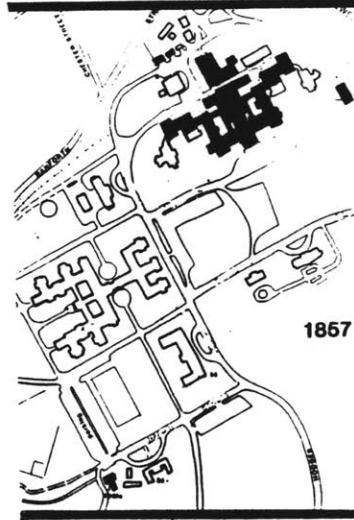
As seen in the examples of the previous section, 20th century reformers had a difficult time undoing the creations of their 19th century predecessors. The rules had changed. Real estate had become a limited commodity, the bureaucracy had gotten larger, and public spending more competitive. Meanwhile, expectations for undoing the asylum and improving care became more and more assertive. A new set of implementation methods and a new generation of facilities were in order, but these were slow in the coming.

The call for a new approach to implementation is clear. Two realities face this reform effort. Firstly, the wish to reform seems durable: society's standards for the treatment of its unwanted have been elevated, and will probably not fall back to earlier levels of indifference. (As long as organized advocates solicit media attention, and "success stories" merit attention, the reform shows every sign of staying alive.) Secondly, unwillingness to pay the high price for reform will also be with us for a long time. The pressure to push away and institutionalize, and the effects of scarce public resources have taken on a new a stronger role in this century and will no doubt be in operation even in the best of economic times.

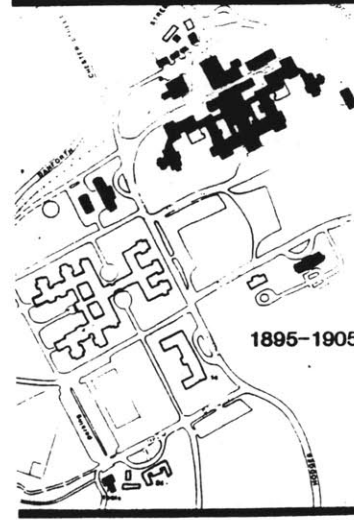
Before focusing on the tools needed for further implementation of the community-scale institutional reforms in this harsh context, it may be best to take a brief look at the facilities in existence today.



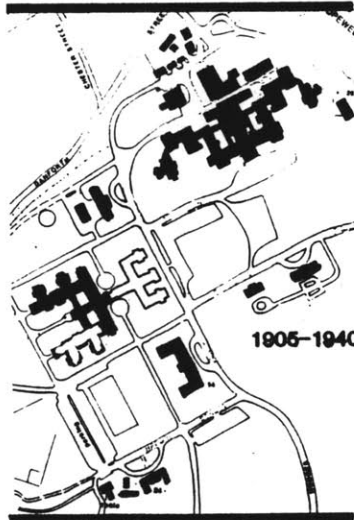
1854



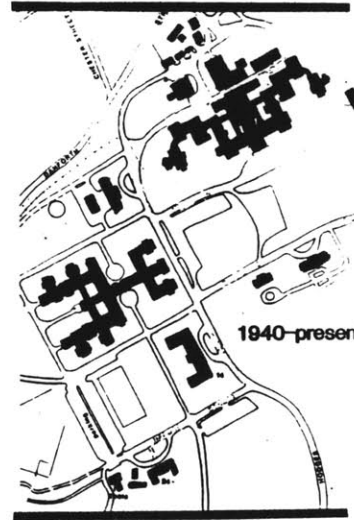
1857



1895-1905



1905-1940



1940-present

GROWTH OF AN ASYLUM Taunton State Hospital, like many of its sister institutions, grew with age. It began as a partially self-sufficient farm with a dairy, piggery, barn and craftshops. A railroad line and coal trestle brought goods and fuel in bulk.

First expansions were new ward space, dining facilities and nurses' dormitories.

Twentieth century improvements in medical treatment and a demand for additional inpatient capacity led to a new "hospital complex" and nurses dormitories. These additions almost doubled the capacity of the asylum.

Plans for a community mental health center in 1970 would have added a multi-winged 68,000 square-foot building to the campus. It was never built.

EXISTING CONDITIONS: THE LAYERED LEGACY

THE ASYLUMS

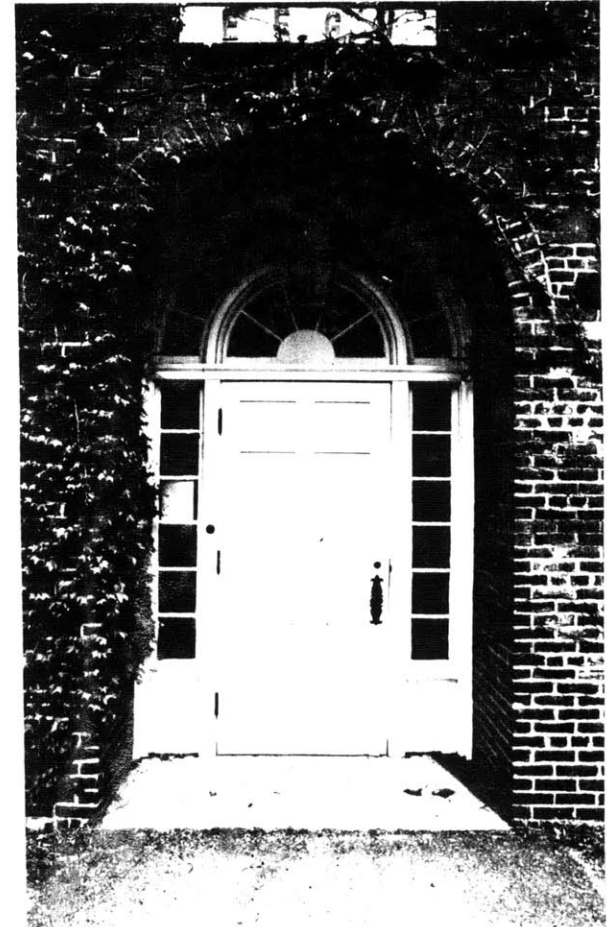
A tour through any of Massachusetts's eight state hospital grounds is a striking and evocative experience. Looming ward buildings with rusty window irons and torn porch screens; paint peeling from the clapboards of the now-vacant caretaker's cottage; the piggery which has collapsed from the weight of its own roof; the huge, patched smokestack of the hospital power plant--all images which stand in sharp contrast to the grassy lawn and mature shade trees which surround them.

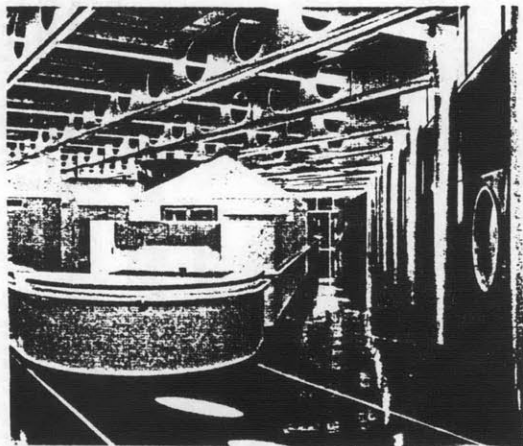
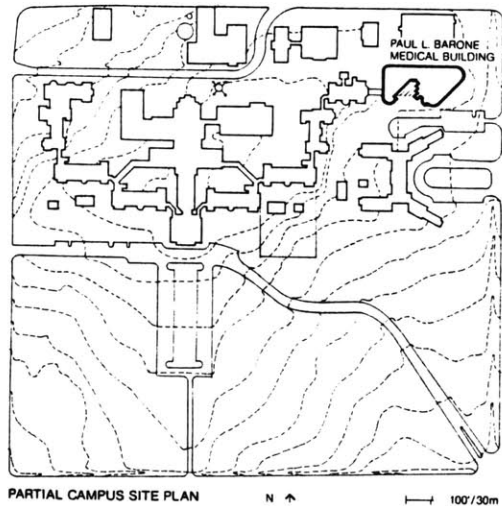
At the typical state hospital, the original aging ward buildings of the 19th century are 85 to 100% vacant and in advanced states of disrepair and deterioration. Long-deferred maintenance and damage from leaks, freezing and vandalism are fighting a winning battle with structures of timber, brick and stone which were built to last.

The "hospital" buildings, added during the medicalization movements of the psychopathic hospital era and during two spurts in the 1930's and 1950's, are largely filled with patients, but more or less not in compliance with most modern institutional codes. Improvement of entire buildings or building sections has been performed on a spotty basis to meet federal certification requirements or the applicable consent decree mandates.

The diverse structures which had accumulated on the grounds of the asylum from its days as a self-sufficient farm include employee cottages and dorms, henhouse, piggery, barn, morgue, greenhouses, garages and blacksmith's shed. They are for the most part vacant, falling down, or used by the maintenance staff.

Entrance to Wards E, F, G, and H, Metropolitan State Hospital. Bird's nest in lamp is a reminder that the wards have been closed for nearly a decade.





Siting of new "community-scale" facilities on existing asylum grounds is not peculiar to Massachusetts. Here, a hilltop Kirkbride-style asylum in Missouri receives a new neighbor--an outpatient and non-acute residential care facility. (from Progressive Architecture 5:82 with permission)

Many employee cottages have been adopted by vendor organizations who have provided a little of their own upkeep through informal agreements with the facility manager. Other buildings have been claimed by agricultural education and community groups.

The grounds have survived best. They show a great deal of pride and attention despite a limited budget--to the credit of the groundskeeper who may have tended the grounds for several generations. Many of the asylums were built on prime farmland and are now actively farmed by local farmers via leasing agreements. Community gardens have sprung up, and the playing fields on the grounds are not infrequently used by schools and nearby community.

The perimeter of the institution grounds have seen the most recent change. Originally sited at some distance from a town, suburbanization has carried housing out to the asylum, with residential neighborhoods now pressing against the asylum's perimeters. Taking advantage of the new proximity of residential communities, planners have begun to locate new cottages--group homes or Intermediate Care Facilities--on the state land which faces the perimeter residential streets. This represents an attempt to create the most appropriate community-based settings as possible without tackling the difficult procurement of sites. It also represents a familiar scenario for the asylum grounds, which have already seen 100 years of insitutional "backfill" --new "layers" of buildings designed to implement community-scale reform driven back toward the buildings they wished to reform.

When considered in total, the inventory of institutions is striking. Just considering the eight original state hospitals (Boston, Danvers, Foxborough, Medfield, Metropolitan, Taunton, Westborough and Worcester), the state asylum establishment still maintains 2,700 acres of land and 7.2 million square feet of building space, with over 3.5 million square feet currently vacant. By adding the space at the state schools, old almshouses and sanatoria, one might conceivably double these figures.

Much of the vacant space has been "mothballed"--that is, utilities and steam lines have been shut off; but difficulty in locating the ancient steam line branches and partial utilization of some near-empty buildings has left some buildings partially heated at a cost that is difficult to verify but certain to be painful to the taxpayer's ear.

Aside from utilities waste, deterioration advances, and the opportunities for reuse of the historic structures becomes more distant. Meanwhile those buildings which are currently in use by patients are only getting haphazard maintenance and upgrading. These and other factors are part of the decisionmaking about the future of the asylum--a process which boils down to the simple questions "What do we keep? What do we fix-up? What do we sell or give away? What do we demolish?"

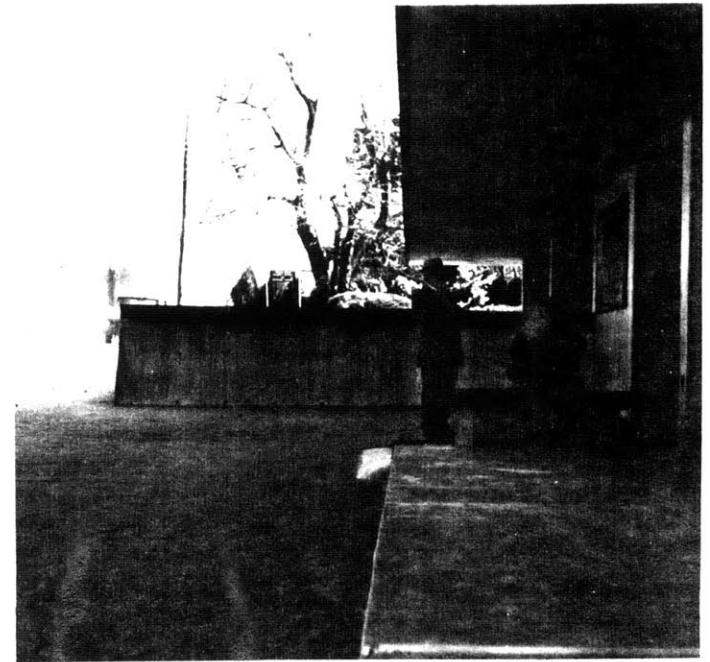
COMMUNITY-BASED INPATIENT FACILITIES

Psychopathic hospitals and, later, community mental health centers and partnership agreements with local hospital psychiatric units were meant to replace the asylum or reduce its use to chronic care only. Despite major gains, the network remains unfinished. A simple estimate indicates that such a network is only one-third complete. (1)

At this moment, the state is involved in preparing a statewide master plan for community mental health centers while also fine-tuning its network of affiliated non-public institutions. Meanwhile, private institutions seem continually reluctant to take on the "difficult" and the uninsured, hence the state seems assured a continued role in caring for the very unwanted.

Planners of public community mental health facilities face a

Waiting for the city bus outside of
Corrigan Mental Health Center,
Fall River, Massachusetts



double challenge: building enough such that the ghost asylums can be fully mothballed or surplusd, and making the new facilities truly community-based. Progress toward both of these would be part of the ingredients necessary for convincing the taxpayer to support such a massive project. But providing a convincing argument for the "price tag" is the first step.

COMMUNITY RESIDENCES AND SUPPORT PROGRAMS

A complex and ever-expanding network of state- and vendor-operated community residences, group homes and intermediate care facilities comprises the last and outermost layer of the 20th century mental health institution.

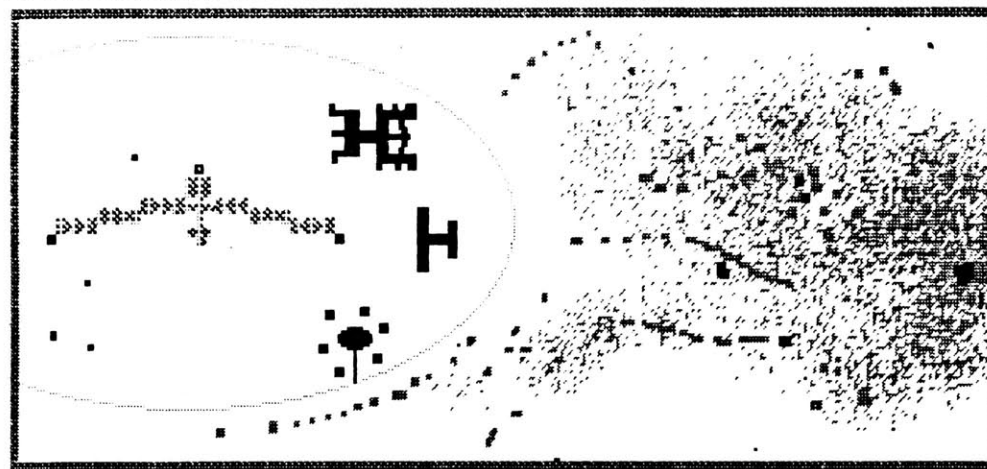
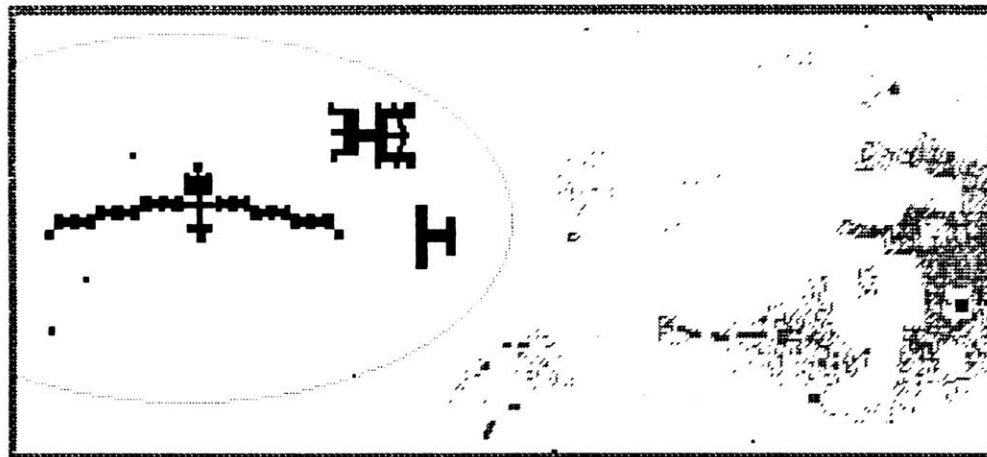
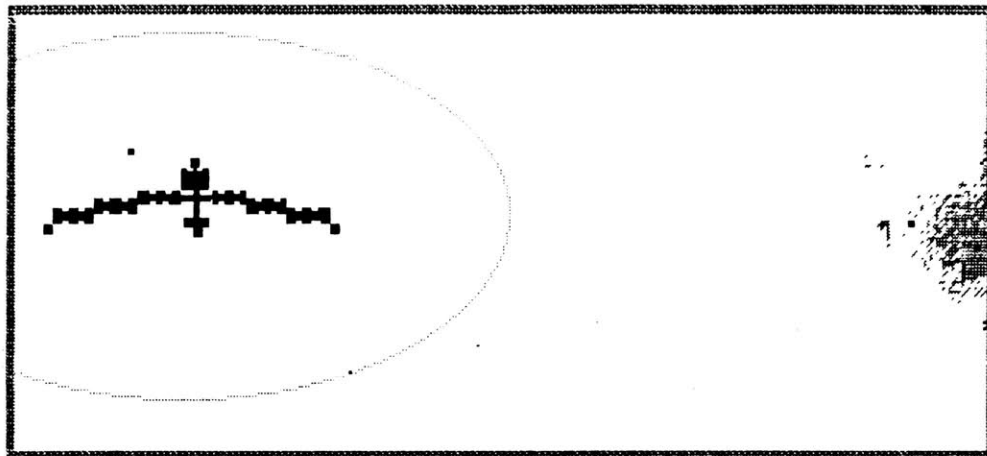
State and federal dollars have directly and indirectly supported the creation of a broad range of formal and informal facilities--from the heavily-regulated ICF to semi-supervised apartments and emergency shelters. These facilities create a "net" which provides thousands of more-or-less adequate living situations but which meets--at some estimates--only about one-third of the problem. Hence the biggest problem with existing community-based residential facilities is that there are not enough.

For the community residences in operation there exist several other substantial problems. Many residences are administered by volunteer or vendor-agencies, which although a generally economical scheme, still requires substantial state-side monitoring, quality-control and contract administration.

With liability and performance standards unclear, and budgets always shrinking, non-state managers of community living situations can be somewhat selective or neglectful about who they work with and the quality of the living situation provided. Especially when budget margins are slim, there is little incentive to cope with the neediest, more "difficult" clients rather than the "easier" clients, or to provide more than a minimally adequate environment.

Labor is also an issue. Higher standards for treatment require professional care, but non-professional salaries are offered--a vicious cycle which steers away prospective labor while "burning out" the current work force.





SCHEMATIC REPRESENTATION OF
CHANGING INSTITUTIONAL PATTERNS

The 19th century asylum was sited on large farm parcels far from cities and towns.

Several waves of expansion and new medical technologies spurred the addition of new "hospital" buildings and clinics. Although reformers had intended many of these new facilities to be community-oriented, they were nevertheless sited on the grounds of the distant asylum.

In the latest phase, suburbanization has carried residential development up to the asylum's perimeter. Difficulty in siting new small-scale "community-residences" and group homes has forced state planners to build these on the state asylum grounds also, although the presence of residential development "just across the street" has allowed many of these new facilities to partially meet their goal of being "community-based" and "normalized".

THE WORK AHEAD

This writing occurs at an active time. An upswing in the cycle of fiscal prosperity allows for constructive planning toward investment in both traditional institutions and community-based facilities. But as we have seen, building community-based and residential facilities will require a different set of tools than those used to implement more-traditional institutional facilities. Both will be difficult and will require a complex diagnostic capacity on the part of the implementing organization.

DEFINING THE "CORE" AND THE "NETWORK"

The "optimal" configuration of a statewide service model for mental health facilities will always be a matter of debate. At the height of the 1970's deinstitutionalization movement it was felt by many that state hospitals would be entirely shut down. Since then, several realities have created a more realistic picture of an optimum facility network. The "absorption rate" of ex-patients in the community, chronic "homelessness" among the deinstitutionalized, and the presence of several special-needs groups requiring ongoing intensive institutional treatment have re-worked reformers' thinking about the "core" facility.

It is becoming clear that many individuals, because of either their inability to respond to treatment, requirements for specialized therapies, or extraordinarily offensive behavior will require a more intensive, institutional, and/or shielded environment. According to a recent estimate, about 15 persons per 100,000 population fall within this category.(2) Although more successful community-based facilities may be able to accommodate them in the future, this core group can best be served at present in the renovated, humane institution.

How "big" is this "core"? How many persons should be planned for? Should the "core" be centralized; regional? Much depends on how many persons can be accommodated by community-based settings. But that puts the planning process back in the vicious circle again. All of the important questions about reinvestment at the

original asylum facilities (all time-critical issues) are dependent on the speed of creating community-based alternatives. This speed is in turn affected by the criticality of the push--the crisis in the availability of beds and care. Meanwhile, the push for community facilities will be cushioned as long as the core institutions are hanging on.

It is clear that an active, three-pronged effort is needed:
1) bring a small "core" of specialized institutional facilities to quality standards, 2) accelerate community-based inpatient and outpatient opportunities, and 3) increase delivery of community residences to the undetermined number of individuals needing supportive and semi-supervised living situations.

ORGANIZATIONAL BARRIERS TO COMMUNITY-SCALE REFORM

The major difficulty in implementation of institutional reform can be characterized as problems with segmentation in the process of public construction. Most problematic; both the budget process and the implementation process are segmented. In the former, the agencies providing social and human services wait somewhat passively for annual allotments of scarce public funds. In the latter, a string of agencies implement those funds. In both processes, reform is diluted, one by the incremental passing of time between initial funding and project completion, the other by a dilution of responsibility as the responsibility for implementation is handed from one agency to another in an attempt to translate human need into bricks and mortar.

A closer look at these barriers may suggest an alternative organization.

SEGMENTATION IN BUDGETING: THE DANGER OF PHASING

Current estimates identify an extensive unmet need for a range of new institutional and community-based facilities. When faced with the question of "how to get from there to here", the common sense answer of pragmatic reformers is "phasing": phase-out the state hospital and phase-in reinvestment in re-scaling the institutions, meanwhile phasing-in new community placements. But "phasing" is problematic. It too easily succumbs to the forces which have been shown in history to press for institutionalization of the unwanted.

Expansion of the first asylums was a phase-by-phase process which never kept pace in size and capacity. Reform in medical treatment and the "medicalization" of the asylum was an unfinished phase-in of a non-custodial approach. Most recently, mental hygiene and the community mental health and mainstreaming movements were concerned with phasing-out the institutions--a plan which is yet to be completed. What elements in the implementation of these phased reforms upset their success? What did reformers not understand about the implementing organization--in this case, the state?

The demand response. Among the philosophers of deinstitutionalization there is shared a simple tenet: "If there is a door someone will knock on it; if there an institution someone will be at the door." (3) Just as water flows to the lowest point, along the path of least resistance, from society's point of view the "easiest" place for an unwanted person to be is the asylum. Hence the deinstitutionalization reformers knew that one needed to "murder" an institution rather than "phase it out", for as long as it was available as a repository for human services clients who were most difficult to work with, a demand for its use would be present. This knowledge may account for the tactics reported to be used by 1970's reformers, including willfull deterioration of the facilities through selective and deferred maintenance and the "dumping" of unready residents to even more unready community programs--both methods designed to get the institution doors closed as soon as possible.

The asylum-builders and medical reformers of the late 19th and early 20th century, on the other hand, didn't have the same problem: the existence of the asylum was taken for granted. Few tried to undo it; rather most were concerned with expansion or, later, with building a layer that was functionally (if not physically) "closer" to the community (e.g., the psychopathic hospital). Hence phasing became mostly a matter of expansion on existing property during this period.

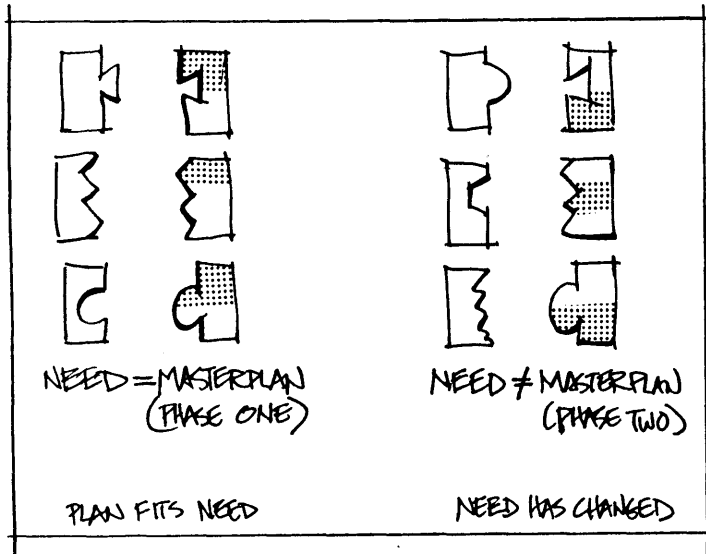
Flaw of the Masterplan. Public dollars are politically "metered" in order to soften the impact of large investments over time. Instead of \$200 million to fully accomplish the task this year, \$50 million is offered for Phase One. Hence phasing becomes an important element of the planning process, mixing time and money in an incremental approach to problem solving. Masterplanning exacerbates this problem.

Phasing out an institution which long "solved" a social problem by replacing it with alternative facilities is not a simple or speedy task. Without a major push to complete the new investments as quickly as possible, the state is in the position of running two systems at once: the asylum, and its slowly-increasing replacements.

Half of the new investment doesn't do much good. Just as if one were building a home in one's spare time with the help of friends. The roof doesn't get finished by quitting time one weekend day, and your investments below are dangerously exposed until the builders return. The question is when. Perhaps they won't return until the next weekend. In the mean time, half-a-roof is less than half-a-solution.

In a political environment where funding for Phases Two through Four of a masterplan is always in jeopardy in later years, phasing becomes a tricky business, and like the half-built house, masterplans come perilously undone. In addition, unlike

the quasi-public and semi-autonomous 19th century asylum, today's unfinished facilities can only rarely raise monies themselves or generate their own revenues to complete the job. Rather, funding is annually decided by the legislature; a decision in one year sets a three-year building plan. Ten-year plans must be carved into these two confused chunks of time. A "phase" is in jeopardy at any one of these times.



In a typical scenario, the masterplan is a static document based on the perceived needs of a target population and the assumptions of a group of reformers who have attained a policy and planning role. Need is established, a plan drawn, and Phase One is financed and implemented. Phase Two, originally based on the beginning assumptions, is always more difficult to gather support for. Phase One had been built three years after planning, and during this time the need has been redefined and the reform has refocused. The original Phase Two may seem outmoded or has lost its political relevance. What is perceived to be needed is a new Phase One, a new masterplan for the new set of assumptions about treating the unwanted.

In this way, masterplanning may be particularly unsuited to the segmented funding process. Rather, reformers in planning roles need foremost to lay down a persistent strategy for planning--a skeletal framework which continually updates a more malleable plan.

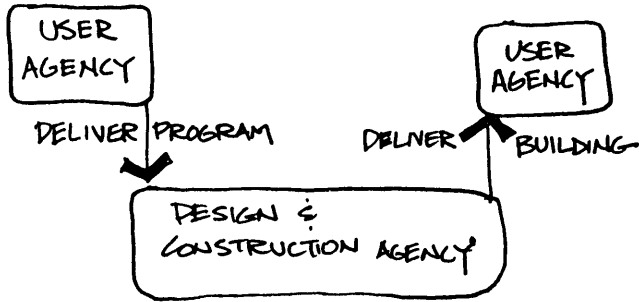
Where phasing is necessary (as it will most likely always be) it may be best to view each funded phase as "Phase One", always based on the freshest set of ideas about what is needed, what is best to build, and what is best to postpone for better days. But a continually up-to-date flow of service-delivery information and lifecycle conditions of the capital inventory is essential to keep these ideas fresh. (The data must be consistent from year to year, too; otherwise each new administrative generation of reformers will conduct its own "needs assessment" and, after much delay, rediscover the same problems, with new names--a segmented thinking process to match the segmented funding process.)

SEGMENTATION OF IMPLEMENTATION

Clearly, the process of building institutions of any scale in a political, segmented budgeting context is at best a process of short-range planning and long-delayed results--enough to dilute any reform by itself, without the need for any additional external barriers to implementation. But not only is the funding process segmented, the implementation process is too--divided into separate agencies which work together with varying degrees of cooperation and coordination in a chronological string of planning, budgeting and building events.

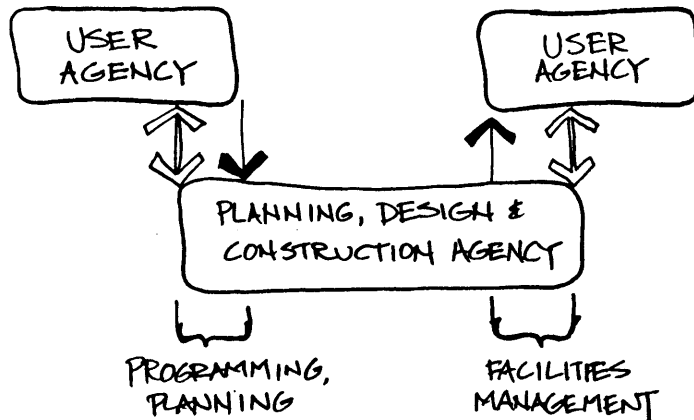
Historic models for implementation of new public institutions put the user-agency in charge. The asylum superintendent, the Board of Insanity or, later, the Department of Mental Diseases or Department of Mental Health advocated for funds for new facilities, and having acquired these set about at imagining a new facility. With medical superintendents in charge of planning for the early asylums, they built the model that they had discussed in meetings with other medical superintendents around the nation--the seductive and simple Kirkbride plan, a plan which put the medical superintendent at the middle of an isolated, self-sufficient and utopian world. Later, as different individuals played the role of the user--physicians, maintenance specialists, psychiatrists, social workers, and, most recently, bureaucrats--new models were born which reflected the new creators' assumptions. Quincy Mental Health Center, detailed above, is a good example--having originally been designed with very little security, a clear example of a novel and untested reform philosophy which was literally translated into a facility's design.

Letting the user alone determine the facility program while not giving the user a parallel responsibility for its budget runs the risk of producing a castle at every opportunity. It also misses opportunities for addressing broader planning goals, questioning programmatic assumptions, and experimenting with informed new approaches to architectural treatment.



Needs-based facility programming improved this process, allowing an agency whose staff was aware of comprehensive issues and of the economies of capital investment to assist the user-agency in fleshing-out the best approach to creating a facility which met its defined need. In certain cases, this agency would even go as far as assisting the user-agency in defining the need itself. It could walk the user agency through a needs-assessment, masterplan, "rolling" masterplan or long-range plan and track the decision to build from its initial budget proposals, through programming, design, construction, and post-occupancy maintenance.

Despite these modern improvements in the planning and construction of institutional facilities, several intrinsic problems still stand in the way of implementation of the community-scale institution.



Even though there is some continuity in responsibility, responsibility to produce an effective facility is still split-up and diluted. As the involved agencies translate each others' directives, values which are not concretized or quantified are open to subjective judgement or, at worst, indifference. Like the child's game of "telephone" in which a message is passed from ear-to-ear, changing extensively in the course of the segmented transition, so reform notions of "community-based" and criteria for design and siting become translated or lost as they are passed through agency channels and subjected to the normal range of oppositional forces. Unless tied to some incentive, the difficult "deliverables" become the first "trade-offs" in the bureaucracy of implementation.

REAL ESTATE BARRIERS

In addition to the barriers imposed by segmentation, one other is critical to the sensitive implementation of public community-scale institutions. This barrier can roughly be described as the state's lack of competitiveness and flexibility--a self-defeating element almost intrinsic to the public-private interaction.

Community-scale institutions must be proximal to or imbedded within their target community. Institutions are real estate and require land to be built upon. Most local and state governments have more real estate and land than any private entity in their jurisdiction. These holdings are, however, rarely proximal to or imbedded within dense communities. Hence it has been not unlikely that the path of least resistance for siting of institutional facilities has always been the isolated asylum's grounds. As seen in the course of history, what began as a partially altruistic motive for rustic asylum sites became also a practical and economic motive: this was the only "available" land.

The state's inability to flexibly buy, sell and build competitively and quickly renders it handicapped in the normal urban and suburban real estate market. This handicap makes difficult any attempt to acquire or construct in urban and suburban communities. Even when the state is replaced by a flexible local housing authority or non-profit agency (as is the case with Massachusetts' Chapter 689 community residence program), market forces for the "highest and best use" and opposition by town officials and neighbors combine to out-price, out-regulate, and out-litigate the prospective endeavor.

CITY MEETS ASYLUM, TWICE

New York's first Bloomingdale Asylum began construction in 1817 on a large rural parcel on Manhattan's Morningside Heights. The asylum grew crowded along with the city and was expanded with new wards and cottages.

By the 1880's, the growing city had reached the asylum. The Ninth Avenue El and the development of Central Park had fueled a boom in real estate on the Upper West Side and the asylum came under intense pressure to relinquish land for private and public development. With W.110th St. as its southerly border and W.120th St. on the north, the asylum presented a major obstacle to real estate developers and rising land prices. At the objection of the institution's administration, W.114th St. first, and then W.116th St. and other east-west routes were carved through the shrinking asylum grounds.

By the turn of the century, Bloomingdale had fled to a large farm in rural White Plains where it is now under a second wave of real estate pressure. Its owner, The New York Hospital has sought to prevent its nomination to the National and State Historic Registers --a status which would limit the option for demolition and conversion to other institutional and market uses.

(Rosner, D. A Once Charitable Enterprise
N.Y.: Cambridge U. 1982)

ORGANIZATIONAL PROSPECTS

Let us summarize the organizational and economic barriers discussed so far:

- Segmented budgeting drives the necessity for "phasing" major reforms. Working within this system requires intelligent "phasing", which in turn is only possible if conditions are exhaustively reevaluated at each planning phase and if there is available a supply of fresh ideas. To do this, the planning organization responsible for implementation must be capable of cumulative "intelligence" over a substantial period and across administrative changes. The political will for reform must also be consistent.
- Segmented implementation dilutes responsibility and the vivacity of less-concrete reform ideas. If a single operations agency coordinates the implementation of a facilities plan from initial budgeting all the way through design, construction and maintenance, this problem is significantly reduced. Nevertheless, no one agency has its "neck on the line" nor is the incentive to build and maintain a high-performance facility strong.
- State and local government bureaucracy is rarely able to compete in the private real estate market--a necessity for implementation of community-scale institutions and community living-situations for special-needs populations. Undeveloped rural parcels, the "institutional area" of town, and asylum grounds have been the historic choices for hard-to-site community-scale facilities.

Undoing these barriers is best performed by circumventing their root causes; that is, circumventing segmentation in budgeting, segmentation in implementation and inflexibility in real property development capacity.

In a unique way, the consent decrees of the late 1970's and 1980's did just that. As a result of several class-action suits, the state was forced to develop and implement a massive capital improvement plan for its mental retardation institutions, including new construction of community-based residential care facilities. Judicial pressure guaranteed legislative funding support (via threats and financial incentives), and a strict schedule of improvements was set. An interdisciplinary working team functioned across agency barriers to provide the "follow through" needed to speed up the process and assure certifiable results.

The results were mixed. Implementation was speedy, although not speedy enough to always meet court deadlines. Costs were steep and reflected the high overhead necessary in quickly designing a new generation of Intermediate Care Facilities and in rebuilding older asylum buildings to meet new facilities codes. But among the more crucial shortcomings, the exigency of the court schedule and the state's own limited capacity for real property acquisition and development forced the implementation team to look to the familiar asylums as sites for the new "community-scale" buildings.

Implementation of upgraded facilities under the consent decrees offers a premonition for what is possible within the existing state system if a guaranteed budget and high-priority teamwork approach is taken. The limitations are also only all too clear. But the success of the process, although born of an unfortunate flaw in services from the beginning, has led more than one current official to call for an "internal consent decree" to legitimize high-priority projects within the state construction agenda.

Taking this idea a step further, the use of special authorities and commissions may be appropriate.

The Authority. Authorities have been used for many purposes where a typical state agency would have been inadequate. They are commonly used as the administrative body for accomplishing large one-time construction projects, such as the building of a large highway or implementing a downtown urban renewal plan. In this role they may act as a conduit for federal funds, or as the public agency capable of "taking" land for public purposes. Unlike state agencies, they may be capable of an internally-driven funding process, generating revenue by issuing bonds or entering leveraged partnership agreements--thus insulating the long-term capital investment process from the annual budget cycle. And unlike state agencies--which have no incentive for production of revenue or cost-cutting because they must "give back" any earned revenues or "savings" to the general state budget--the authority (and the commission) may recycle its revenues and savings towards its own ends. Finally, the authority may buy, sell and own real estate, and do so in a fundamentally less complicated bureaucratic environment than the state agency.

Authorities are created only after considerable political momentum and the presence of substantial incentives and opportunities for success (such as the availability of federal seed funds or the likelihood of successful revenue-generation, such as tolls in the case of a highway, or fees in the case of a parking garage or convention center). A special purpose or focus is necessary: the authority must solve a problem. But authorities are looked upon suspiciously. They add another layer of administrative overhead and state-backed debt liability; they also have been known to long outlive their usefulness and to use their state powers too broadly for some tastes.

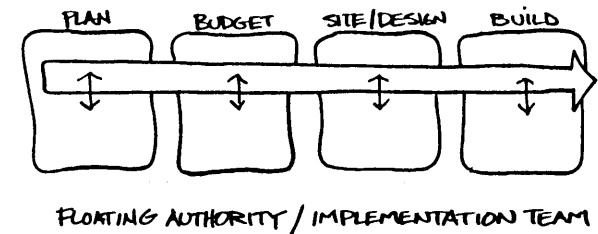
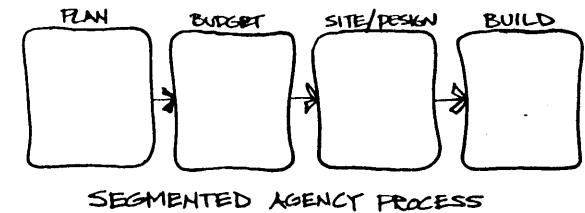
How to accomplish the "internal consent decree"--a commitment to reform--in a system which has been historically ill-fit to conduct comprehensive capital investments for an "unwanted" and largely non-voting constituency group?

If sufficient momentum can be gathered behind the idea that a one-time, large-scale investment "push" is necessary to correct the institutional facility system for mental health populations in the state, the "authority" may be the organizational means to this end.

Taking a lesson from the interdisciplinary, cross-agency team which supervised the implementation of the consent decree efforts, a low-overhead, skills-based "floating" authority could similarly work within and across existing agency boundaries to steer a high-priority implementation plan through the current organizational obstacles. Where existing agency methodologies were sufficient, these could be utilized or driven by the "piggy back" authority. Where existing agency abilities fell short (for example, around real property issues) the authority would exercise its own capacity. The authority would also carry its own budget along with it, reimbursing its host agencies for work or staff which it "borrowed" and financing renovations, property acquisition and new construction where necessary.

The problem of segmentation in the public budgeting, organizational and implementation processes seems here-to-stay as an intrinsic part of the modern governmental system. But if the public delivery system learns from the failures of its reforms in history, a one-track implementation approach for high-priority social and environmental problems may become a popular solution.

Like the problem of siting hazardous waste facilities or other noxious public goods, implementation requires a politically-insulated, fast-moving administrative entity. It must be capable of negotiation, leverage and compensation, and must be self-driven and goal-oriented. The "roofless", quasi-public authority --comprised of a technical administrative team, fueled by an internal financing capacity, and capable of objective, region- and state-wide decisionmaking--may be the only administrative entity capable of the task.



DEFINING THE ELUSIVE GOAL

Even if an organizational entity evolves which is capable of a genuine effort at implementing a new generation of community-scale facilities, the ability to produce the actual built-effect is not assured.

An "institution" like the asylum is a tangible, defineable thing. Walls, security, isolation, largeness--all are some of the many elements which would be universally agreed upon as part of the institution. As a building, it has a heavily-stylized and often governmentally regulated interior and is expected to meet certain requirements for safety and health. Where it is located is not crucial, as long as generally reachable by staff and in emergencies. Its exterior design is only driven by the expediency of its interior program and the image of appropriateness held by its creators.

But whereas an institution is a tangible thing, its functional opposite--the community-based facility--will always have a somewhat elusive definition. What does "community-based" mean? When is group home functionally "in" a residential, normal environment? When is a community mental health center designed and sited to optimize its intended goal of "openness" to the community it serves while still offering some degree of separation?

Although regulations have some effect on the standards of quality in interior design for typified community residences and mental health centers, the facility is never held up against a comprehensive appraisal of its performance as a whole.

Perhaps the greatest difficulty in doing this is the mixed agenda of dimensions to evaluate. The facility must meet geographic, architectural, safety and programmatic goals.

Less tangible elements such as transportation are crucial to performance of an outpatient facility. Similarly, a group home that is not accessible to shopping cannot teach shopping skills

adequately. Yet, performance criteria rarely exist, or when applied become the first trade-offs when the siting becomes difficult and the implementation endangered. And unlike commercial and residential facilities in the private market, profit, desirability and "location" do little to drive performance standards.

Large institutions are generally designed from the inside out. Their external configuration doesn't make much difference, except to be pleasing, functional and fit the available site. Kirkbride's designs directly fit the goals of linearity and control of access points. The centralized design allowed patients to be steered toward the dining rooms, day rooms, and baths, ward by ward, several times daily.

Designers of community-based institutions face a different challenge. Community-based facilities must be designed from the outside in: they must fit a pattern of local thinking and risk making an acceptable statement about what goes on inside. The community-based facility is "injected" into the context of a public environment already willing to be suspicious of the new facility for the unwanted. In this sense, the site and the external design are truly the "message".

How to accomplish performance-based siting and design? Firstly, linking performance to reward or punishment rarely fails. Formal "certification" by an accrediting organization or agency links hospital environments to life-safety, insurance and federal reimbursement standards. Standardization and certification of less tangible performance criteria such as overall design and siting for community-based facilities could be similarly linked to funding. But standards require research, and much needs to be learned about the psychology of facility-use and the patterns it holds. Once established, the next step would be to incorporate this research basis into appropriate regulations.

Secondly, the new facility has to make more than just practical estate market. Although government has been doing this for

sense. No matter how well-designed a community-based facility is, it may always be considered noxious at first. To make the elusive goal more "do-able" and less subject to public opposition public planners may join institutional facilities with other, more desirable public improvements (such as recreational facilities), or offer other compensation to the town or nearby residents. Used in conjunction with other performance criteria, such methods of offsetting negative reaction offer a little more room in choice of sites and design.

NOTES FOR CHAPTER FOUR

1. Making a simple estimate about the size of the need for new or expanded institutional facilities can only be just that: great variation in the concept of the optimal public sector delivery system and in the perceived level of need only allow a rough range of projected facility need overall, although data for specialized groups and individual regional facilities are fairly accurate. The estimate given herein is the author's rough estimate based on a review of the needs literature.
2. For a complete discussion of this issue in an urban context, see Gudeman and Shore, 1974
3. A phenomenon discussed often during author's interviews with mental health administrators, personnel, and advocates-- here most forcefully retold by Pocasset Community Mental Health Center director Mary Love.

CONCLUSION

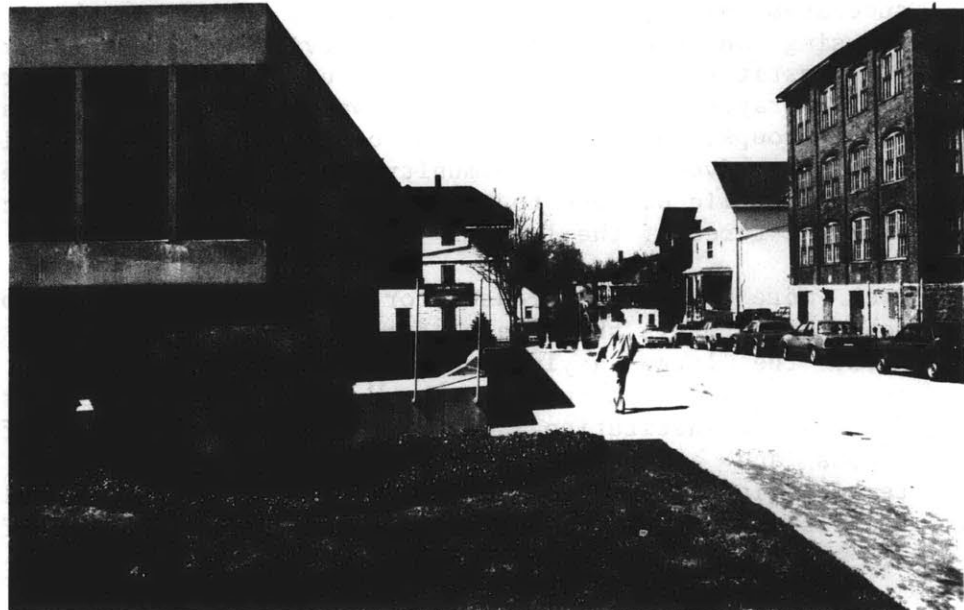
The movement toward community-based institutions fundamentally forces the public sector to enter into competition in the private real estate market. Although government has been doing this for decades in the field of public housing for families (and, more recently, the elderly) it is now in the position of "injecting" a previously institutionalized and excluded population back into the community which did the excluding in the first place. The difficulty in doing this has been evident in the number of facilities in history which attempted to take a community-scale form but which were forced back to the historic distance of the asylum grounds.

Is the cost of implementing the community-scale reforms worth it? Several realities tell us that it is. The community-based care movement has already shown a great deal of momentum and demonstrated many successes. Public sentiment about these successes has been positive, with many "public interest" stories focusing on the "new life" for individuals who had previously been institutionalized. Poor institutional conditions are still not tolerated. They are closely watched by both media and advocacy groups, and still a focus of legislators' attention. In addition, advocates for community-based care no longer rely solely on public outrage to effect reforms, but have successfully used the force of the law.

Even more important a reason for continuing with the community-scale reforms is the steady advance of technology. As we have seen, the large asylums resulted both from society's will to segregate and from the then-current technologies for treatment. Changes in institutional care resulted in part from reforms in ethics and attitudes, and in part from the presence of new technologies (such as medical treatments and social work). Likewise, deinstitutionalization--or the "undoing" of asylum

care--can be seen as a radical response to the availability of new medications and a network of services and helping-professions.

Throughout history, as technology changed and improved, new institutional facilities slowly changed shape. Now entirely outmoded from a treatment point of view, the asylums are slowly being replaced. But the accelerated rate of change in modern medical and technological approaches toward disabilities demands that the new generation of facilities keep pace. Many of today's "unwanted" will have a greater capacity for valuable participation in society in the future, and the "institutions" built today must be prepared for this. As more and more persons become capable of community living, additional settings will be necessary. Commitment to the implementation of community-scale institutions today will ensure that the gains made by future medical, therapeutic and prevention technologies will be accommodated.



Corrigan Mental Health Center is set in the middle of a residential neighborhood, adjacent to a hospital.

What will it take to implement these reforms? The capacity for consistent financial support and "follow through" by the public sector implementation agency is clearly necessary. Organizational changes which could enhance the capacity for real estate development and performance-based design and siting--such as a special state authority or a siting commission--would be helpful but inevitably controversial. Mixing new community-scale institutions with public improvements may force their acceptance by local communities but provide relatively few avenues for implementation. Most likely, all of these approaches need to be utilized together.

But most important to implementing the community-scale institution is maintaining momentum toward bold but safe experimentation. Deinstitutionalization was an experiment; it partially succeeded and partially failed. The new "institutions" which it created tell us much about what to build in the future. Where it failed, many individuals are clearly still in need of care (e.g. the homeless mentally ill and other special disability groups). This failure tells us much about the numbers and types of facilities that have yet to be created.

Experimentation has also begun to erode a persistent vicious circle. For the first time in many years, society has been forced to live in proximity to those who have always been pushed away. Many neighbors have been given a chance to see that the presence of a group home in their neighborhood does not undermine their safety or their property values. Likewise, others have found that the emergency services team at the community mental health center has been a benefit rather than a liability.

The experiment is not yet complete, however, and the vicious circle still largely intact. Aggressive negative attitudes prevent community-scale institutions from being implemented. The lack of community-scale institutions prevents

society from getting exposed to its unwanted, reducing the chance for a softening of attitudes.

That recent experiments in community-based care have not improved social attitudes is evident: even advocates for improved care have begun to admit the failure of attempts to gain community acceptance and have begun to advocate centralized institutional care. Together with those who call for the reinstitutionalization of the homeless, they represent the backlash against the reforms which dispersed the asylum and its residents.

Two group homes located along a residential street, two blocks from shopping and downtown. An excellent site, won after considerable neighborhood opposition. Sponsors: Watertown Housing Authority, Perkins School for the Blind, Commission for the Blind, Department of Mental Health, and Executive Office of Communities and Development.



Until public attitudes are confronted they are not likely to change. Until community-scale institutions demonstrate their ability to serve their target groups without harming the community, difficulty in implementation and opposition from neighbors are likely to remain. Clearly, the pressure to institutionalize can only be "undone" by an effective alternative. Implementing the successful community-scale institution will continue to be an uphill battle for reformers in the decades to come, but will continue to be one of the most valuable ways of building respect for individuals for whom society has built only asylums.

BIBLIOGRAPHY

ARCHITECTURAL RECORD "RX: ENVIRONMENT; NEW DIRECTIONS IN MENTAL HEALTH FACILITY DESIGN" JUNE 1983

BEERS, CLIFFORD W. A MIND THAT FOUND ITSELF: AN AUTOBIOGRAPHY NEW YORK: LONGMANS, GREEN & CO. 1908

BEIGAL, ALLAN "THE REMEDICALIZATION OF COMMUNITY MENTAL HEALTH" HOSPITAL AND COMMUNITY PSYCHIATRY NOV 1984 VOL 35 NO 11

BRIGGS, LLOYD VERNON RESTRAINT INSTEAD OF TREATMENT: A RELIC OF MEDIEVAL TIMES IN OUR PRESENT HOSPITALS FOR THE INSANE BOSTON: W.M.LEONARD 1910 (MASS ARCHIVES)

"WHAT CAN BE DONE FOR THE PREVENTION OF INSANITY BY THE TREATMENT OF INPATIENT CASES IN GENERAL HOSPITALS AND WHAT HAS BEEN DONE IN THE PAST" JOURNAL OF AMERICAN INSANE VOL.67, NO.4, APRIL, 1911 (MASS ARCHIVES)

BROWN, W.A.F. "COTTAGE ASYLUMS" REPRINT MEDICAL CRITIC AND PSYCHOLOGICAL JOURNAL LONDON: SAVILL AND EDWARDS 1861 (MASS ARCHIVES)

COMMONWEALTH OF MASSACHUSETTS, BLUE RIBBON COMMISSION ON THE FUTURE OF PUBLIC INPATIENT MENTAL HEALTH SERVICES MENTAL HEALTH CROSSROADS REPORT, BOSTON, 1981

DEPARTMENT OF MENTAL HEALTH CLOSER TO HOME: COMMUNITY MENTAL HEALTH PROGRAMS IN MASSCHUSETTS PROMOTIONAL BROCHURE 1978

COMMISSIONERS APPOINTED UNDER A RESOLVE OF THE LEGISLATURE OF MASSACHUSETTS TO SUPERINTEND THE ERECTION OF A LUNATIC HOSPITAL AT WORCESTER REPORT, 1832 (MASS ARCHIVES)

ESTES, CARROLL L. AND JUANITA B. WOOD "A PRELIMINARY ASSESSMENT OF THE IMPACT OF BLOCK GRANTS ON COMMUNITY MENTAL HEALTH CENTERS" HOSPITAL AND COMMUNITY PSYCHIATRY NOV 1984 VOL 35 NO 11

FREEDMAN, RUTH I. AND ANN MORAN "EXECUTIVE SUMMARY OF THE REPORT 'WANDERERS IN THE PROMISED LAND: THE CHRONIC MENTALLY ILL AND DEINSTITUTIONALIZATION'" INTRODUCTION TO THE SUPPLEMENT MEDICAL CARE DECEMBER, 1984 VOL.22 NO.12 P.1143

* GREENBLATT, MILTON; RICHARD H. YORK AND ESTHER LUCILLE BROWN FROM CUSTODIAL TO THERAPEUTIC PATIENT CARE IN MENTAL HOSPITALS: EXPLORATION IN SOCIAL TREATMENT NY: RUSSELL SAGE FOUNDATION 1955

GUDEMAN, JON E. AND MILES F. SHORE "BEYOND DEINSTITUTIONALIZATION" THE NEW ENGLAND JOURNAL OF MEDICINE SEPTEMBER 27 1984 VOL.311 NO.13 P.832

HAMMOND, WILLIAM A. "THE NON-ASYLUM TREATMENT OF THE INSANE" SPEECH TO MEDICAL SOCIETY OF STATE OF NEW YORK NY: G.P.PUTNAM'S SONS 1879 (MASS ARCHIVES)

HEBBERT, R. W. THE DEVELOPMENT OF STATE INSTITUTIONS FOR THE MENTALLY DEFECTIVE IN THIS STATE FOR THE NEXT DECADE ALBANY: THE CAPITOL 1912 (MASS ARCHIVES)

JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION 1968 ANNUAL MEETING, ATLANTIC CITY "PLANNING AND CONSTRUCTION ISSUE: MENTAL HEALTH FACILITIES" FEBRUARY 1, 1968

KIRKBRIDE, THOMAS STORY REMARKS ON COTTAGES FOR CERTAIN CLASSES OF PATIENTS IN CONNECTION WITH THE INSANE HOSPITALS UTICA: NEW YORK STATE INSANE ASYLUM AT UTICA 1851

ON THE CONSTRUCTION, ORGANIZATION AND GENERAL ARRANGEMENTS OF HOSPITALS FOR THE INSANE PHILADELPHIA: PENNSYLVANIA HOSPITAL FOR THE INSANE 1854 (MASS ARCHIVES)

MASSACHUSETTS MENTAL RETARDATION PLANNING PROJECT REPORT: MASSACHUSETTS PLANS FOR ITS RETARDED: A TEN YEAR PLAN THE MEDICAL FOUNDATION, INC. 1966

OKIN, ROBERT L. "HOW COMMUNITY MENTAL HEALTH CENTERS ARE COPING" HOSPITAL AND COMMUNITY PSYCHIATRY NOV 1984 VOL 35 NO 11

POHLMAN, JOYCE G. "HOUSING THE UNSERVED MENTALLY RETARDED IN MASSACHUSETTS" MASTERS THESIS MASSACHUSETTS INSTITUTE OF TECHNOLOGY, DEPARTMENT OF URBAN STUDIES AND PLANNING JUNE 1984

• ROTHMAN, DAVID J. CONSCIENCE AND CONVENIENCE: THE ASYLUM AND ITS ALTERNATIVES IN PROGRESSIVE AMERICA BOSTON: LITTLE, BROWN 1980

• ROTHMAN, DAVID J. AND WHEELER, STANTON EDS. SOCIAL HISTORY AND SOCIAL POLICY NEW YORK: ACADEMIC PRESS, 1981

SIEGAL, ALAN P. AND BORIS M. ASTRACHAN, MICHAEL S. LEVINE "REEVALUATING THE WORK OF A COMMUNITY MENTAL HEALTH CENTER: THE CARE OF CHRONIC PATIENTS" HOSPITAL AND COMMUNITY PSYCHIATRY NOV 1984 VOL 35 NO 11

SPECIAL SENATE COMMITTEE TO STUDY THE IMPACT OF DEINSTITUTIONALIZATION ON THE CARE, QUALITY AND MANAGEMENT OF THE MENTAL HEALTH AND MENTAL RETARDATION SERVICES IN THE COMMONWEALTH OF MASSACHUSETTS FIRST INTERIM REPORT SENATOR ARTHUR J. LEWIS, JR. CHAIRMAN (SENATE 1914, 1983) 1984

THOMPSON, J.W. AND ROSALYN D. BASS "CHANGING STAFFING PATTERNS IN COMMUNITY MENTAL HEALTH CENTERS" IN HOSPITAL AND COMMUNITY PSYCHIATRY NOV 1984 VOL 35 NO 11