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Downsizing the Massachusetts Mental Health System: The Politics of Evasion

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The Politics of Evasion

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For the past three decades the topic of the proper role of state mental hospitals has been vigorously debated as a major public policy issue in Massachusetts. The state has had two runs at hospital closings: the first between 1973 and 1981, when the deinstitutionalization policy flourished, the second between 1991 and 1993, when the privatization policy was developed. In making the case for this seismic shift, a governor's special commission concluded that the state had too many hospitals for too few patients at too high a cost. This study provides a detailed analysis of the problems that beset the Department of Mental Health when it sought to implement the hospital reduction strategy and restructure its service delivery system. From a practical perspective, it focuses on the closing phenomenon in general, and the closure of Metropolitan State Hospital in particular. Overall, the specific problems presented a formidable challenge that placed what appeared to be inordinate demands on the stakeholders involved — patients, families, providers, and advocates. The major emphasis is on mental health politics and the many participants who influence policy and programs. These experiences offer much to be understood by and transmitted to policymakers.

The Contending Forces

Public service bureaucracies like the Massachusetts Department of Mental Health (DMH) are notoriously cumbersome and inefficient. They often have to contend with powerful and well-organized public service employee unions, which drive up costs and complicate policy innovation and organizational change. Perhaps there is no better illustration of this phenomenon than the downsizing of the mental health care system. Between 1991 and 1993, the state closed three adult mental hospitals and a children's psychiatric center. Over the years the quality of treatment at these four institutions had steadily deteriorated. To be sure, the deliverers of mental health services had become unduly burdened by political and contractual obligations to organized groups. Mental health advocates and labor unions denounced these plans as schemes to destroy the social safety net of patients. Although the results of these changes were not altogether beneficial, they at least provided an alternative approach to the traditional way of doing things. This innovation, if still extremely controversial, broke the stranglehold of power that the contending forces maintained over the system.

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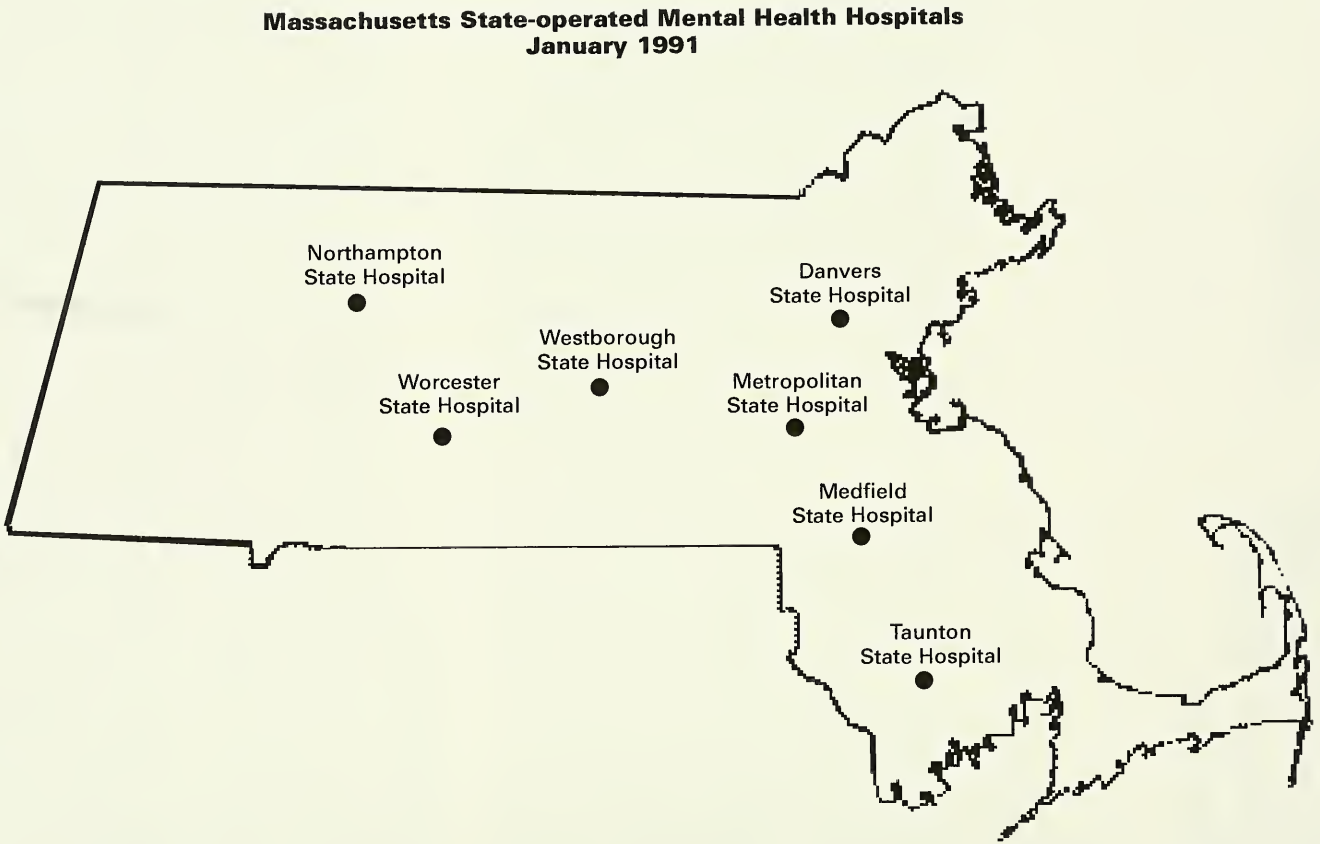
Figure 1


Massachusetts State-operated Mental Health Hospitals
January 1991
Northampton
State Hospital
Danvers
State Hospital
Westborough
State Hospital
Worcester
State Hospital
Metropolitan
State Hospital
Medfield
State Hospital
Taunton
State Hospital

Mental illnesses are among the most devastating conditions in society. Severe mental disorders, such as schizophrenia and bipolar disorder, otherwise known as manic-depressive disorder, are incurable, incapacitating, and extremely difficult to treat. They cause incalculable suffering for patients and wreak havoc on their families. Those afflicted lose touch with reality. As Clea Simon puts it,

> After all, mental illnesses by their nature involve a person's ability to think clearly and rationally. The mood, or affective disorders, such as bipolar, may produce extreme emotional states. The thought disorders, such as schizophrenia and other psychoses, may produce hallucinations and delusions.[1]

During a psychiatric breakdown or full-blown psychosis, a person's whole world falls apart. Sometimes it ends tragically, in suicide.

Few social problems are more perplexing and intractable. Given the erratic and often unpredictable course of mental illness, the problems that accompany it do not lend themselves to simple solutions. Many troubled families find their lives disrupted and torn asunder. They wind up in dire straits; older parents particularly feel the effects of their own aging and wanting to see a mentally ill son or daughter restored to stability and living independently. It is essential to recognize that while mental illness can be treated, there is presently no cure. During the acute phase of illness, most patients require short-term intensive services in secure settings, usually locked hospital wards. This in-volves either voluntary or involuntary commitment.

In Massachusetts, with a population of nearly 6 million people, an estimated 44,730 adults are diagnosed with serious mental illness. With an annual budget of $520 million for fiscal year 1996, the DMH service system is designed to accommodate 80,000 consumers. This beleaguered department has been a recurring managerial nightmare for Republican and Democratic administrations alike. Indeed, the agency has always been regarded as complicated to manage. Buffeted by changing social demographics and the competition for scarce resources, the state's mental health system has been vulnerable to underfunding and inadequate staffing for as long as anyone can remember. Forty years ago there were more than 23,000 patients in the custody of state-operated mental hospitals scattered around the commonwealth. Today, as a result of restructuring policies that were implemented during the early 1990s, the Bay State has about 1,280 beds of its own, plus another 1,250 beds in smaller units in independent hospitals and other facilities operated by publicly funded private-sector management under contract with DMH.

More than 165 years ago, Massachusetts led the nation in building a network of public asylums whose spacious outdoor campuses provided fresh air and a serene environment for the mentally ill. In their prime, these large congregate hospitals functioned best as an extended system. They responded to the needs of the insane, the aged infirm, the poor and disabled, and the dispossessed who could not afford proper medical care. With the passage of time, these facilities have become increasingly obsolete, outdated relics of a bygone era. Contributing to their obsolescence were the dramatic changes in psychiatry and community mental health programs that have taken place over the past forty years.

On closer inspection, mental health can be classified as a latent issue. A taboo topic that no one wants to talk about, it is the opposite of a hot-button issue. Mental hospitals are out of sight, and therefore out of the public's mind. From time to time hot-button

events do occur, but for the most part the problem receives little public attention, with which nobody wants to deal. Too often it falls prey to the politics of evasion.

There are essentially four contending forces at play here. First, mental health is a social problem whose complexities are routinely pushed aside. Without more knowledge about how to cure such illnesses, there may be no immediate resolution. Second, mental health care involves a changing technology that seeks to stabilize people, but because the adverse side effects of mind-altering drugs accompanies it, this new technology is not fully understood. Nor are the "miracle drugs" user-friendly, for they have potential benefits and risks. In handling this technology, doctors have been naive about releasing patients from hospitals. Some who are deemed well enough to live in the community have proved to be a danger to themselves and others. This social disruption, plus the lack of tolerance for deviance in the larger society, explains why it takes so long for new programs to develop. Third, the bureaucracy and labor unions are entrenched forces that wield considerable power so that legislators and governors have been reluctant to take them on. Fourth, mental health advocates have made a significant impact on policy development. The rise of such activists as Ben Ricci, who first challenged the system in the early 1970s, have made their presence felt in Massachusetts. The primary mission of activists, who have engaged in the politics of public advocacy in order to combat the politics of evasion, has been to protect the rights of patients and to hold service providers more accountable. Because the varied rights are sometimes in conflict with one another, the interplay of these forces explains why change comes so hard. None of them operates in isolation, and they are contradictory and contentious. Understanding the ways in which they complement and counteract one another makes the hospital closings more comprehensible.

The Shift to Privatization

Hardly anything could have prepared the residents of Massachusetts, who had just experienced the prosperity of the so-called Massachusetts Miracle, for the economic and fiscal disasters that would befall them in the years between 1988 and 1992. As a prosperous economy faltered and then collapsed, the business community began to downsize and lay off employees. The high-tech and defense industries were especially hard hit. By the summer of 1990 the Bay State, like the rest of the nation, was in the midst of a full-blown recession turning into a depression. Banks failed, the savings and loan industry collapsed, investments turned sour, depositors lost their savings, retail sales slumped, housing construction declined, major industries went out of business, and unemployment rose to new heights. Chelsea's city government declared bankruptcy and was placed in receivership. Cries for downsizing were heard in both the public and private sectors.

The telltale signs that people were hurting were evident as early as 1986. State and local debt had doubled since 1980, and expenditures almost doubled in those six years. These events caused a serious decline in public revenues, which in turn led state officials to increase taxes and cut services. This intolerable situation produced enormous pressures to economize. The time of genuine reckoning was at hand. Faced with a fiscal crisis, the executive and legislative branches of state government were compelled to cut back on social services and welfare funding.

As the state's fiscal crisis deepened, the Democratic leaders on Beacon Hill began downsizing state government. Such a course of action was at odds with the spirit

of their party. Since the days of the New Deal, most of them had favored an active, involved role for government, particularly when it came to meeting the needs of low income families. Nevertheless, the Democrats made good on threats to slash the state budget. Beneath the majestic golden dome of the State House, which Charles Bulfinch had designed in 1798, they cut $36 million from DMH's budget for fiscal year 1991, reducing it from $497 million to $461 million. They also reduced the authorization for assisted housing. The battle over these budget cuts was bitter and acrimonious.[2]

Under the pressure of fiscal deficits, antitax pressures, and the rising costs of human services, the Michael Dukakis lame duck administration began making drastic budget cuts, but they were not sufficient to cover the revenue shortfalls. The state constitution requires a governor to submit a balanced budget, but despite two consecutive billion-dollar tax increases, Massachusetts had a $1.8 billion deficit when Dukakis left office. The state was on credit watch and its bond rating had sunk to almost that of a junk bond. All these events generated intense public anger, for many taxpayers believed that the politicians themselves were to blame for the state's fiscal problems. Public fury reached a boiling point during the 1990 elections.

In the primary election, which was only a warm-up for the main event, the two major parties selected gubernatorial candidates who ran as self-styled political outsiders. In the general election, Republican William Weld, a politician of patrician pedigree, was pitted against Democrat John Silber, the outspoken and controversial president of Boston University. It turned out to be a hotly contested and bitterly fought race in which the outcome remained very much in doubt until the end. The enraged voters had become increasingly distrustful and cynical of government.

A graduate of Harvard Law School and a former U.S. attorney in the Ronald Reagan administration, Weld was pro-choice and pro-gay rights, but he was a hardliner when it came to crime, spending, and taxes. In addition to his base of mainstream Republicans, Weld appealed primarily to women, gays, minorities, and disaffected Democrats. As the campaign wore on, he railed against big government and extolled the virtues of free enterprise and the workings of the marketplace. His disdain toward bureaucracy was vitriolic. At one point, he derisively referred to state employees as walruses, a comment that did not endear him to this constituency. Privatization, reinventing government, and total quality management were the popular buzzwords of the day. Ideologically a freewheeling libertarian, Weld promised the voters no new taxes. This popularly understandable rhetoric quickly translated into a politically viable philosophy that was shrewdly attuned to the temper of the times. In the closing days of the campaign, Silber seemed to stumble. Strident and contentious as ever, he bungled a television interview with Natalie Jacobson, which cost him dearly. In the end, Weld narrowly defeated Silber, the women's vote carrying him to victory.

Pressures on the newly elected governor — the head of the first Republican administration in more than sixteen years — to overcome past tradition and cut through the complexities to a prompt solution of the budget deficit were strong. Given the prevailing skepticism about the fiscal capacity of state government, the impulse to "privatize" was almost irresistible. Vigorous gubernatorial action would be possible under these circumstances. Fresh from the campaign, Weld called on state administrators to privatize functions wherever they believed such action would save money or improve services. He moved aggressively to gain control of a recalcitrant bureaucracy and to reduce the large deficit he had inherited. Dukakis holdovers, who were plentiful, departed only with the greatest reluctance, compounding the atmosphere of distrust and deceit. Per-

suaded as to the policy utility of privatization, Weld eagerly embraced public-choice economics as a substitute for institutional development. His was a minimalist approach to government. As a deliberate strategy, Weld sought to reduce the size of state government, comprising 72,000 employees. These were trends thoroughly consistent with the governor's temperament and philosophy.

For more than a decade the state's human services budget had been growing at an alarming rate. Because of its legislators' liberal commitment toward the poor and needy, Massachusetts spent more money on human services than any state except New York. Unfortunately, at the very time when the demand for these services was steadily increasing, the commonwealth was losing the economic capacity to finance them. A disproportionate share of the mental health budget went toward financing its outmoded and antiquated hospitals. By 1991 the annual average cost of caring for a mental patient in a state hospital was $120,000. To put it more strongly, 6 percent of DMH consumers were using 47 percent of its resources. Although more than 750 inpatients were ready to be discharged, they could not be placed in the community for lack of assisted housing. As of January 1991, the adult inpatient census at all DMH facilities — seven state hospitals and eight community mental health centers — was 2,021.

As secretary of the executive office of Health and Human Services, Governor Weld appointed David Forsberg, who had formerly headed the regional office of the U.S. Department of Housing and Urban Development. Even before Weld was inaugurated, the immediate focus of his principal economic advisers was to bring the fiscal crisis under control. They proposed doing so by imposing effective cost containment measures that would harness the so-called budget busters, identified as Medicaid, debt service, pensions, group health insurance, and the Metropolitan Bay Transportation Authority. It was these big-ticket items that caught the public eye. There were no magic elixirs to resolve the perplexing issues that Weld chose to tackle. Alarms were sounded from various quarters in the spring of 1990. The gap between public revenues and expenditures had been documented in a report published by the McCormack Institute, which analyzed the state's fiscal crisis and sent warning signals of trouble ahead.[3]

Responding to this crisis, the Republican governor placed a cap on spiraling debt service costs that limited capital spending over the next five years to $4.5 billion. Weld refused to borrow money to cover the deficit. He refinanced the outstanding debt and spread it out over a longer period of time and threatened to veto any tax increases. By adopting such a strategy, the governor had put the legislature in a box. It was a well executed political squeeze play.

Over and beyond this, the Weld administration discovered how to milk the federal cash cow by way of reimbursements. In 1991 Kathy Betts, an obscure state employee, spotted a loophole in the Medicaid regulations. The provision was originally designed to reimburse hospitals that treat a disproportionate share of poor people, but almost every state discovered its dual use as a means of financing other projects. The result was a $500-million windfall for Massachusetts, an instant remedy for its fiscal crisis. The official clinical rationale for closing the mental hospitals was that patients do better in community settings. But the fiscal rationale was even more compelling. Although Medicaid did not cover mental patients in state institutions, it paid half the costs for patients in community care. The yield was $21 million a year in federal funds.

The overall strategy called for the purchase of service contracts. Packaged under the policy tag "public managed care," the DMH program consisted of five components: (1) closing state hospitals through privatization; (2) moving more resources into the

community; (3) developing a comprehensive community support system model; (4) creating an infrastructure for quality and utilization management and; (5) integrating the dual systems of care that existed between the Department of Mental Health and the Division of Medical Assistance (Medicaid). These sweeping policy changes, which were introduced by the newly appointed commissioner, Eileen Elias, shifted much of the burden for mental health care from the state to private management. Hindsight was to reveal that the length of public hospital stays was substantially shortened, and the number of institutionalized patients was sharply reduced, from 2,330 to 1,160. Contracting with private agencies to provide services formerly supplied by state government was not exactly a new idea. Since the 1960s, services had been increasingly provided by private, not-for-profit agencies under government supervision. What was new, of course, was shifting the locus of service delivery to private enterprise.

Central to the policies then being fashioned were two recent changes in state law that signaled a move toward privatization. The first, a statute passed in 1987 (Chapter 167), authorized the creation of psychiatric units in private or general hospitals. The second, legislation passed in 1990 (Chapter 150), authorized Medicaid to implement a managed care program for recipients. The economic theory behind managed care was to move people out of high-cost institutional settings. Chapter 167 allowed the state to share the cost of mental health care with third-party payers by transferring Medicaid patients out of ineligible hospitals and into reimbursable acute-care facilities. The hospital financing law was due to expire in October 1991 and its renewal was regarded as problematic. Subsequently, new hospital financing legislation reduced regulatory requirements and created opportunities for selective contracting with health care providers. This legislation was particularly helpful in removing barriers to caring for patients with long-term serious mental illness in private or general hospitals.

His alert sense of these trends shaped the strategy of Governor Weld, who described himself as a social liberal and a fiscal conservative. On February 26, 1991, as the pressures of office descended on him, he appointed a seventeen-member special commission to study the problem of state-operated hospitals. This blue-ribbon commission was comprised of four state legislators, two Democrats and two Republicans, a labor union official, a family member, six experts on health care and housing policy, three agency commissioners, and two cabinet secretaries. It was stacked in the sense that most of its members were favorably disposed toward shifting care for persons with disabilities from large state institutions to private community-based organizations, hospitals, and nursing homes. Their work began immediately under the direction of David Forsberg, who served as chair. He was assisted by his able deputy, Charles Baker, who chaired a working subgroup of state employees. As the point men for the Weld administration, Forsberg and Baker worked well together. A politically savvy administrator, Forsberg possessed well-honed political skills, while Baker, who had come over from the Pioneer Institute, a conservative think tank, was a good number cruncher and a superb technician.

With a specific focus and genuine political clout among its members, the commission moved at a rapid pace. In whirlwind fashion, they took their show on the road and inspected most state health facilities. This tour de force consisted of thirty-one site visits and fifteen hours of public hearings that were held in various parts of the state. The commission spent numerous hours deliberating and studying background materials. Based on their work, they found among other things that the state had a shrinking patient population and an excess capacity of hospital beds.

The nature and extent of this problem were clearly outlined in their report.

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

A spirit of open inquiry prevailed among the commission members. Much of their deliberation focused on the impact of federal aid and what the states were able to do with it. The major problem was how to maximize federal reimbursements for mental hospitals. Only those patients twenty-one years of age and under and sixty-five years of age and over were eligible for Medicaid reimbursement. Conversely, those between the ages of twenty-two and sixty-four were ineligible. Commission members recognized the trend that national mental health care was moving toward a noninstitutional approach. After crisis intervention and acute care had been rendered, the integration of community services was viewed as a better solution than restricted institutional care. In shifting to such an approach, the trick was to separate housing needs from treatment needs. Clients could not obtain Medicaid money for housing except through waivers. Drawing on their experience in the housing field, both chairman David Forsburg and Eleanor White, who served as deputy director of the Massachusetts Housing Finance Agency, played a critical role in reminding their fellow commission members of considerations that they might otherwise have ignored. The recent crash in the real estate market made it easy for clients to obtain assisted housing. For his part, Charles Baker knew how to access housing that was not treatment oriented. New federal and state laws made it illegal to dicriminate against the mentally disabled.[5]

Four months later, on June 19, 1991, the governor's special commission released its report "Actions for Quality Care." Charged to develop a specific plan, it concluded that a systemwide solution was warranted. Devising what it termed a "right-sizing" hospital reduction strategy, the commission recommended closing nine of thirty-four inpatient facilities over a three-year period with patients being moved either to the community or to public or private hospitals. Among those facilities recommended for closing were three adult mental hospitals, three public health hospitals, and three schools for the mentally retarded. Describing community-based services as "highly desirable, highly effective, and less expensive than institutional care," the commission also called for the development of 2,000 new community residential placements and associated community support programs (700 of these specifically targeted for persons with mental illness). In addition, it recommended that 300 new general hospital acute-care beds and 200 new long-term-care nursing home beds be created for former state hospital patients.

As a sign that it was operating in good faith, the commission explicitly acknowledged the failures of past efforts to deinstitutionalize clients and therefore promised that no patient would be moved from a state facility slated for closure until an "equal or better" alternative care setting was available.[6] The commission estimated that its recommendations would save the state approximately $60 million in annual operating costs and another $144 million in capital avoidance, which would not have to be spent to

bring antiquated facilities up to the standards of the Joint Commission on Accreditation of Healthcare Organizations and the Health Care Finance Administration.

This was not a policy brought forward by overwhelming popular demand. Activists and mental health professionals had talked about it for years, but no political groundswell existed in its behalf. In the fall of 1990 the Massachusetts Association for Mental Health had published a working paper suggesting that three state hospitals — Danvers, Metropolitan State, and Northampton — were prime candidates for closure. According to Bernard Carey, the executive director, the intent of the group was to give this paper to the winner of the gubernatorial election.[7] Interestingly enough, these were the same three hospitals that the governor's special commission put on the closing block.

Before the Department of Mental Health could close any of its hospitals, Governor Weld first had to accept the commission's recommendations. Barriers to policy implementation, such as collective bargaining agreements, stood in the way of executive action. Closing underused hospitals would prove to be very difficult politically. Previous administrations had been either unwilling or unable to take on the legislature and the powerful state employee unions. Stimulated by the work of the governor's commission and given the green light by Weld, DMH quickly moved to close three of its seven remaining adult hospitals and Gaebler, its one children's hospital. All signals remained on go. Much like the military base closings on the national level, it was a change pro-cess not without pain and considerable conflict.

From a political standpoint, the governor's special commission had the practical effect of shifting the locus of decision making. As such, it provided a convenient buffer for Weld. A bipartisan consensus existed among the four state legislators who served on the commission. Democrats Edward Burke and Barbara Gray and Republicans Arthur Chase and Edward Teague voted in favor of the plan. The only negative vote was cast by Laura Spenser of the American Federation of State, County, and Municipal Employees Council 93, who represented organized labor. Taking a strong stand against privatization and the laying off of state employees, she filed a minority report.

Among those hospitals placed on the hit list of recommended closings was Metropolitan State, where a planned phasedown from 400 to 120 patients was already well under way. The two other adult mental hospitals scheduled to be closed were Danvers and Northampton. Selection of these three institutions was based mainly on the grounds of their inefficiency, costliness, and underutilization. Beyond these criteria, all three were situated in areas where there was a large provider base and private hospitals could handle acute care. Finally, their closure was deemed politically feasible.[8]

The downsizing of Metropolitan State predated Weld's appointment of Eileen Elias as mental health commissioner in June of 1991. The governor was eager to appoint women to high-level positions. Elias replaced Henry Tomes, a holdover Dukakis appointee, who had resigned a month earlier. Before coming to Massachusetts, Elias had worked for twenty-five years as a psychiatric rehabilitation counselor in both the private and public sectors. She had recently served as area director on Cape Cod and the offshore islands. Not only was she the first woman commissioner in a state renowned for its entrenched old-boy political network, but she was even more of an outsider in that she originated from Philadelphia and New Jersey. Furthermore, she had no formal connections to the prestigious Boston area academic institutions that exercised considerable influence in the state's mental health arena.[9]

In response to the agenda for change mandated by the Weld administration and her own reform vision, Elias worked with people from across the state, developing and

1990	
November	Adolescent unit transferred to Somerville Hospital.
November 5	Central Middlesex admissions diverted to Westborough State Hospital.
December 17	R1 closed.
1991	
January 2	Tri-City (TC) admissions diverted to Danvers State Hospital and private facilities; two patients transferred to Worcester State Hospital; Cambridge/Somerville (C/S) admission remained; cost funded through June 1991.
January 2–10	Fourteen patients transferred to Westborough State Hospital.
January 16	One patient transferred to Lindemann Mental Health Center.
January 29	One patient transferred to Worcester State Hospital; Commissioner Tomes meets with interested families at Kline Hall.
February 4–12	Four patients transferred to Worcester State Hospital; twenty-four patients transferred to Westborough State Hospital.
February 5	R4 closed.
February 11	B1 closed.
February 15	One patient transferred to Farren Care Center.
February 16	Shuttle service to Worcester and Westborough State hospitals commenced.
February 20	Two patients transferred to Westborough State Hospital.
February 27	Two patients transferred to Worcester State Hospital.
March 13	Three patients transferred to Westborough.
March 20	Two patients transferred to Westborough.
April 2	Five patients transferred to Westborough.
April 4–9	Four patients transferred to Worcester.
April 1–15	Pierson Road (C/S) residence opened for eight patients; Saugus House residence opened for eight patients; Woburn House residence opened for eight patients; Banks Street, Waltham, residence opened for eight patients.
April 17	Three patients transferred to Westborough.
April 23–29	Hammond Street residence (C/S) opened for eight patients; on-grounds Residence I opened for six patients; Watertown apartment opened for four patients.
May 2	Semrad Unit shut with closing of D1 and A2.
May 9	Maynard House opened for ten patients.
May 21	One patient transferred to Worcester.
May 30	Watertown apartment opened for four patients; one patient transferred to Worcester.
June 6	One patient transferred to Westborough.
June 20	Commissioner Elias announced the closing of Metropolitan State Hospital to families and staff.
July 3	Danvers cottage opened for four patients.
September 3	Admissions service moved to R1.
September 24	Cambridge Hospital temporarily relocated Cahill 4 to R2.
November 6	Magazine Street opened for ten C/S patients.
November 13–20	Five patients transferred to Danvers.
November 15	McLaughlin House opened for six central Middlesex patients.
November 20	Marguerite Terrace opened for twelve central Middlesex patients.
November 21–25	Three T/C patients discharged to existing community residences.
December 3–5	Ten patients transferred to Westborough.
December 5–10	Five patients transferred to Danvers; C/S opened apartments for twenty-four patients.
December 10	Four patients transferred to Westborough.
December 16–30	Burke Unit shut with closing of ME2.
December 10–30	Seventeen patients transferred to Medfield State Hospital.
December 28	C/S Unit shut with closing of M&S2.
1992	
January 31	Metropolitan State Hospital officially closed.

articulating the vision of change and challenging them to work with her to develop a blueprint for improving the system. Her concept was based on principles of consumer empowerment, community-based organized systems of care, flexible use of resources, protection of the local service system and accountability. But these principles carried consequences that, unless anticipated and managed, ensured policy disasters. Feisty and determined, Elias fought hard to achieve her goals.

Dr. Annette Hanson, a psychiatrist who came from the private sector, was named deputy commissioner for clinical and professional services. By law, the department's second in command is required to be a board-certified psychiatrist if the commissioner is not. They were assisted by general counsel Jennifer Wilcox and two other deputy commissioners — Valerie Fletcher in charge of program operations and John Ford in charge of budget and finance. This team was responsible for implementing the recommendations of the governor's special commission.

These hospital closings, so painfully generated, aroused intense opposition. Hostility to the plan was concentrated in those areas where the targeted hospitals were located. The battle to keep them open was fought by those most directly threatened and most capable of effective defense and counterattack. They included adversely affected special interest groups such as the Massachusetts Alliance for the Mentally Ill and the American Federation of State, County, and Municipal Employees. Encompassing thirty-four local chapters across the state, the alliance is a grassroots family advocacy organization whose main purpose is to lobby on behalf of relatively powerless people. In addition, Governor Weld received a petition signed by more than 5,000 citizens urging him not to close the facilities.[10]

Undeterred by this opposition, Weld remained firmly committed to his restructuring initiatives. Emboldened by his commission's plan and convinced that it would result in a substantial reduction of public spending, the governor forged ahead. At a press conference, he declared, "While the top priority of the special commission is client care, their recommendations will result in tremendous savings to the Commonwealth."[11] Even so, DMH administrators first had to close the hospitals before any savings could be realized. Operating with money from a reserve account, they encountered the problem of how to free up existing resources for community services while keeping the hospitals open until they could be emptied. This was a formidable task.

By the end of January 1992, DMH had closed Metropolitan State Hospital, which was then the largest public mental hospital in Massachusetts. With a 412-bed capacity, it served twenty-three communities located within the greater Boston metropolitan region. Five months later, in June 1992, Danvers State Hospital, which serviced the northeastern region with 155 beds, was closed. As a subsequent recommendation of the governor's commission, the Gaebler Children's Center, which housed 56 emotionally disturbed children under the age of fourteen, was closed in September 1992.

But already a reaction was setting in. Northampton was the only state hospital in the hinterland of western Massachusetts. It housed 145 patients and operated under a court-ordered consent decree. The legislative delegation from this region was strongly opposed to its closing, fearing the prospect of losing a major business that would have a negative impact on the local economy. It therefore gave Commissioner Elias an exceedingly hard time and tried to persuade her to change her mind. Despite these strenuous objections, Northampton was closed on August 26, 1993.

Because of the perceived benefits of privatization, the Weld initiative prevailed. It had considerable appeal. The fact that the general public was angry with state govern-

ment fueled support for Weld's program. Public opinion polls indicated as much. A poll conducted by the Becker Institute in 1993 showed that 53 percent of those surveyed approved of privatization, while 39 percent were opposed to it. A similar poll commissioned by the *Boston Globe* showed a favorable rating of 45 percent and an unfavorable rating of 33 percent.[12]

The trade-offs between political ideology and political reality are always tricky, whether played out nationally or at the state and local levels. This restructuring program proved to be no exception. According to the figures released by the governor's special commission, it estimated that closing the three adult mental hos-pitals would save the state $36.94 million annually in net operating expenses and another $40.03 million in capital costs. Considering Metropolitan State Hospital by itself, they estimated that its closure would result in operating savings of $12.93 million annually and $16.78 million in capital savings.[13]

These cost-benefit arguments did not sway those who believed that the proposed hospital closings would forever preclude a safety net for the mentally ill. Skeptics questioned the accuracy of these figures. Despite their differences in numbers, most of the money saved was reallocated to financing a wide array of community services, facilitating greater patient access, and expanding appropriate care options. Mental health professionals considered this method of residential care more cost-effective and less stigmatizing than institutional care. A similar managed care approach, aimed at reducing Medicaid expenditures, was evident in public welfare. With this goal in mind, the Division of Medical Assistance contracted with Mental Health Management of America, a private vendor, to deliver mental health and substance-abuse services to Medicaid recipients. These were fundamental shifts in conventional definitions of mission, in development of resources, financial and human, and in the physical siting of mental health services. Case management, however, was not privatized. All in all, it represented a major restructuring of the mental health care system in Massachusetts.

Not surprisingly, labor unions strongly opposed the hospital reduction policy, arguing that closures would significantly worsen the intolerable situation of hundreds of state workers already laid off owing to severe budget cuts. Furthermore, they argued that increasing privatization of the mental health system would lead to disparities in the quality of services for the profoundly mentally ill. In late 1991 the Service Employees International Union Local 509 filed suit against the Weld administration, charging it with illegally implementing privatization of the mental health system. The suit accused state officials of illegally laying off more than 800 state employees who worked in private agencies. Many of the discharged state workers were then rehired by private providers, but at lower wage and benefit rates. Although the litigation was unsuccessful, the unions continued their efforts to roll back state privatization policies.

The political fallout from the closings made most state legislators unhappy. Weld's restructuring program was anathema to Democrats on Beacon Hill, who, by the end of 1993, mounted a concerted counterattack. The Senate Committee on Post Audit and Oversight criticized DMH for not having enough private hospital beds available before closing Northampton.[14] The House Committee on Post Audit and Oversight, chaired by Democrat William Nagle of Northampton, was even more critical. In December 1993 state senator Marc Pacheco, a Democrat of Taunton, introduced legislation that prohibited a state agency from privatizing services unless it could prove a minimum saving of 10 percent of its costs. Pacheco feared that Taunton State Hospital, which was located in his legislative district, would be the next one closed. Pacheco's "antiprivatization" bill

was vetoed by Governor Weld, but the Democrats mustered the necessary two-thirds vote in each house to override his veto, and it became law. In July 1994 the irate lawmakers overrode another gubernatorial veto of a legislative rider attached to an "outside section" of the budget that prohibited the closing of any more state hospitals.

Framing the Issue: Why Close Metropolitan State?

This study focuses on the impact of the consolidation and transfer of services at Metropolitan State Hospital as a point of departure. The episode raised several hard questions that did not yield easy answers. Why such a major change? What would happen to the clients in its custody? Where would they go? Could they be transferred to alternative hospital facilities or community group homes without jeopardizing their health and safety? Could the Department of Mental Health protect the safety of the larger society and the rights of the mentally ill at the same time? What would happen to the clinical treatment staff and other hospital personnel who faced imminent layoffs? Could they find jobs elsewhere in the system?

These questions of public policy and public management and their ramifications have been debated with increasing fervor for the past thirty years. They found their origins in the policy option of deinstitutionalization, which resulted in the wholesale discharge of patients that started in the sixties and continued throughout the seventies. This controversial reform exposed the cracks in the system, which in turn led to the first round of hospital closings in the mid-1970s. The following sections summarize the painful history of these efforts and the mistakes that were made along the way. Acknowledging the embarrassing failures of deinstitutionalization, one must ask the obvious questions, Why again? Why now? If this strategy failed then, what made the policymakers think that it would succeed this time? What was the critical difference? As discussed later, these are developments worth examining.

Opened in 1929 on the eve of the Great Depression, Met State, as it was popularly known, had been in operation for sixty-three years. During this extended period it had provided both acute and long-term care for patients suffering from various mental and personality disorders. Over the years thousands upon thousands of patients had been treated there on their road to recovery or stability. Most referrals originated with families who found themselves unable to cope with the bizarre and erratic behavior of a troubled member. The hospital admitted people from three of DMH's nine catchment areas. These included the Cambridge-Somerville area; the Beaverbrook-Concord – Mystic Valley area; and the Tri-City area, which encompassed the cities of Everett, Malden, and Medford.

As it happened, the quality of care at Met State in the late 1980s left much to be desired. Most of its patients suffered severe mental illnesses ranging from paranoid schizophrenia to bipolar disorder. Some of these illnesses are associated with chemical changes in the brain, which caused their victims to lose touch with reality. Theirs was a world haunted by failed treatments and fearful delusions and hallucinations. Those who suffered psychotic relapses returned to the hospital for repeated commitments. The recidivism rate was fairly high. The most costly aspect of mental health is hospitalization — the average cost per patient per year at Met State in 1991 was $98,500. By marked contrast, a similar stay at a community setting cost, on average, $55,000 per client, which included residential, day, and support services.[15]

In carrying out its responsibilities, Met State was plagued by numerous problems.

Client concerns that had been so troubling to so many were legendary, serious care deficiencies and staffing shortages being among the most prevalent.[16] This led to many reports of abuses, for example, individuals being misdiagnosed or overdrugged and neglected in back wards. The factors accounting for these problems were both episodic and long term. After beginning with high hopes and large budgetary outlays, Met State prospered in its early years. Before long it encountered financial problems and found itself continually underfunded and understaffed. Year after year it experienced successive expansions and contractions of public and political support. This pattern of unstable funding explains in large measure why the hospital declined. Indeed, it was no stranger to cycles of reform and retrenchment, nor was it spared from sordid scandal, corruption, and incompetence. For better or worse, it had weathered these storms and withstood the passage of time and change. By 1991 it had become a remnant of a bygone era when bigger and better hospitals were seen as the only viable option for the mentally sick.

The decision to close Metropolitan State was based largely on the worn-out condition of its buildings, their replacement value, maintenance, and capital funding, and their physical and functional obsolescence. In short, this sprawling hospital complex was underutilized and too expensive to operate. Another consideration was the excess capacity of private hospitals in the local area. Adopting conventional cost-benefit analysis and long established criteria used in hospital consolidations and mergers, the governor's special commission concluded that Met State lacked an appropriate "physical environment." It politely explained its rationale this way:

> The Metropolitan campus was built in two groups of buildings. The buildings are in fair condition but are inappropriately built for today's health care standards. The layouts add to inefficient operating costs for staffing, energy, security, communications, and maintenance. The site utility structures and power plant are original and need significant repairs/rebuilding. Estimates to rebuild the newer portion of the campus for 120 institutional beds and 80 transitional beds approaches $17 million . . . These funds would be more appropriately invested in community programs and other state facilities.[17]

Clearly, Met State was one of the most inefficient and least cost-effective hospitals in the system. At this point it had become a proverbial white elephant. Like a rusty old battleship about to be withdrawn from active service, this imposing hospital facility was ready to be decommissioned and mothballed. From start to finish, the two-stage decommissioning process took fourteen months to complete. The initial phasedown took place during the eight months from November 1990 to June 1991. The second stage began shortly thereafter and concluded when Marylou Sudders, its chief operating officer, closed its doors on January 31, 1992. In truth, the decision to close Met State had been in the works for some time. It was implicitly made by Dukakis and explicitly affirmed by Weld. In retrospect, there was not much question about closing Met State at this juncture. Considering the downsizing that was already taking place, the hospital was on its way out by the time Weld assumed power.

With Met State's continued existence threatened, its 827 employees were confused and outraged at this turn of events. They were not only afraid of losing their jobs, but they also displayed a human anxiety that was deeply rooted in individual self-worth. Worried employees asked each other, "What will happen to us once the hospital is shut down? Will we lose our jobs and have to go on unemployment? Or can we exercise our bumping rights and get transferred to other state hospitals?" The closing evoked deep emotions that ranged from fear of the new to maintaining things as they are.

Unwilling to see Met State expire, they engaged in a power struggle for institutional survival. Like their counterparts at Danvers and Northampton, who faced a similar predicament, they fought hard to keep the hospital open. Reluctance and resistance to change was extraordinary, especially when imposed from outside.

Patients and their families were even more upset. After all, they had the most to lose. The families feared that their relatives would lose their social safety net. Not only that, the sudden modification of conditions disrupted the normal routine of patients. It meant breaking up their social networks and the continuity of their clinical treatment that was an integral part of their support system. Closing the hospital caused severe hardship and required adjustments for all parties involved. The whole episode provided a compelling example of organizational change in a volatile environment.

Trying to anticipate the consequences of their actions proved especially important to the administrators. They sensed the probable organizational impact and understood that it would cause much pain and anxiety. Consequently, they devised strategies to help the affected stakeholders cope with their losses, both real and imagined. Most important of all, they wanted to maintain the clinical integrity of the process. Related to this, and a matter that sharpened each of the issues they faced, was the complexity of transferring patients to alternative care facilities without compromising their health and safety. For many this involved moving from a restrictive setting to a less restrictive one. It was an enormously complicated task that was fraught with risk as well as the uncertainties and complexities inherent in organizational reality. A few months beforehand, a class- action lawsuit had been filed by lawyers who sought to protect the basic civil rights of patients. This raised the question of whether cooperation among the parties involved in the closure process could flourish or whether the arena was destined to be adversarial.

As principal participants reconstruct the Metropolitan State case, the community involvement was extensive. It included consumers, families, employees, trustees, and advocates. After stubborn resistance at the outset, all parties eventually signed on in advance of the closing. But this appearance of cooperation on the part of both labor and management did not come easy. The administrators had to invent new ways of allowing the various stakeholders to participate in the planning and decision-making processes that affected their lives so deeply. To acknowledge sharply divergent views, mutual accommodations and adjustments were the order of the day. They all showed genuine respect and sympathy for the patients.

Ultimately, it was this sense of shared purpose that made it possible for them to work closely together. Labor relations in the past had left much to be desired, both as a process and as an impediment to new policies. The failure of past attempts to create a viable framework for talks was attributable to the lack of trust and credibility on both sides. For starters, DMH placed a hiring freeze on all job vacancies and promised to give Metropolitan State employees the first crack at them. The major negotiations among the nine public employee unions and the senior management team took place at the hospital site in Waltham. Specific grievances were handled at the Office of Employee Relations in Boston. In conjunction with state employee unions, DMH set up an Office of Competitive Bidding to assist employees in bidding on contracted work. What emerged was a policy process that mixed outside and inside participation.

Herbert Kaufman has identified three internal reasons why organizations resist change. First, there are almost always contradictory judgments made by the members of an organization as to whether the change is necessary. Second, ineffective deci-

sion making processes usually obtain. Third, the implementation of new directions is imperfect — slippage between decision and action occurs because the instructions are likely to be ambiguous or impractical or require that members cease what they are accustomed to doing and do something different.[18]

Reinforcing Kaufman's explanation of organizational resistance to change is the theory of escalating commitment to the status quo. Institutional officials, employees, and constituency groups become so emotionally, intellectually, financially, and structurally committed to an ongoing pattern of behavior that they inevitably find themselves buried "knee deep in the big muddy."[19] This resistance to change is intensified when an individual or group perceives itself as personally responsible for an action or outcome so that stubbornness compounds formal commitment and informal lethargy. Furthermore, civil service rules and collective bargaining agreements make it extremely difficult to terminate state employees.

All these factors were present in one form or another and in varying degrees in the closing of Met State. Failure to consider them promised a recipe for disaster. The well-organized state employee unions wielded substantial power as did the medical clinicians, who saw their authority and professional turf on the line. The full range of contending forces was felt. For the most part, the administrators anticipated the resistance and dealt with it as sensibly and expeditiously as possible. They had to manage a different and more demanding organizational change. For them, knowledge of how a mixed version of headquarters-field and site-based organizations work was essential to achieving their goals. They realized early on that if not handled properly, layoffs and employee bumping rights could prove disastrous. The same was true with regard to the legal implications of the transfer of each client. The whole operation could easily have become unraveled if they had gotten tied up in adversarial litigation and time-consuming court delays.

Sifting through the evidence, one comes away generally impressed with the orderly and efficient manner in which Met State was closed. Although not all the participants and observers will agree with this general conclusion, the plain fact is that the closure was implemented with considerable success. Critics, like Philip Johnston, who served as secretary of human services under Governor Dukakis, charged that the hospital closings were entirely budget driven and had nothing to do with mental health. As he saw it, the outcome was the direct result of a coalition of strange political bedfellows, including the budget cutters and antihospital ideologues.[20] Other critics complained vociferously that many patients were transferred to facilities that did not provide the "equal or better" settings they had originally been promised.

As far as the media were concerned, the partisan *Boston Globe* directed the most fire at DMH in general and Commissioner Elias in particular. The agency also took a pounding from other media observers. Perhaps the most searing criticism was leveled by Mark Lecesse, the political editor of the *Boston Tab.* In an article titled "Too Much, Too Fast," he wrote:

> The Weld administration has spent three years closing state mental hospitals and farming out services to private contractors. It has cut the number of long-term patients in state mental hospitals nearly in half, and the toll on the mentally ill, especially children. has begun to show.[21]

Coupled with this barrage of criticism was the accusation that privatization amounted

to union busting and that Weld was hostile toward state employees. These explanations have some merit, yet they are not entirely convincing. Whatever the variance in opinions and perceptions, few informed observers could quarrel with the key fact that the Met State closing did work. It was a bold stroke well executed. Community involvement was as pivotal at Met State as it was at Danvers and Northampton.

What follows then, drawn from imperfect documentation and even more imperfect memory, is a plausible but not definitive reconstruction of the rise and fall of Metropolitan State Hospital. It traces the evolution of the mental health system in Massachusetts in terms of both history and policy. Successive sections characterize the economic and political environment in which the demise of the hospital took place. They treat the clinical, legal, human resources, and labor-relations constraints involved, as well as the political and personal agendas that influenced the decision. The last sections suggest reflectively what lessons there are for today. But the reader must remember that these conclusions are those of a political scientist, not a mental health professional.

The Policy Process and Bureaucratic Setting

In elaborating on the key features of the Massachusetts mental health care system, one observes that the bureaucracy is far more a life unto itself than even Max Weber imagined. In policy and organizational terms, it clearly qualifies as a complex system. Over time, the Department of Mental Health has evolved into an agency that sets policy and oversees program development. The state is the sole mental health authority, for there is no local or county mental health control as exists in other states. The central actors in DMH policymaking — politicians, administrators, and medical experts — provide most of the ideas for most of the strategy in the various phases of the process. It also features the involvement of the private sector in what is now known as public-private partnership. These attributes are on the rise.

While the DMH bureaucracy has a life of its own, it no longer operates as an autonomous line agency reporting directly to the governor as it once previously did. Thus, it has limited agency discretion. The statutory mission of DMH is broadly defined "to provide for services to citizens with long-term or serious mental illness, early and ongoing treatment of mental illness, and research into the causes of mental illness." The department also assumes responsibility for providing emergency services to adults, children, and adolescents who experience a psychiatric crisis and request assistance.

Back in April 1971, Governor Francis Sargent reorganized the executive branch of Massachusetts state government, creating a new super agency known as the Executive Office of Human Services. DMH, which was then responsible for both the mentally retarded and the mentally ill, was placed under its jurisdiction and budgetary control. As a result of this reorganization, the commissioner of mental health reports to the governor through the secretary of human services. To make things more complicated, mental health advocates, who tend to be adversarial, began using legal means to challenge the way in which DMH administered its facilities.

In 1972, Benjamin Ricci, an activist from Amherst, filed a class-action lawsuit against the department on behalf of a group of clients at the state school for the mentally retarded in Belchertown who were subjected to dreadful living conditions. The case of *Ricci v. Greenblatt* triggered other lawsuits that sought to hold DMH accountable for its alleged neglect and mistreatment of clients. Since the civil rights of the patients were involved, this litigation wound up in federal district court, where it was assigned to

federal judge Joseph Tauro. Subsuming all these issues under a consent degree, Tauro ordered certain improvements to be made at these institutions. Subsequently, in 1986, DMH was split into two separate agencies. The legislature created a new Department of Mental Retardation, which necessitated a parallel bureaucracy and parallel funding. After retaining jurisdiction of the case for twenty-one years, Tauro finally disengaged on May 25, 1993.

Operating under this structural fluidity, DMH no longer had exclusive command of its own turf. For example, the Department of Public Health is responsible for substance abuse, yet DMH treated many substance abusers. A web of intricate relationships — contracts, interagency agreements, intergovernmental grants — bind public and private agencies together in almost every important endeavor. It is under these policies and programs, which are multiagency, multigovernmental, and both public and private in character, that DMH administrators are frequently required to work with intervening elites. Functioning always under powerful political oversight, these women and men perform the critical role of turning simplistic and often contradictory policies into operational programs that the street-level bureaucracy can carry out.

Since its inception in 1938, the Department of Mental Health has functioned as a headquarters-field organization with its central office located at the state capital in Boston. In 1990 its field operations were divided into seven regions and twenty-four area offices, which were scattered across the state. Later that year commissioner Henry Tomes decided to reorganize the department with the intention of giving area directors more power and keeping case managers in area offices.[22] This decision was driven by budgetary and political constraints. To trim expenses in hard times, Tomes put a stop to the leasing of expensive area offices. With Medicaid picking up the cost, the state made a policy decision in 1990 to launch clozapine trials, for DMH wanted to make this new medication available to more patients. The advent of clozapine was expected to have a significant impact on the management of serious mental illness, and it was hoped it would help to reduce the future need for long inpatient stays.

As state employees, DMH personnel are part of the permanent civil service, working regular hours in regular places. Their behavior is governed by rules, regulations, and directives formulated at headquarters with the expectation of uniform responses in the field. Field actions, which are routinely reviewed at headquarters, can vary all the way from surreptitious evasion and outright obstructionism to enthusiastically embracing the opportunity to initiate reform. Beset by conflicting demands from the field, central office personnel have been known to distance themselves from area directors and hospital administrators, especially when trouble arises or policy initiatives go awry. In bureaucratic parlance, this difficult terrain is known as the quicksand of bureaucracy where the footing is slippery and at times treacherous.

Throughout its sixty-three-year history, Metropolitan State Hospital had operated as a site-specific organization where bureaucrats and clients coexisted with one another. Located off Trapelo Road in Waltham, it was run in 1990 by a chief operating officer and a staff of physicians, nurses, hospital attendants, social workers, security guards, and building managers. As one participant recalls, "Met State was a fiefdom in and of itself; it had its own rules and its own code of conduct."[23] Most of its employees worked in rotating shifts around the clock. The hospital was a highly labor-intensive enterprise that typically allocated about 85 percent of its budget to personnel. As Robert Wood explains,

> These organizations have visible physical structures in which "service-providers" and "service-receivers" live together continually or for a substantial portion of the day. There are aspects of communities here — entire cultures with mores and practices that are indigenous and with attitudes never described in manuals. They bear little resemblance to the offices of motor vehicle, employment, transportation, and economic development agencies. Nine to five is not the order of the day. Site-based organizations simply do not work according to the usual rules.[24]

Making the distinction between public and private hospitals is also useful. Perhaps the most notable example is McLean Hospital in Belmont. Located one mile from Met State, it is a teaching hospital that offers high-quality care, but serves a much different client population, a more affluent and less troublesome group than was likely to appear at Metropolitan State. Although McLean provides substantial free care, it admits those who are less disturbed and have the ability to pay. This practice is called creaming. By marked contrast, Met State accepted anyone who needed help regardless of individuals' financial circumstances. Its patients were among the most disturbed and the most vulnerable. Lacking medical insurance, they were unable to pay. That there are similarities and differences between public and private hospitals is hardly surprising, but the inequities are striking. All of which underscored the fact that there was a two-tier mental health system operating in Massachusetts, one for the rich and upper-middle class and one for the poor and dispossessed.[25]

The Evolution of the Mental Health System

It is important to examine how the state mental health system evolved. Historically, of course, Massachusetts has been in the vanguard of caring for the mentally ill, a pioneer in building a series of public asylums that became its trademark. From colonial times until the first quarter of the nineteenth century, the insane had been kept in local jails and county almshouses or with family and friends. Founded in 1830, under the leadership of Horace Mann, the first state mental hospital in America was built in Worcester on a site overlooking Lake Quinsigamond, opening in 1833. Administered by Samuel Woodward, its influential and well-respected superintendent, this hospital became a model for the rest of the nation to emulate. Originally designed to accommodate 120 patients, Worcester served three basic functions: treatment, custody, and social control. By 1850 it had more than 500 patients.[26]

It is well to remember that during the Jacksonian era the states did most of the governing in America. By contrast, the national government played a smaller role. The tradition of local autonomy, which began in colonial times, was strong in New England, and states' rights reached its zenith in the Civil War. Not since anti-Federalist days had the fervor of grassroots democracy and states' rights burned more brightly. Other states followed the lead of Massachusetts, and by 1844 eleven of the existing twenty-six states had public asylums.

In 1839 the city of Boston established its own asylum for the insane on 214 acres of prime land in Mattapan. This was a time when Irish immigrants arrived in Boston in great numbers. Strangers in a new land, mired in abject poverty, and devout in their Catholicism, these urban newcomers confronted a hostile environment. Fear and antipathy toward Irish Catholics had reached new heights in 1834 when an angry mob of nativists set fire to a convent in Charlestown, where Ursuline nuns ran a boarding

school for children. The intensity of hatred between Catholics and Protestants continued for generations as they fought over their ethnic and religious differences. The unprecedented flood of emigration from Ireland during the late 1840s and early 1850s shocked nativists even more as the Irish fled their famine-stricken homeland to escape the ravages and devastation of the "great hunger." Almost all these people were descended from families who had clung to their faith through centuries of persecution. Their lives were scarred by starvation and disease, humiliation, and brutal oppression at the hands of the British.[27] In antebellum Boston, the Irish underclass was despised and discriminated against as much as, if not more than, the black underclass. Abolitionists, who abhorred slavery, were caught up in their own moral self-righteousness and the glory of their cause.

In 1841 Dorothea Dix discovered widespread neglect and abuse of the mentally ill in Massachusetts. Starting in East Cambridge, she found them chained in jails and almshouses, locked in cellars, and isolated on farms. Appalled by what she saw, Dix spearheaded a personal crusade for their humane treatment. A social reformer with true grit and determination, she worked tirelessly in their behalf and lobbied the state legislature for expanded facilities and proper institutional care.[28] In Dix's time, psychiatrists and lay reformers believed that insanity was as curable as most other ailments. Confinement, they insisted, was not a punishment but a cure. Given the extent of medical knowledge in 1833, there was little to be done beyond the anticipated curative powers of the asylum. All these factors gave rise to the cult of curability.

Over the course of the next century, Massachusetts developed an elaborate network of public asylums. At the outset, the state and local governments shared responsibility for mental health. According to historical accounts, state funds were used to pay for the buildings and the superintendent's salary, but much of the financial burden remained at the local level. Counties, towns, and villages paid a per capita fee for their indigent patients, but local officials tended to be parsimonious. Most of the state hospitals were constructed during the second half of the nineteenth century, which was the heyday of the "moral treatment" movement. These lunatic asylums, as they were commonly known, came on line one at a time, each in response to a distinct need. Overcrowding at Worcester led to the creation of new asylums at Taunton in 1854 and Northampton in 1858. Each served a localized area but accepted patients from other parts of the state.

Upper-class Yankees, who were mostly Whigs and abolitionist Republicans, comprised the ruling elite. They sited these hospitals in quiet, rural farming towns where land was cheap, purposely separating them from the community. Such a serene and idyllic environment afforded patients plenty of fresh air and a retreat from the pressures of modern society while contributing to their physical health and vigor. The patients were sealed off from the outside world and wrapped in protective custody. Little thought was given to the stigma that such isolation and social exclusion imposed. Pejorative terms such as "lunatics," the "nut house," and "funny farms," were even more stigmatizing. The general public considered insanity a shameful form of deviance.[29] They viewed victims as social misfits.

Individual hospitals were operated independently by a board of lay trustees appointed by the governor. This made them accountable to the public, but the psychiatrists complained about lay control. The trustees hired superintendents to manage the asylums. Hundreds of employees were needed to staff the wards of these large hospitals and to maintain their physical plants. Most of the hired staff were native-born white Anglo-Saxon Protestants who lived on the hospital grounds in dormitories built for this pur-

pose. They usually managed to get their family members put on the payroll, and before long nepotism became rampant. Social and recreational activities were organized to promote staff morale. Interfaith and Catholic chapels for religious worship were eventually built on each campus. In many ways these asylums became self-contained communities that contributed to the local economy.

Much of the hospital land was used for farming. Patients were put to work tending the crops and large dairy herds. The revenues earned from the sale of such agricultural produce went to defray operating costs. Under the 1864–1885 superintendency of Pliny Earle, Northampton had the most efficient patient work program in the country. The hospital was virtually self-supporting. As historian Michael Moore observes:

> The patients were to receive humane and dignified treatment under the watchful eye and direct care of the superintendent, the doctor who attended to every medical and administrative detail of the hospital. Combined with regular physical and intellectual activity and a tightly regulated schedule, this system of "moral treatment" would lead the ill back to health. Both the location and the physical design of the buildings were intended to enhance the therapeutic effect of the hospital.[30]

During the late nineteenth century Massachusetts went from a largely rural and agricultural to a largely urban and industrial state. Its society was different in the Gilded Age, more diverse in its demographic pluralism and more demanding in the workplace. Up to that time most emigrants had come from the British Isles, France, Germany, and the Scandinavian countries. The diversity of emigration then began to change dramatically. By the 1890s the majority of emigrants were coming from southern and eastern Europe, from Italy, Hungary, Greece, and the Balkan countries as well as Poland, Lithuania, and Russia. They were recruited as a source of cheap labor to work in the textile mills, leather tanneries, and shoe factories. Their assimilation into the larger society was slow and painful. In the meantime, the downtrodden Irish, who suffered depression, anxiety, and distress, had filled the asylums. David Mechanic has described their plight in language worthy of lengthy quotation:

> The general contempt of Massachusetts society for the Irish immigrants, who constituted a growing proportion of the insane, led to increasing pressures on the mental hospital to take on many new patients. With the growing number of patients — the mass of them held in low esteem by the community as well as by mental hospital personnel — it was impossible to maintain the administrative and environmental attitudes necessary for moral treatment. Moreover, with a growing number of patients and limited resources, it was necessary to develop more efficient custodial attitudes and procedures. The contempt in which the hospital held its clients and the low social value accorded them by the society at large neither stimulated hospital administrators to demand greater resources to care for their patients nor encouraged the community to provide further and more intensive support.[31]

Whatever the difficulties, the incidence of mental illness was on the rise. Insanity was defined vaguely enough to permit egregious admissions. The wording of the law was so vague that it could be applied to persons whose real problems were poverty, homelessness, and physical disability. Under such conditions, unprecedented numbers of people were declared insane and confined to mental hospitals. The sheer magnitude of the problem resulted in overcrowded and understaffed asylums. Madness was growing at a rate much faster than society could cope with it.

Party politics and patronage also influenced the growth and expansion of asylums. Like other social control institutions, such as prisons and reformatories, public asylums were viewed as lucrative sources of jobs and contracts that party politicians could bestow as a reward to their loyal supporters. Steeped in this political culture, Massachusetts built several hospitals during the post–Civil War era. A palatial asylum designed and built on a grand scale was erected at Danvers on a hill overlooking the countryside. With iron bars placed across its windows, this facility was completed in 1878 at a cost of more than $1.5 million, an expenditure deemed extravagant at the time. Before the end of the century three other asylums appeared — at Westborough in 1886, Foxborough in 1893, and Medfield in 1896. These institutions made new spaces available and gave local officials a good excuse to redefine their senile poor as insane and shift the financial burden to the state.[32]

There were then 219 almshouses in Massachusetts, which were populated by the homeless poor, the disabled and drunkards, vagrants and common criminals, many of whom were immigrants. As reformers succeeded in closing these institutions, state asylums were forced to absorb increasing numbers of the aged poor. Almshouses at Bridgewater, Monson, and Tewksbury, established in the early 1850s, were converted into public asylums for the mentally ill and mentally retarded. Bridgewater became a prison hospital for the criminally insane. Operated as a maximum security prison, it now falls under the jurisdiction of the Department of Corrections.

These public asylums were overseen and inspected at least twice a year by a state Board of Health, Lunacy, and Charity, which was created in 1879. This agency was replaced in 1886 by the state Board of Lunacy and Charity, which in turn was replaced by the state Board of Insanity in 1898. Many reformers, who favored centralized administration of asylums, argued that they were vulnerable to patronage. Despite this concern, the asylums jealously guarded their local autonomy and enlisted important political support when a governor or a state agency threatened to tighten central control. When a serious threat to their independence arose, local officials could be expected to voice strong objections. With the Republicans securely in control of state politics, the asylum system increasingly served as a patronage vehicle for their party.

Expansion of the public asylums took place in close correlation with the rise of the Progressive movement. Since the medical profession claimed responsibility for treating insanity, citizen influence was only peripheral to the closed world of the asylum. To be sure, the doctors exercised absolute control, and the public came to accept a medical explanation of madness. John Sutton argues as follows:

> Late nineteenth-century policies toward the insane and the poor were premised on an ideology that portrayed social problems as fundamentally individual and moral in origin. Throughout the Progressive era, the imagery of Protestant moralism that underlay this ideology gradually gave way to a medical model of deviance, but the basic discourse of individualism remained intact.[33]

Given the state's expansion mode, another public asylum appeared at Gardner in 1901 at the dawn of the twentieth century. Three years later, in 1904, the state assumed full financial responsibility for care of the insane. As a result of this takeover, Massachusetts entered into negotiations with the city of Boston and purchased its municipal asylum in 1908 for the sum of $1 million. Seven years later, in 1915, yet another asylum appeared, this one at Grafton. It came on line when the nation witnessed the emergence

of the mental hygiene movement. Its proponents argued that mental illness could be eradicated through education in human relationships, but the millennium failed to arrive. In due course, moral treatment was replaced by a focus on the incurability of psychiatric disorders and the somatic basis of mental disease.

Research was a luxury that most mental institutions could not afford. The Boston Psychopathic Hospital was an exception. Established in 1912 as the research arm of Boston State Hospital, it sought to develop new medical approaches for combating mental illness. As a result, Boston soon became the mecca of psychiatry in America. While Boston State served the "incurable" of the day, the experimental Boston Psychopathic attempted to accommodate "incipient, acute, and curable insanity." This teaching and research center was renamed the Massachusetts Mental Health Center in 1956. On a smaller scale, a pathology laboratory was established at Westborough. It operated under the direction of Solomon Carter Fuller, a distinguished black neuropsychiatrist who conducted research on the biological influences of mental health.

Meanwhile Massachusetts, like the rest of the country, had swung from the conservatism of Grover Cleveland and William McKinley to the progressivism of Theodore Roosevelt and Woodrow Wilson and, in the 1920s, back to the conservatism of Calvin Coolidge and Herbert Hoover. At this time Metropolitan State appeared at Waltham, the last asylum to come on line. It was the biggest and most modern hospital in Massachusetts. Collectively, these thirteen state institutions functioned as an extended system that proved beneficial to all of the state's 351 cities and towns.[34]

As the years went on, the state hospitals gradually fell into a long, cold slide of decline, victims to circumstances largely beyond their control. Incremental decisions were being made which in the long run would have serious negative consequences. Eventually the system would break down, but long before reaching the point of collapse it found ways to correct itself. Operating on tight budgets, the hospitals struggled with fiscal problems, staff reductions, low morale, and the departure of clinicians. Continual turnover and staff burnout became a perennial problem. Party politics and patronage also contributed to their decline. While the Republicans continued to dominate state politics during the first half of the twentieth century, the construction and maintenance of asylums channeled state and local patronage to loyalists of both major parties.

Through the New Deal, the Fair Deal, and the Eisenhower administration, the public asylums became more custodial than therapeutic, dumping grounds for those afflicted with alcoholism, epilepsy, senility, and other chronic geriatric illnesses. Admitted and left to be forgotten, these people were consigned to living and dying in these instititions. As was true in other states, the asylums had become human storage bins that were abusive, uncaring, and unresponsive. In 1946 they were dubbed snake pits by Mary Jane Ward, who wrote a graphic, personal account of her incarceration in a state hospital. Her best-selling book, *The Snake Pit,* was made into a movie in 1948.

The demanding nature of care for the mentally ill, has always taken a toll among those who provide it, for they have found their jobs filled with stress and tension. They are constantly exposed to physical danger and assaults by violent patients. Says one observer,

> The state hospital was a hard place to work. Hospital workers provided care to many of the neediest members of society, people who often could get help nowhere else. They provided this care at a hospital that was constantly underfunded and over-

> crowded, as part of a system which often thwarted their best intentions. They endured the stigma that haunts the mentally ill in our society. Most of these employees were good and caring people who tried hard to help their patients.[35]

Although reformers persisted in their efforts to achieve greater centralized administration and control of the state hospitals, inevitably, the bureaucracy continued to evolve. In sparse outline, it passed through successive stages of evolution that witnessed the creation of a Commission of Mental Diseases in 1916, a Department of Mental Diseases in 1919, and finally a Department of Mental Health in 1938.[36] DMH's initial emphasis, then, was constricted. It stressed the overriding importance of state hospitals and the molding of people to fit the system rather than the search for alternatives. With the outbreak of World War II and the staffing shortages that resulted from emergency wartime mobilization, the major emphasis was placed on occupational rehabilitation. Psychia-trists in America played an important role in screening military recruits and in treating soldiers who broke down mentally under the prolonged stress of combat. After the war, the establishment of the National Institute of Mental Health in 1948 was a watershed event legitimating a new federal role in mental health.

The old pressures, already identified, returned to the 1950s agenda. Staff shortages continued to be a major problem. Because better-paying jobs were offered elsewhere, it became increasingly difficult to recruit and retain a reliable workforce. Replacements, while available, were not always of the best quality; many were untrained and unqualified. As more psychiatrists practiced privately to earn more income, they shunned work at state hospitals. Foreign physicians were hired to take their place. New pressures reinforced the old ones. Client admissions were again skyrocketing. Staff shortages led to mostly custodial care and very little treatment or therapy. As the system reached its peak capacity in 1955 with a combined census of more than 23,000 patients, the hospitals were in danger of being overwhelmed and imperiled by overcrowding. Influential reformers became increasingly disenchanted with the characteristically custodial institutions. The hospitals had become part of the problem rather than part of the solution.

In February 1955 Congress commissioned a study of the human and economic problems that emotionally disabled people faced and agreed to fund demonstration projects that sought to improve services. This study was conducted by the Joint Commission on Mental Illness and Health, a nonprofit corporation. Jack Ewalt, then commissioner of mental health in Massachusetts, served as its executive director. The report, *Action for Mental Health,* published in 1961, called for creating community mental health centers and reducing the size of state hospitals to no more than 1,000 beds. The report drew from the experiences at Worcester State Hospital with regard to patient reduction and outpatient and aftercare services. These new ideas were promoted by President John F. Kennedy, whose legislative initiative was enacted by Congress as the Community Mental Health Centers Act of 1963. Signing this statute shortly before his assassination. Kennedy declared, "The time has come for a bold new approach." Local services locally administered was identified as the bold new approach. The hope was that the large state hospitals would become a thing of the past. In 1964 Massachusetts produced its own report, "Strategies of Mental Health Change," which reiterated the theme that local care was the wave of the future. That goal was the central thrust of the ensuing law.

The System Disassembles

In 1966, when Republican John Volpe was governor, the state legislature passed the Comprehensive Mental Health and Retardation Act. This landmark legislation, Chapter 735, and subsequent program stemmed from the idea of creating community mental health centers. Venturing into this domain of still uncharted territory was a pioneering endeavor, for there were virtually no residential care or psychiatric day treatment programs available in Massachusetts. Central to this legislation was the concept of a service area, a designated geographical locale in which clients would receive coordinated services from various human service agencies. Chapter 735 divided the state into seven regions and forty area offices, each with its own citizens' advisory board. Citizen participation through a monitoring role was a major breakthrough of this adventure, analogous to the Great Society programs that called for greater citizen involvement.

In 1967 Governor Volpe appointed Milton Greenblatt, a man with impeccable credentials that satisfied demands for both professional achievement and administrative experience, as commissioner of mental health. A graduate of Harvard Medical School, Greenblatt had previously served as assistant director of the Mass. Mental Health Center and as superintendent of Boston State Hospital. The task of implementing the new statute and setting up citizen area boards fell to him. Soon to follow was the "unitization" of all state hospitals, a policy designed to give area directors clinical and administrative control of inpatient units. Unitization assigned patients to hospital wards by their community of origin. A shaky and unpredictable process, it at least linked inpatient care to a fledgling community-based service system.[37]

Almost simultaneously, the deinstitutionalization movement forced itself on the nation's agenda and captured public attention. This crusade launched a stinging counterattack on the efficacy of state hospitalization, which soon became a rallying cry for mental health champions across the country in the late sixties and throughout the seventies. This reform, fueled by federal money, was designed to place patients in community residences and halfway houses as an alternative to warehousing them in large custodial institutions. For at least a generation or two, the pressure to deinstitutionalize increased in almost all the states in the nation, but the pace was agonizingly slow in some of them.[38] If there was a social laboratory in which to test this reform, it was Massachusetts, for nowhere else was it advanced so vigorously.

In 1969 lieutenant governor Francis Sargent was thrust into the governor's office when John Volpe went to Washington to accept the cabinet post of secretary of transportation in the Nixon administration. After Sargent was elected to a full term as governor in 1970, his attention fell on reorganizing the executive branch, creating "super" agencies, and controlling the bureaucracy by political appointments that reached far down into the middle ranks of departments and agencies. He named Peter Goldmark as the first secretary of human services. One of Goldmark's objectives, shared by Sargent, was to move as many people as possible out of the large human service institutions and into smaller community facilities. Goldmark's strategy relied on forcing bureaucratic agencies to act by applying pressure from constituency groups at the grassroots level.

While this was going on, the state legislature amended Chapter 123 in 1970 to clarify hospital admissions and commitment policies. The law's provisions were changed to protect the civil liberties of mental patients and to prevent egregious admissions and un-

due incarceration. No longer could people be committed for mere vagrancy. Only those who were deemed a "danger to themselves and others" could be locked up involuntarily.

Whatever its merits, the Goldmark strategy of citizen participation ran directly counter to Greenblatt's philosophy of keeping the physicians on top as well as on tap. Perceived as a doctor's doctor, Greenblatt did not attempt to close any state hospitals. Reluctant to adapt to the shifting winds of political change, he maintained the status quo. Not surprisingly, the hospital superintendents, all psychiatrists, loved him, but this affection was not shared universally. Under fire from a citizens' task force on children out of school, Greenblatt stonewalled their efforts to monitor the implementation of Chapter 750. This law called for the delivery of mental health and educational services to emotionally disturbed youngsters who were most at risk and unable to function within a traditional public school. The children's task force was led by Hubie Jones, a black social worker and community activist who engaged the task force in public advocacy and confrontational politics.

After a series of disagreements on programs and policies and a steady drumbeat of criticism from citizen area boards and other constituency groups, Greenblatt crossed swords with Jones in a clash that became highly visible.[39] The commissioner was also called to task by the Lolas commission, which had investigated the deaths of four mentally retarded clients at Belchertown. Although an internal probe conducted by DMH absolved Greenblatt of any negligence in the matter, the Lolas commission found him partially responsible and therefore called for his resignation. These events led to his forced departure in December 1972. In her aptly titled book *Managing the State,* Martha Weinberg wrote, "Buffeted by a department that was changing rapidly but in no single clear direction, by new constituency groups with which he had few natural ties, and by a superior who wanted to move the department more quickly and in different directions than he did, Greenblatt left his post."[40]

The search for Greenblatt's successor produced a different atmosphere. Legislation was passed making the commissioner's appointment coterminous with the governor's incumbency, a move that was intended to assure greater accountability. To quote Weinberg again, "Pressure was also building to have a commissioner whose primary experience and training had been administrative and political rather than medical; and in the spring of 1973, as the search was being conducted, the General Court abolished the requirement that the commissioner be a board-certified psychiatrist."[41]

After a six-month search, Governor Sargent appointed William Goldman, a San Francisco psychiatrist, as commissioner of mental health. Sargent had heard Goldman speak at a governors conference in Colorado and was impressed by him. While Goldman had attended medical school in Boston, he had spent most of his career in California, where he had been director of a community mental health center and a leader in the national movement to establish more such facilities. Goldman, realizing that Massachusetts was far behind other states in obtaining its share of federal funds, brought with him fellow Californian Edward Sarsfield, who was placed in charge of federal relations. Sarsfield knew which kind of programs qualified for federal assistance.

Ambitious, energetic, and often abrasive, Goldman was a social change agent extraordinary, and accordingly his actions deeply affected DMH. He set a new tone as well as a new direction for the department by allowing the citizen area boards to participate in the budget process and by refusing to curry favor with the medical establishment, which was viewed as a sacred cow. The direct opposite of Greenblatt, he saw doctors as stubborn resisters of change and impediments to new policies. Goldman infu-

riated them by refusing to fund psychiatric residencies at many of the affiliated university hospitals and clinics;[42] he also prohibited psychiatrists who were on the state payroll from working more than half time at their private practice.

A complex and controversial personality, Goldman knew where he wanted to go and didn't mind stepping on sensitive toes and running roughshod over people in order to get there. In a personal interview, he candidly revealed his style and strategy as a public person.

> What this department needs is unambiguous authority. Nobody knew what the hell they were supposed to be doing. I can't promise that I have the right answers, but at least I could give some leadership to people who didn't know where to turn. I wanted to establish that the citizens were going to have some control over the department and that there was nothing sacrosanct about the medical community. I don't go in for the consensus mentality which has dominated this department for years. It's fine if you don't intend to do anything, but by pursuing a consensus you lose years. It's better to let everybody know where you stand and to shove yourself and the department out onto the firing line. Everybody here is desperate to have somebody to follow. That's the only way to manage this department — by leading it.[43]

Goldman was the original architect of closing hospitals, and under his leadership DMH began disassembling the system. Of the eleven state hospitals still in operation, three were closed within a span of three years. In 1973 Grafton was the first to be shut down, in 1974 Gardner was closed, and in 1975 Foxborough followed suit. These were the so-called snake pits, but they were hardly the worst.[44] Most of their clients were transferred to other state hospitals. No money was saved in closing Grafton, but the state did manage to save $5 million in closing Gardner. These savings were immediately put into community programs, which was no small accomplishment. The first round of hospital closings broke new ground and paved the way for subsequent closures.

As a result of these events and initiatives, the Massachusetts inpatient population declined steadily. Between 1960 and 1972 the combined census was dramatically reduced from 23,000 to 9,800 patients. At the end of 1975, 4,876 people were in state mental hospitals. Dependency on these institutions had become the lowest of any eastern state. As hospitals continued to empty their wards throughout the seventies and early eighties, the total figure was reduced to 2,950 by 1984, 23 percent of what it had been in 1955. Such a large-scale reduction was spurred by new psychotropic drugs and the infusion of federal Medicare and Medicaid funds. Many of those discharged during this period were elderly patients who were placed in nursing and rest homes. Times had changed, and federal intervention was critical. This reform set the stage for the events that followed.

Recalcitrant Institutions Dragged into Court

Michael Dukakis was first elected governor in November 1974. His upset victory over incumbent Francis Sargent had been too narrow and the campaign too publicly divisive for him not to appoint men and women of substance and ideas. During the campaign Dukakis had attacked Sargent for mishandling the Russell Daniels case. A former patient at Belchertown, Daniels had been convicted and sent to Norfolk prison for murdering an eighty-three-year-old woman. Advocates argued that his confession had

been coerced and signed without legal counsel. In another campaign matter, the Massachusetts Psychiatric Association had endorsed Dukakis on the condition that Commissioner Goldman must go. This was the context in which the governor entered office and found a sizable fiscal deficit awaiting him. When he appointed Lucy Benson as secretary of human services, she refused to meet with Goldman, a Sargent holdover, who had put together a package of new ideas for her. Soon afterward Goldman was fired, presumably for referring publicly to Dukakis's policies as neo-Nazi.

Lee Macht, who had been director of a community mental health center in Cambridge, was brought in to replace Goldman for a brief stint as interim commissioner. Picking up where Goldman left off, Macht oversaw the closing of Foxborough State Hospital, which was accomplished in an orderly and well-structured manner. Robert Kaplan, the regional administrator, was able to reach an agreement with the public employee unions that made jobs available to their members at state institutions within twenty-five miles of Foxborough. This agreement went a long way toward assuring union cooperation.

In 1975 Massachusetts, with the second highest unemployment rate in the country and the largest state deficit, faced its continuing unemployment problem. Confronted with the difficulties posed by urban minority populations and challenged by well-organized state employee unions, liberal-minded public officials had responded to their demands at a level that tax revenues could not support. Many people feared that Massachusetts was becoming a welfare magnet. Social demographics were changing rapidly as the newest wave of urban immigrants arrived in the state. Blacks, Hispanics, and Asians had come to the Bay State seeking the same economic opportunities that had attracted the struggling European immigrants two or three generations earlier.

As people of color, they met with racism and bigotry, but their demands for accommodation were more far-reaching and more expensive than the European immigrants'. Marching under the banner of civil rights and affirmative action, they demanded decent housing, better jobs, and integrated schools. After nearly a decade of political and legal battles, reflecting more than a century of stored-up fears and antagonisms, desegregation came to the Boston public schools. The tensions brought to the surface by court-ordered busing exploded into racial violence in September 1974.

Brought up short by the deficit and inflation, Dukakis made deep budget cuts and reduced spending on welfare entitlements and social services. He applied a "meat cleaver" to bring the budget under control. State spending for public higher education was greatly reduced. Although economic factors prompted this action, it had political repercussions. To the extent that minorities represented a growing political force, first in urban and then in state politics, they created a countervailing response to Dukakis's effort to reduce spending. Political responsiveness to group pressures remained the norm, but the traditional sources of patronage had not disappeared.

Cross-pressured, the governor incurred the wrath of prominent liberal Democrats and human service providers, who were clearly estranged. The chasm between them became wide and deep. For purposes of Dukakis's first term, their political support was critical, but it was strained to the breaking point. Barney Frank, a liberal Democrat, openly attacked the governor as a "perfect political ingrate." To add to Dukakis's fiscal woes, the energy crisis and the Arab oil embargo set off a new scramble for scarce public resources, while the previously secure world of state administrators was invaded by the third branch of government, the judiciary. The threat to mental health programs across the state was real.

Advocates began to stir up trouble, using legal means to bring the Department of Mental Health to the bar of justice. A new breed of lawyers, spawned during the civil rights movement and the halcyon days of the Great Society, came to fashion complicated remedies intruding on the most detailed practices of state administrators. They sought to advance the rights of mental patients and to disclose the widespread deficiencies in the system. For instance, Frederick Wiseman produced the 1967 documentary film *Titicut Follies*, which revealed the horrible conditions at Bridgewater State Hospital and sent shock waves throughout Massachusetts. Initially sealed by the courts, it was subsequently released, but only after advocates began court proceedings to allow it to be shown to the general public. Even so, the state Supreme Judicial Court limited the viewing audience and conditions under which it could be screened.[45]

Activists continued to disclose that the Massachusetts mental health system was fraught with abuses, neglect, filthy and unsafe conditions, and mismanagement on a systemwide scale. Slapped with a class-action lawsuit in 1976, state officials at Northampton State Hospital were hauled into court. In the famous case *Brewster v. Dukakis*, the plaintiffs charged that they had a legal right to psychiatric treatment in a less restrictive setting than a state hospital and, conversely, that the state had an obligation to provide such a treatment setting. A similar fate befell the schools for the mentally retarded at Belchertown, Fernald in Waltham, and Monson, which allowed their clients to live in squalor. These recalcitrant institutions had to be dragged unwillingly into court before they would do anything to improve the despicable conditions that prevailed. The consent decree was the preferred instrument of judicial intervention. In effect, the courts became the administrators. The world of mental health practice was becoming more complex.

After Foxborough was closed, Lee Macht stepped down as commissioner. Dukakis replaced him with Robert Okin, who was strongly committed to community mental health services. Only thirty-three years old, Okin had served as commissioner in Vermont from 1973 to 1975. Prior to that, he had been a consultant to the Boston regional office of the National Institute of Mental Health. Completely different in style and strategy, Okin was a dedicated, hard-working, and driven administrator who recognized that the care of psychiatric patients needed to be further brought into the mainstream. Psychiatry was still outside the realm of other medicine. Realizing that the system was broken, Okin declared that his goal was to close all the state hospitals and single-mindedly went about creating such change. No one tested the limits of deinstitutionalization more than he. What Okin understood well, but did not acknowledge, was that the cities and towns were ill prepared to receive such a massive exodus.

A commissioner with a compelling vision, Okin foresaw the day when mental illness would be treated not within state hospitals but within private general hospitals. In this context, he was a true visionary and a forerunner to privatization. For the time being, however, Okin insisted that community services take precedence over everything else. As he told one colleague, "I would rather see mental patients eating out of garbage cans in the streets than to see them endure the miserable conditions on the back wards."[46] Believing that the systemic problems could not be fixed until the hospital function was placed elsewhere in the mental health delivery system, he was adamant that state employees not be allowed to move into community settings or private group homes. The commissioner felt that they were trapped in the same institutional mind-set as the patients.

As a zealous reformer obsessed with his vision, Okin pushed vigorously to advance

the cause, putting intense pressure on the regional administrators to scale down the hospitals. Caught in the middle, they were viewed as the enemy by both the hospital superintendents and the unions. Here the state missed a rare opportunity on Okin's watch. DMH could have reached an agreement with the unions but failed to do so. Union officials were apparently willing to help the state downsize and close its hospitals, provided that their members would be assured jobs in group homes. That proposal was on the table, but the state never acted on it. This intransigence at the bargaining table resulted in an unfortunate standoff.[47]

Metropolitan State Hospital was supposed to be closed in 1978, but that did not happen. The plan was for McLean Hospital to replace Met State in terms of acute and long-term care, but the Public Health Council turned down the plan.[48] Meanwhile, the eight remaining state hospitals continued to decline and decay, becoming little more than holding cages for the acutely and chronically insane. All eight were guilty of flagrant neglect and harm to nearly helpless people. The back wards were filthy and appallingly inhumane. Patients were not only stripped of their self-esteem and human dignity, but the restive and unruly ones were forcibly placed in seclusion and mechanical restraints, some forced to take medication against their will. Grim stories about physical and sexual abuse abounded. Hospital attendants often played mind games with patients by threatening to send them to Bridgewater with the criminally insane if they acted up or otherwise caused trouble. Since the law called for strict security, this kind of intimidation and cruelty was no idle threat.

As Dukakis came to the end of his first term in 1978, he was unable to patch up the differences and bitter feelings that split the Democratic Party into warring factions. Seizing the opportunity to take advantage of the split in the ranks of the Democrats, Edward King, a conservative Irish Democrat and former director of the Massachusetts Port Authority, challenged Dukakis in a party primary. By appealing to disaffected Democrats, King scored a stunning upset victory and went on to win the governorship in the general election.

A few weeks later, in December 1978, the state and the plaintiffs, who had been engaged in the *Brewster* case for the past two years, entered into what became known as the Northampton consent decree. It mandated that "clients were entitled to live in the least restrictive, most normal residential alternatives and to receive appropriate treatment, training, and support suited to their individual needs."[49] This decree buoyed Okin's prospects. Some colleagues suspected Okin of playing a double-agent role in aiding and abetting this litigation. In truth, he supported the consent decree.

Governor King reappointed Okin as commissioner on February 5, 1979. Measured by federal standards, Northampton was not the worst mental hospital. That dubious distinction belonged to Boston State Hospital, which housed 3,600 patients as late as 1964, when it was considered a disaster. The hospital was slated to be closed in 1975. In fact, some 100 geriatric patients were transferred to Lemuel Shattuck Public Health Hospital in 1976. But this phasedown proved to be politically sensitive and unacceptable to the community, so Okin was forced to back off. He subsequently accelerated the pace of deinstitutionalization. In March 1981 the average daily census at Boston State had dwindled to 147 patients, and, after its 142 years of operation, Gerard O'Connor, its superintendent, closed this venerable institution.

At this juncture Okin left DMH to accept a job as chief of psychiatry at San Francisco General Hospital. By this time he had become too expensive for the King admin-

istration, which was not committed to a vision of community services. Among his many talents, Okin had the ability to go to the legislature to get the money he needed. Upset by the budgetary implications, King no longer desired to keep such an independent commissioner. Okin had obviously worn out his welcome.

On April 7, 1981, King appointed Mark Mills to fill the vacancy. Mills, who had served as chief executive of the Mass. Mental Health Center, took the job as a stepping-stone. Before his last position, he had been chief resident in psychiatry at the Veterans Administration Hospital in Palo Alto. He held a law degree from Harvard Law School and a medical degree from Stanford University, an educational background that equipped him to handle his new job, but during his two-year tenure few if any significant ideas were transformed into policy. Some colleagues viewed Mills as being too narcissistic to accomplish much of anything. He defended the practice of DMH clinical personnel working part time in community clinics. The state Ethics Commission had ruled that such a practice was in violation of the conflict-of-interest laws.[50]

In December 1979 Okin had appointed a blue-ribbon commission to examine the state of Massachusetts mental health services and project what lay ahead. After seventeen months of studying the vexing problem, this group released its report "Mental Health Crossroads" in May 1981, a month after Mills had come aboard. The commission set out its suggestions as to the way forward. Some of the lines in this report read like prophecies. Echoing Okin's sentiments, the commission recommended closing all state hospitals, but nothing came of its report, for good reason.[51]

The Department of Mental Health was then engaged in political battles over funding on Beacon Hill. The beleaguered department came under increasing attack as the largest and most poorly managed state agency. By his own admission, Mills publicly acknowledged in 1981 that no one knew exactly how many employees the department had on its payroll. Management weaknesses were glaring. As a complacent bureaucracy, DMH lacked standards of accountability as well as standards for assuring quality care. There were few if any incentives for personnel to perform well. The department suffered from poor staff recruitment and training as well as the inability to transform new ideas into workable programs. Along with this complacency came an unwillingness to admit mistakes and take corrective action. All these signs were indicative of a public agency that had lost its sense of mission, confused its priorities, and forgotten the public it was supposed to serve.

Clearly, DMH was an agency in continual disarray and turmoil. Its administrators were taking a beating not only from legislators, but also from advocates and unions, which became obstreperous and obstructive. DMH was beset on all sides. Proposition 2½, which limited local taxation, was causing problems in public finance at the municipal level. The politicians on Beacon Hill were taking public money away from state agencies in order to finance local aid. Between 1981 and 1982 DMH lost 1,200 positions. During the remainder of the King administration, the agency behaved in self-serving and protective ways. Hunkering down to a siege mentality, it stonewalled not only advocates but also compliance with the court-ordered consent decrees.

Amid the swirl of this turbulence, employees at several state hospitals went out on strike in 1982 to protest their low pay and poor working conditions. Faced with a crisis situation, Governor King mobilized the National Guard and sent state troops to run the hospitals. In the fall of 1982 King turned out to be a one-term leader — Dukakis defeated King in a much heralded intraparty rematch and recaptured the governorship.

What Went Wrong?

Anticipating the consequences of any policy is always difficult at best — new ideas are not easily translated into policy. Policymakers usually land in trouble if they do not portray reality or identify correctly the attributes of a problem and the options for its resolution. In essence, this is what happened in Massachusetts. Moreover, the reformers seriously underestimated the economic and political power needed to close hospitals like Northampton and Boston State.[52]

Without going into the horrors of what one finds inside the walls of a state hospital, suffice it to say that it is not a pretty picture. Only those who have endured such experiences or seen what goes on can describe the reality of such an institution. The cruel and sadistic treatment therein was vividly portrayed in Ken Kesey's book and movie *One Flew over the Cuckoo's Nest.* Unitization was supposed to have corrected these abuses, but they still persisted. Despite the similarity of all mental hospital experiences in their broadest outlines, each carries its own daily agonies with occasional small triumphs.

Displeasure with the mental health system was widespread at the end of the seventies. The recurring public outcry for better treatment grew louder and more persistent. Administrators such as Rae O'Leary, who had spent most of their careers in state hospitals, were thrust into crisis management. O'Leary's experience was typical for many, who ended up frustrated and angry. O'Leary expressed her anger by saying, "Conditions were so horrible in these hellholes that they should have been blown up."[53] Barbara Hoffman, who began her career as a hospital attendant at Met State in 1956, was somewhat more philosophical. Interviewed by Okin for the job of regional administrator in 1978, she told him, "I hope to see daisies growing on the hill where Met State stood."[54] When she ended that career in 1986, Hoffman had seen eleven commissioners come and go, but Met State remained standing. The average tenure for a mental health commissioner nationwide was eighteen months.

After years of neglect, the aging infrastructure at Danvers State Hospital was crumbling. Although most of its older buildings had been condemned and were no longer in use, the hospital stood, in the words of one newspaper reporter, as "a monument to society's neglect of the mentally ill."[55] Much the same could be said for the rest of them, which symbolized the politics of evasion and the decaying status quo. To record the substantial decline of these institutions is not to suggest that they had outlived their usefulness or that disaster befell the commonwealth. Bad and ragged as it was, the system was better than nothing. At rock bottom the state hospitals provided support of last resort for the indigent mentally ill — there was no place else for them to go. This conundrum, which lay at the heart of the policy paradox, explains in large measure why Dukakis did not try very hard to close them.

Deinstitutionalization may have been a sound concept, but it was a policy almost bound to backfire, for the consequences of its implementation on community life were not anticipated. Because of poor planning and inadequate funding, the Department of Mental Health lacked the necessary resources to handle such a wholesale discharge of patients. It presented the classic dilemma between need and capability. As a consequence, the policy was implemented untested and irresponsibly. Most patients were literally dumped into the streets, where they roamed hungry and ragged and slipped through the cracks in the system. Without the necessary community infrastructure, the reform was doomed to failure. Small wonder that the policy resulted in chaos and ambiguity.[56]

Left to fend for themselves, the ex-patients were too disoriented and too confused to make their way through the maze of public bureaucracies to get the help they needed. For the most part they tended to cluster in urban centers where, in Massachusetts, an estimated 1,500 and 3,600 mentally ill persons — no one knew the exact figure — ended up homeless. Some found lodging in local jails, in general hospital emergency rooms, and in rundown tenements and shabby rooming houses. Others slept in street store entrances or in homeless shelters like the Pine Street Inn in Boston. Still others wound up back in the revolving door of state hospitals. Under these circumstances, the end result was bound to be disappointing. To this day Robert Okin firmly believes that deinstitutionalization did not fail. On the contrary, he contends that it was never given a real chance to succeed. Okin's argument may find favor in academic circles, but not in government.[57]

Some programs survived to prove themselves in the eighties, but the Reagan administration used block grants mainly to combat drug abuse. The federal government continued to provide planning grants to states for community mental health services but virtually abandoned direct funding of services. By 1983 there were only ten community mental health centers operating in all of Massachusetts. Most areas of the state had psychiatric day and residential programs, but these were always filled to capacity with waiting lists for admission. Community opposition was a major obstacle to supported residential sitings. Residents, who were eager to maintain property values, recognized the problems of the mentally impaired but insisted that the solution should lie somewhere else, not in their neighborhoods. These frequently voiced protests became known as the NIMBY — not in my backyard — syndrome. By default, DMH left it to the homeless shelters to provide for those who resisted conventional treatment and wandered the streets. While some general hospitals had psychiatric units, only voluntary patients were admitted.

Once More into the Breach

At the beginning of his second term as governor, Michael Dukakis appointed Manuel Carballo as human services secretary. Severely criticized in his first term for not appointing people who had made a campaign contribution, Dukakis was not about to repeat that mistake. Carballo, who had unimpeded access to the governor, started searching for a replacement for Mark Mills. Both he and Dukakis wanted a manager. In February 1983 Carballo told the press, "We need someone able to manage an agency that has lost a sense of direction and has been subject to a great deal of criticism."[58] Seven people, not one of whom was a physician, were under consideration for the position. As Miles Shore, a psychiatrist at the Mass. Mental Health Center, wryly observed, "The commissioner should have real experience in public administration to rebuild the department. To have someone identified with program development would send the wrong message for these times."[59]

Five months later Dukakis had decided that James Callahan met the requirements and appointed him to the post in May 1983. Callahan, the first nonpsychiatrist to hold the position, was a capable and articulate administrator. He had previously managed two public health facilities, Lemuel Shattuck Hospital in Jamaica Plain and the Massachusetts Hospital School in Canton and served as secretary of elder affairs in the first Dukakis administration. The governor, along with his top aides, distrusted the department as an inept and clumsy bureaucracy, considering it weak and ineffectual. He suggested that Callahan might want to clean house.

On November 10, 1983, in an effort to shake up the agency, Callahan fired three assistant commissioners and seven regional administrators. This famous incident involving four women and six men became known as bloody Thursday. Robert Porter, the chief operating officer, gave the dismissal order, which no one had anticipated, for it was shrouded in utmost secrecy in a department known for its leaks. By clearing out the old and bringing in new blood, Callahan could start with a fresh slate.[60]

Insiders felt that the ten administrators were unfairly scapegoated. They saw their firings as a ploy to divert public attention from the strains of the system, when in fact, after a decade of huge expenditures, the Dukakis regime refused to pour any more money into deinstitutionalization.[61] Ironically, two of those dismissed went on to become mental health commissioners in other states. Donna Mauch, who had served as assistant commissioner from 1981 to 1983, became commissioner in Rhode Island, and Michael Hogan, following a similar route, became commissioner first in Connecticut and subsequently in Ohio.

A few weeks after this incident, the state Supreme Judicial Court ruled in *Rogers v. Okin* that patients committed to mental hospitals have a fundamental right to refuse treatment with mind-altering drugs, or if not mentally competent to speak for themselves, to have a judge make that decision for them. The case had been brought on behalf of Ruby Rogers and six other patients at Boston State Hospital. Originally filed in 1975, it was a landmark battle that had gone all the way from the federal district court in Boston to the First Circuit Court of Appeals and then to the U.S. Supreme Court, where it was remanded for state adjudication.

Justice Ruth Abrams, who wrote the unanimous decision, declared: "The doctors who are attempting to treat as well as maintain order in the hospital have interests in conflict with those of their patients who may wish to avoid medication."[62] Psychiatrists attacked the decision as an unwarranted intrusion by the courts into medical decision making that would render access to treatment more difficult for the most seriously ill. Advocacy groups were delighted with the court ruling because it gave patients a choice.

A series of unhappy events combined to dramatize the housing problem that former patients faced in Massachusetts. Sadly, tragedy struck three times within a relatively short time. In June 1981, Cookie Wilson, a mentally ill woman, died as fire engulfed an abandoned town house in Boston where she was spending the night. Two rooming house fires, one in Worcester on April 19, 1983, and the other in Beverly on July 4, 1984, claimed the lives of fourteen clients. These tragedies sparked a legislative investigation and focused media attention on their plight.[63] The ensuing publicity raised the level of public awareness.

So the pressure built within the Dukakis administration, and with notable public support and debate, to improve the mental health system. When Manny Carballo died in late January 1984, Dukakis appointed Philip Johnston to replace him as human services secretary. A liberal and compassionate Democrat, Johnston was a former state legislator who had once worked as a hospital attendant at Northampton. He saw mental health as "one big hole that needed to be reformed."[64] Dukakis and Johnston each had a personal stake in the issue, since both their families had been touched by mental illness. Both felt that the policy of deinstitutionalization had gone too far. They saw the possibility of midcourse corrections and changes in Dukakis's second term, but before they could do anything, they first had to organize for political action.

In August 1985 Edward Murphy was brought over from the Department of Youth

Services to replace Commissioner Callahan, who returned to his academic duties at Brandeis. Although Murphy came from a criminal justice background, he had a reputation as a strong manager. Before leaving office, Callahan warned against any move toward reestablishing large hospitals to warehouse people.

Consensus on the future direction of mental health was hard to achieve. From Johnston's perspective, a war had been waged for the past twenty years over whether to pour more money into hospitals or to put it into community services. Based on the incidence of mental illness, Johnston wanted to know how many state hospital beds would be necessary to solve the problem. This number, in his judgment, had to be defensible. The scale of the problem he had identified and probed clearly required 2,150 beds.[65]

Not coincidentally, policy control remained securely in the governor's office. Catherine Dunham, the executive director of the Massachusetts Council of Human Services Providers, was brought in to replace Johnston as Dukakis's human services policy adviser. Having started her career as a teacher in a reform school, she was pro-deinstitutionalization and highly regarded by service providers. Dunham was expected to build bridges with the provider community. Amid this flurry of activity, Jean Dietz of the *Boston Globe* and other media observers had failed to note the critical element of power signified by these personnel assignments.

By 1985 the Dukakis administration was committed to a gubernatorial message on mental health reform. It began with an initiative known as the Mental Health Action Project, which brought together a broad coalition of policy advocates. A covey of medical experts, departmental specialists, and constituency group leaders appeared on its steering committee. It was an impressive working group whose thirteen members came from a variety of perspectives and posts. Anita Pyatt, who headed the state Alliance for the Mentally Ill, took a lead position. She persuaded the steering committee to endorse the idea of using vacant state land for establishing therapeutic communities and assisted housing for the mentally ill. This would enable them to live independently and alleviate the burden of aging parents faced with having to care for them. After much debate on the efficacy of the programs of the seventies, a consensus emerged in shaping the policy agenda. The technique yielded a written document as a departure point for subsequent discussions with the governor.[66]

Major improvements were to be made at the seven state hospitals. The goal of DMH was to bring them up to the standards of the Joint Commission on Accreditation of Healthcare Organizations for purposes of approval. Metropolitan, Taunton, Worcester, and Westborough were targeted to become regional specialized care facilities that would provide long-term inpatient and quarter-way residential services for clients with a variety of clinical needs. A battery of suggestions emerged from the meetings of the steering committee. Essentially, their work resulted in three major policy proposals: (l) a capital outlay program; (2) a quadrupling of housing units; and (3) a package of community living and treatment options. They submitted their recommendations to the governor in late November 1985.[67]

Dukakis was in western Massachusetts on December 19 and then flew by helicopter to Met State, where he delivered his special message, a propitious event in terms of both timing and location. The governor called for a five-year plan designed to renovate and refurbish the existing hospitals and to overhaul the outpatient care system. He saw the problem as one that had been deteriorating for decades and was sure to become worse if ignored. Only a massive infusion of money and new construction would

suffice. With a soul-searching review of successes and failures, Dukakis declared:

> We are painfully aware the system of care envisioned in 1966 is not yet fully developed. Many areas of the Commonwealth lack emergency screening and crisis services; housing opportunities for chronically mentally ill persons remain extremely limited; and little support is provided for families caring for mentally ill relatives. Hospital care for those needing acute or long-term psychiatric treatment does not in many cases meet even marginally acceptable standards. We are all well aware of the tragic plight of homeless mentally ill.[68]

Dukakis's speech, so typical of him, was objective, detached, and measured and clearly the result of long reflection. It boosted the morale of those who labored anonymously in the field of mental health. The governor bestowed on them the public recognition and appreciation that was long overdue. George Sigel, the medical director at Met State, who had served on the steering committee, was more than pleased. His reaction could be noted in the press. "We are overcrowded and operating at two-thirds of the staff we need. The hospitals have been neglected. This is the first expression the work we do is of value there has been in years."[69]

Dukakis was then riding the crest of his power and popularity in Massachusetts. In 1986 he was easily reelected to a third term as governor with an overwhelming majority. He had the best of both worlds. With a prosperous state economy, there was plenty of money to go around and no reason to rock the boat. Presidential ambitions may have made him more accessible to group pressures. In any event, a master plan for each state hospital was developed during 1986 and the first phase of improvements actually began. For instance, the boilers and oil pumps at Met State were replaced. Systemwide improvements were to be completed over the next five to seven years. In order to expedite the planning and design review process for hospital renovations and new construction, a waiver of the determination of need certification was obtained.

But financial and political constraints prevented Dukakis from delivering on the recommendations. Three factors doomed his revitalization efforts. First, wrangling over the proposed plan of state representative Angelo Scaccia to redevelop Boston State Hospital hurt badly. Chapter 579, which mandated the process for disposition of surplus property, required the participation of local officials and citizens from the communities in which the vacant land was located. In this case, the citizens' advisory committee got bogged down in petty squabbles and could not put its act together. Second, legislative inertia caused considerable delay and inaction. Stalled for two years in the General Court, the $340-million capital appropriation was not passed until the spring of 1987. Third, and by far the most crippling blow, the state economy suddenly went from boom to bust.

In 1987, when the state economy was still booming, Dukakis decided to run for president largely on the strength of the Massachusetts "miracle." The governor not only lost his ill-fated presidential campaign in November 1988, but George Bush's attacks on his record damaged his reputation as an efficient manager. Then the climate changed as the state's inflated economy began faltering. Tax revenues fell well below projections. Hard pressed for resources, the state raised taxes and cut services. Johnston was forced to make budget cuts totaling $1 billion and to eliminate 5,000 human services positions from a base of 30,000 jobs. Bowing to reality, the governor abandoned the struggle. As Johnston recalled, "We were barely under way when the bottom dropped out of the Massachusetts economy and our project was stopped in its tracks."[70]

Despite his public pronouncements, Dukakis was unable to deliver. Curiously, the human services community did not attack him the way it had done during his first term — this was no time for recriminations. Motivated by a desire to cast himself in a favorable light, Dukakis was eager to maintain a liberal image in his search for higher public office. Disagreements and disappointments were papered over in the interests of party politics. The truth is that neither the governor nor family members wanted to close any more hospitals.

Although a cadre of distinguished people was actively involved in the Dukakis administration, ideologues came to the fore in policy matters. In May 1988, at the height of the presidential primaries, the Department of Mental Health joined forces with the state Alliance for the Mentally Ill in promoting an antistigma campaign. As its central theme, this campaign sought to prevent the need for isolating mental patients from the community, an issue on which the governor and the antistigma ideologues parted company. The latter viewed him as trying to rebuild the institutional settings that had created the problem in the first place. After the failure of the Mental Health Action Project, the promising coalition of citizens, politicians, administrators, and experts broke apart. The steering committee dissolved and the impact of its ideas on mental health policy was negligible.

The History of Metropolitan State Hospital before Closure

Now let us turn to a brief chronicled history of Metropolitan State Hospital. In 1927, two years before the Great Depression began, state officials purchased 378 acres of pristine farmland in the western suburbs of Boston. This property, then valued at $68,922, intersected the municipal boundary lines of Belmont, Lexington, and Waltham when these suburbs were quiet farming communities. The rural landscape contained rolling hills, woods, and streams. Stone walls that once formed boundaries between farms still remain with their symmetry and beauty. It was typical New England countryside out in the boondocks. Under construction from 1927 to 1935, the sprawling hospital complex took eight years to build at a cost of $1.8 million. Some of the work in the later stages was done by the Works Progress Administration. At the time it was considered the most modern mental health facility in the nation.

Groundbreaking for the administration building took place on December 27, 1927. Two years later, on December 26, 1929, the first thirty-six patients were transferred from Grafton State Hospital to Met State, whose official opening was celebrated on October 29, 1930. Among the dignitaries on hand for this occasion were acting superintendent Clifford Moore, Governor Frank Allen, and former Governor Alvan T. Fuller, the latter two governors stalwart Republicans. This was a transition year that marked the end of the old political order and the coming of the New Deal in Massachusetts. Democrat Joseph Ely was elected governor in 1930. Yankee hegemony was beginning to give way to the Irish political ascendancy, though the Republicans still dominated the state legislature. Irish Democrats like James Michael Curley and Charles Hurley soon followed Ely into the governor's office.

The original group of seventeen buildings that comprised Met State included the medical-surgical building with its dome top and six patient living areas, which was not completed until 1935; the service and cafeteria building where food was prepared and served; the continuous treatment group (CTG) building for patients; and two large em-

ployee dormitories. The heating plant, originally fueled by coal, was later converted to fuel oil. An elaborate system of underground tunnels, which ran beneath all these buildings, carried the steam lines, enabling employees to travel from one building to another during inclement weather and to transport food the same way. The Furcolo building, named for the deceased wife of a sitting governor, was added in 1957. There were two single-sex admission wards, one for women and the other for men. Chronic patients were sent to the back wards. Met State was a hospital within a hospital, treating patients with both mental health and general health care.

The massive CTG building provided eight wings of patient accommodations connected by a continuous circular corridor. Each wing had three wards, a total of twenty-four, which were lettered alphabetically. At the center of the complex was a secure courtyard, used for recreational purposes, whose orientation provided significant advantages to the patients and staff with controlled access to all parts of the facility. The individual wings afforded each ward a secure open porch area with a southern exposure for maximum sunlight and fresh air.

This new enterprise started well. The hospital, designed for a physical capacity of 1,248 beds, admitted some 1,182 patients in 1931. They were to require a minimum of staff supervision and were expected to participate in work programs such as agriculture, laundry, and hospital industries. By 1932 Met State already exceeded its capacity with 1,315 patients. Some 45 acres of land were under cultivation as part of its working farms, which continued to operate until the late 1960s.[71] In the depression-ridden thirties, the hospital was partially staffed with working patients from other hospitals. Regular employees, who lived off campus, had to get to and from work on their own since no direct public transportation was available. Hospital administrators tried for years to obtain some kind of bus service, but to no avail.

Several hospitals were located in the immediate vicinity. Nearby were both the Fernald School for the mentally retarded and the Middlesex County Hospital, the latter established in 1930 as a tuberculosis sanitarium. McLean Hospital in Belmont was a short distance down the road. Adjacent to the Met State campus was the Gaebler Children's Center, a sixty-bed facility built in 1952. It accepted referrals of emotionally disturbed children from across the state. In 1984 Dukakis signed an executive order prohibiting the placement of citizens under the age of nine in adult mental hospitals. Although Gaebler was a separate entity, it shared Met State's laundry, pharmacy, groundkeeping crew, and engineering and electrical staff.

On entering the Met State grounds, one could not help but notice the name of William F. McLaughlin inscribed in bold letters above the white portico of the main administration building. Dr. McLaughlin, who served as its dedicated superintendent from 1952 until 1974, was by all accounts an all-powerful father figure and highly respected physician whose entire professional life was wrapped up in Met State. A kind, gentle, and dignified person, McLaughlin lived on the grounds and cared deeply for the people in his charge. Conciliatory by nature, he was not a fighter. He accepted his lot and rarely clamored for more funds or complained but did the job with the resources at hand. He left the day-to-day management of the hospital to his administrative assistant Paul O'Leary with whom he operated as a team. Afflicted with poor eyesight, McLaughlin used a magnifying glass for reading. Whatever his shortcomings as a superintendent, he inspired people to accomplish what they otherwise would not have done. Beloved by his staff, he was the last of a vanishing breed of superintendents who attended to patients and made their rounds on the hospital wards. The patient population at Met State reached its peak of 2,200 during his tenure.

While at the helm, McLaughlin succeeded in maintaining the hospital's Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation, which assured a steady flow of federal funds, but state money gradually diminished, much of it reallocated by the central office to other hospitals. With tight budgets, state funds slowed to a trickle, forcing deferment of physical maintenance. This inevitably produced deteriorating conditions, a long-term difficulty. Personnel, with its high rate of turnover, was always a major problem. According to Jack MacDougall, who served as personnel director from 1971 to 1989, staffing levels had fallen from the normal standard of 1.3 staff for each patient to .3 staff per patient during the Dukakis years.[72] Staff shortages necessitated the use of prison inmates from nearby Concord, who were transported to and from the hospital on a work release program, for general duty.

Although McLaughlin did not officially retire until September 1978, he had stepped down as superintendent four years earlier. He was followed by a succession of ten administrators with various titles: Arnold Abrams, Ernest Cook, Barbara Hoffman, Melvin Tapper, Frank Karlon, Katherine Olberg, and Phyllis Oram. Audrey DeLoffi, who took over in December 1985 and was given the new title of chief operating officer, was succeeded by Fernando Durand and Marylou Sudders. Nothing better illustrates the managerial turnover problem than this line of succession from 1974 to 1992.

There was a pattern of incompetence and poor management. Met State lost its JCAHO accreditation in 1980, and from then on it was all downhill. By this time the physical plant was in bad shape, incrementalism had taken its toll, and patients complained about poor heating, poor ventilation, lack of air conditioning, foul odors, and filthy conditions. Only three of the seventeen original structures still housed patients. The aging buildings were falling apart: crumbling bricks, leaking roofs, and a wasteful heating system characterized their physical deterioration. In August 1983 the hospital was forced to operate without running water for two days, a debacle that occurred when a fifty-five-year-old water pump broke and caused the water tower to run dry.[73] Water had to be trucked in by mobile units of the National Guard.

Since the old steam lines had few operable control valves, much vacant space in the abandoned buildings remained heated, resulting in huge energy losses. Other mechanical, electrical, and emergency systems were outdated and inefficient. It was estimated that the hospital wasted about three-quarters of its annual $1.7-million heating budget.

Citizens who sat on the Cambridge area board were outraged by such waste, for they took their citizens' monitoring role seriously. While observing patients huddled together in dilapidated wards and dingy day rooms, board chairman Bruce Houghton told a group of visiting state legislators in April 1984, "These people are at the end of the line, the last to be deinstitutionalized, the last to get other services. Some are violent. Others have no place else to go. If any were covered by medical insurance, they wouldn't be here. But no one questions whether they are better off here than as victims of the street."[74]

Many other illustrations of Met State's dilapidated and rundown condition could be cited, but a few more examples will suffice. The superstructure supporting the wooden roof of the Furcolo building had rotted to the point where it was deemed structurally unsound; engineers feared the roof might collapse with a heavy snowstorm; the elevators frequently failed to work, which meant that physically disabled patients had to be carried up- and downstairs during fire drills; the electrical wiring and lighting were wholly inadequate; spare parts were hard to obtain; and water faucets had to be removed from one building to repair those in another.

Virtually no aspect of the operation was functioning at acceptable federal standards. Most experts agreed that the cost of restoring Met State to meet these requirements was prohibitively expensive. Even executive office health and human services secretary Philip Johnston admitted as much. In April 1989 the Division of Capital Planning and Operations hired an engineering consulting firm to study the problem. The engineers estimated the restoration cost at $38.8 million.[75]

Some sixty-six acres of the hospital property adjoined the Beaverbrook reservation, an area that had been designated as a protected wetland. When a fuel oil spill near the boiler building had been detected by the Department of Environmental Protection, it had cost the state $30,000 to clean up this hazardous waste. There was also a paupers cemetery where some 300 deceased patients from Met State and the Fernald School had been buried. Instead of traditional headstones, their graves were marked with small concrete blocks that identified them by patient number and religious preference, but client names were kept on file with their numbers. Many towns and cities openly resisted the siting of housing for the mentally ill, but Waltham, which had repeatedly demonstrated its support for the hospital and its clients, was an exception. While local town and hospital relations were relatively good, the three surrounding municipalities hardly communicated with one another. The typically narrow perspective of local governments found them preoccupied with their own problems and conflicts over zoning and land use issues.

Met State Rocked by Scandal

What goes on inside a state mental hospital is typically a mystery to the public and elected officials alike until dramatic events draw attention to it, usually when a dangerous patient escapes or when a scandal breaks. Such incidents usually prompt an investigation and sensational media coverage. A major scandal occurred at Met State in February 1990, when four male employees — a security guard, a mental health worker, a nursing supervisor, and a plumber — were charged with having sexually abused five female patients. This sordid affair reached into a fairly high level of management, and the story was widely reported in the local press.[76]

Initially, DMH conducted its own internal probe. Scott Harshbarger, the Middlesex County district attorney, then made a separate investigation. Charges were filed against the accused, administrative hearings were held, the four state employees were found guilty, and all were fired for cause. In addition, thirty-one other hospital employees who knew about the incidents were reprimanded for having failed to report the sexual misconduct, which they were required to do by law. Under fire to clean up the mess, Audrey DeLoffi resigned as chief operating officer. She was replaced by Fernando Duran, who took charge for a brief period, staying long enough to sign the disciplinary actions.

Marylou Sudders, who had been recruited by assistant commissioner Katherine Olberg, replaced Duran. Sudders was a social worker and the area director for central Middlesex County. Interestingly enough, although she had never worked in a state mental hospital, Sudders was brought in to close Met State.[77] Her more immediate objective was to improve the patient environment, and she moved vigorously in the first months to meet this goal.

Adept with people, Sudders proved herself an able administrator. She realized that the repercussions of the sex scandal had seriously damaged staff morale. Most em-

ployees felt they were victims of guilt by association. Working in an atmosphere of suspicion and intimidation, they all felt tainted. As she struggled to take the initiative, Sudders decided to address the problem head on, her goal being to change the culture. On November 30 she sent the staff an initial memo detailing her position in terms of what she expected of them by way of improving patient care, upholding patient dignity, and protecting patient rights.[78] Whatever the inspiration, Sudders's statement allayed the fears of some, but the issue would not go away. Many employees still believed their thirty-one coworkers had taken a bad rap.

The Transition Team Develops a Plan

When the fiscal crisis broke in October 1990, Henry Tomes, who had succeeded Edward Murphy as mental health commissioner, realized that he had to solve a specific problem his organization faced. Because of sharp reductions in state funding, he discovered a $10-million deficiency in the Met State operating budget. Tomes decided that the only way to recoup this revenue shortfall was to downsize the hospital. He therefore asked Rae O'Leary, the Metro West area director, to devise a plan to compensate for the deficiency, expecting her answer within an hour. Agreeing to do it, O'Leary mapped out a plan later that evening at home.[79]

The major responsibility for this downsizing initiative rested with the Metro West area. In September 1990 a total of 827 employees worked at Met State, approximately 475 of whom were direct care staff (415 nursing personnel and 60 clinicians). Of the total full-time equivalents, 53 percent were minorities, mostly Haitians, who worked in food service and housekeeping. As the newest wave of urban immigrants, they were the only people who would accept such low-paying, menial jobs, and they experienced various cultural barriers. Since the Haitians were assigned entry-level positions, they ranked low in seniority and civil service status and their bumping rights were affected accordingly.

A veteran of the Foxborough State Hospital closing in 1975, Rae O'Leary was a career psychiatric nurse who had climbed through the ranks in the Department of Mental Health. A tough bureaucratic infighter, she not only knew the territory but believed that anything could be done if managed correctly. In her view, the client always came first. O'Leary detailed the specifics of her plan in a public document and identified a set of key functional areas that needed to be addressed. These included the clinical process, human resources, labor relations, legal issues, communications, physical plant and property, and administrative operations. O'Leary felt that a specific work plan for each area had to be developed before any client transfers could be made. In budget and management terms, she analyzed the problem as follows:

> The budget reduction which would occur January 1, 1991, resulted in the ability to fund only 439 staff, a reduction of 288 [full-time employees]. This, in turn, defined the number of clients who could be cared for at the facility. With an overall staff to patient ratio of 2 to 1, a marginally acceptable level, 220 clients could be cared for by a staff of 439. Therefore, the census would need to decrease from 400 to 220, a reduction of 180, during the nine-month period between October 1990 and June 1991.[80]

For O'Leary the next step was putting together a transition team that could do the job. Anticipating opposition that might emanate from DMH headquarters, she sought ways of effectively neutralizing this threat by placing central office staff as liaison on

the key functional areas of the transition team. Acting as chair of the team, she persuaded Dan Nakamoto, assistant commissioner for community programs, to serve as liaison to her. She then picked the following personnel and gave them their assignments. They included Marylou Sudders, clinical concerns and placements; Connie Doto, patient transfers; Maryellen LaSala and Jeff McCue, labor relations/human resources; Doris "Chip" Carreiro and Richard Ames, legal affairs; Brian Devin, administrative operations; Lauren Flewelling and Mary McGeown, internal and external communications; and Peter Callagy, physical plant and property. Their participation proved critical in the development and execution of the plan.

At their initial meeting, O'Leary assembled everyone in a room and explained her ideas about downsizing the hospital. At the end of her explanation, she told them bluntly they could either accept the challenge or they could leave. She also let them know that she would be as committed to them as they were to her. This kind of loyalty inspired motivation. No one left the room. As Doris Carreiro recalled, "Rae's brilliance was in her capacity to recognize the people who could get things done."[81] More basically, O'Leary wished to manage and was ready to move.

With O'Leary in charge, the transition team became the symbolic hub of the wheel that moved the operation forward. The next step was to articulate a set of principles to guide them in their decision making and other activities. The team defined these principles as follows: (1) the process must be client focused, sensitive and clinically appropriate; (2) no client will move to a treatment setting clinically less appropriate or in poorer physical space. In most instances clients will move to improved care in improved space; (3) the process must be open to allow input and assistance from affected individuals, including clients, involved citizens, families, staff, providers, etc. The communication system must be ongoing and impeccable; (4) the process must be sensitive and supportive to staff whose positions have been defunded but who are responsible for client care during the phasedown. Layoffs will occur only as a last resort.[82]

For O'Leary, recouping the $10-million deficiency was the defining problem. Brian Devin, the operations manager for the Metro West area, soon discovered that they were $1 million short of their goal. At first glance, O'Leary worried that this might have been a miscalculation on her part. However, she quickly realized that it was due to the cost of maintaining the Cambridge-Somerville unit, where most of the patients were hospitalized. The Metro Boston area office wanted to keep this unit open. Since the funds followed the consumers, any cost overruns were ultimately rectified by the central office.[83]

It should be noted that the DMH reorganization in 1990 had strengthened O'Leary's hand. In her capacity as Metro West area director, she was placed in charge of two hospitals, Westborough and Met State. This situation worked to her advantage, because most Met State patients were eventually transferred to Westborough.

Marylou Sudders was a key actor, a quick study with the capacity to listen and to bring people on board. She managed the daily activities at Met State while O'Leary supervised the interfacility and interagency details. Both were strong-willed women whose managerial styles differed and whose personalities clashed at times, but both were heavily invested in the hospital closing. O'Leary sought greater control, more rigid lines of responsibility and authority, whereas Sudders seemed more flexible and ready to meet unforeseen contingencies. Sudders believed that someone from the Cambridge-Somerville area office should have been put on the transition team.

She saw the issue as being larger than Metro West and felt that other area directors should have been involved. She also felt that the time lines were too tight and too abbreviated.

The Resistance Surfaces

No sooner had the plan been announced than trouble started. The hospital trustees opposed the downsizing, which was hardly surprising. Of the fifteen trustees who served on the board, eight were either mental health recipients or family members. In a statement distributed to employees on November 27, the trustees declared,

> As a citizen board, we recognize that the current fiscal crisis in our state requires that some difficult decisions be made, and we also acknowledge that there are some logical components to this plan. However, as advocates of the patients at Met State, we strongly believe that the timetable for implementation is extremely unrealistic and unacceptable.[84]

In disseminating this statement, the trustees had set the tone of resistance for the entire organization.

Internal squabbles among staff surfaced. Most employees considered the transition team a hit squad that was following orders from the central office. Others believed that Met State was being closed as punishment for the sex scandal. Surreptitious obstructionism appeared in the form of an underground newspaper that opposed the phasedown. Its editors, who were identified as the clinicians at Cambridge Hospital, viciously attacked Sudders, derisively referring to her as Queen Boney. Some of this criticism amounted to personal hostility and bitterness. Sudders snuffed out further publication of this house organ by threatening to report its editors to the medical licensing board.

Anonymous and alarming rumors started circulating. Emotional statements were made to the effect that the transfer of long-term chronic patients would result in their death. A review of the literature was launched immediately by O'Leary to determine the validity of such rumors, but there was little evidence to support them. These obstructionist tactics were described by Alan Greene, a member of the Alliance for the Mentally Ill, as "a rearguard action designed to stop the closing."[85]

Much confusion and consternation prevailed. In the midst of all the turmoil, a dangerous patient escaped from the hospital but, fortunately, was captured by the local police within forty-five minutes and returned to the hospital. It was DMH policy to search for a patient on its grounds and to notify state and local police to look for the patient outside the campus boundaries. Once the immediate uproar subsided, Sudders contacted Dr. Mona Bennett at the central office, who had the patient transferred to Medfield that same evening.

Implementing the Phasedown

The initial phasedown began on November 5, when the Central Middlesex area closed its admissions. This decision allowed for the shutdown of a receiving ward on December 17, but the administrators soon realized that it would be necessary to maintain admissions to serve patients from the Cambridge-Somerville area. The Tri-City area

made alternate plans to divert acute admissions to Danvers, which enabled them to close their admissions by January 1. The census at Met State on November 30, 1990, was 382 patients.

O'Leary sensed from the start that the trustees might be a problem. She therefore asked Henry Tomes to meet with them in order to address their concerns and to request their assistance. He did so on November 28 and explained to them that it was his decision to downsize. On January 29, Tomes met with interested family members at Kline Hall and told them essentially the same thing. By so doing, the commissioner took responsibility for the decision and provided a buffer for O'Leary.

At these meetings Tomes specifically addressed the clinical issues along with hardship and access issues. He spoke about plans to install local telephone lines at Westborough and Worcester and to provide a shuttle bus service between the two hospitals. An independent psychiatrist was identified to review individual hardship cases. A contact person was identified at each hospital for family questions and concerns. Family support meetings were scheduled at Met State. A patient transfer packet was developed and distributed to unit directors and department heads. Arrangements were made for patients to have their funds and medical records transferred, to have their pictures taken prior to transfer, and to have luggage purchased for them. These steps were taken at the end of the third Dukakis administration, when the economic life and social structure of the state were undergoing wrenching change.

The Legal Barrier

While Fernando Durand was still in charge, the Cambridge and Somerville Legal Services had filed a class-action lawsuit on behalf of Joann Dottin and seven other patients who were in custody at Met State. The suit charged state officials with failure to release them and to provide appropriate community services. These patients were ready to be discharged, but DMH was unable to place them. Among their lawyers was Steven Schwartz, who had argued the Northampton case. Counsel contended that their clients were being held illegally.

Realizing that this litigation (*Dottin v. Dukakis*) could complicate things and bring the phasedown to an abrupt halt, Richard Ames, who was general counsel for DMH, set up a meeting with the plaintiffs' lawyers. At this meeting Doris Carreiro, Rae O'Leary, and Marylou Sudders presented the transition plan. During these prelitigation negotiations, Ames and Carreiro were able to persuade counsel for the plaintiffs to hold the case in abeyance. The latter agreed to cooperate if they could exercise some kind of veto power in the community placement process. This agreement allowed the phasedown to go forward without further delay.

Interestingly enough, both Marylou Sudders and Katherine Olberg provided testimony by way of an affidavit on behalf of the plaintiff, whereas Rae O'Leary testified on behalf of the department because it was in her view the "right thing to do." As it turned out, the legal issue never came to a head because DMH found community placements for all but one of the eight patients, who, it was determined, required continued hospital care. So she was transferred to Medfield.

Once this major hurdle had been cleared, the phasedown proceeded on schedule. All patient records were carefully reviewed for legal status, guardianship status, and the need for in-court decree modifications. Judge Kevin Doyle of the Waltham District Court agreed to hold special court sessions for cases needing review or modification

prior to transfer. Transfers were made pursuant to law (Chapter 123, section 3). Few, if any, patients contested the transfers.

Met State staff attempted, where possible, to elicit patient input in the process of planning for new community programs and services. Patient ideas concerning transfer options were also elicited. In addition, patients assisting in planning their discharge into the community retained the right to refuse specific placements during the planning process. Once patients were discharged, they were systematically tracked by DMH for ninety days.

The Transfer of Patients

The medical director of Westborough met with Met State clinical staff to review clients identified for transfer on December 7. A reciprocal meeting was held at Westborough the following week. On January 2, 1991, two weeks before Governor William Weld was sworn into office, the initial twenty-five patients were transferred into existing vacancies at Westborough, where a new ward was established later that month to accommodate an additional twenty-five to thirty clients.

Simultaneously, a request for proposal (RFP) was issued for forty-two residential beds in the Metro West area and eight residential beds in the Cambridge-Somerville area. Another sixteen-bed RFP was issued by the Metro North area. Area staff were involved in site searches with local realtors and Community Development Corporation housing partnerships. In addition, a twenty-bed housing program was set up on the Met State campus. It was comprised of three homes that were scheduled for occupancy in January and February of 1991.

Once the phasedown began, the work and commitment of hospital employees allowed for the supportive and orderly transfer of patients. The first few months were the most difficult, mainly because the institution was still reeling from the sex scandal. Local telephone lines for towns surrounding Met State were installed at Westborough and Worcester hospitals, thus facilitating family-to-client and client-to-client communication at no increased expense. A twice-a-week van service was established. Family support meetings run by Worcester and Westborough staff were begun at Met State and transferred to the receiving facilities.

In terms of a media strategy, Sudders did not talk with the press unless she first cleared it with the central office in Boston. She was very protective of the hospital and relied on the clinical leadership to keep the ranks together. Obviously, there was considerable disruption in the treatment of patients, but they continued to receive their medications and psychotherapy.

The transfer process was difficult, even heart wrenching, with mistakes being made, plans being changed and modified, and unexpected events being encountered. According to Sudders, the toughest decisions involved which patients to send to other hospitals and which to send to community settings. Dr. Kenneth Minkhoff, brought in as a consulting psychiatrist to review difficult placement cases when the staff could not reach consensus, was assisted by Marilyn Berner, a clinical social worker and lawyer. They evaluated individual situations and made their recommendations accordingly. The purpose of this independent review was to obtain another opinion to help reach consensus rather than to override an unpopular decision.

Those patients who were ready for community placement were accommodated in new residential and day programs in their area of origin. Since they originated from

Metro Boston, Metro West, and the North Shore, these three areas were where the new residential expansion took place. Some 311 new residential beds were developed between fiscal years 1991 and 1992. Three other state facilities — Danvers, Medfield, and Westborough — received patients who needed continued inpatient care. These institutions developed new community programs and quarter-way houses to accommodate their patients awaiting discharge, which enabled creation of sufficient inpatient bed space for Met State transfers.

The transfer to Danvers presented a special problem. Careful consideration was given to the fact that patients were being moved from one closing state hospital to one that was scheduled to close six months later. Since the newly built psychiatric unit at Tewksbury Public Health Hospital was not ready for occupancy, these patients would have to be moved twice. This troublesome issue was thoroughly discussed with family members and the affected patients, and only with their concurrence would this move take place. Rae O'Leary strenuously objected to this decision. Given the overcrowding and understaffing at Danvers, she felt that the double move violated the principle of providing an equal or better setting.

The Reduction in Force

Hospital employees who received a reduction-in-force notice were understandably alarmed at the prospect of losing their jobs, their main fear being loss of job security. In the early stages, DMH provided fourteen days' notice to employees opting for a voluntary layoff or those who felt the impact of the layoffs because they received no reassignment or bumping options.

At the outset, the employees encountered a cold, impersonal bureaucracy that was maddening. In their eyes, DMH exhibited what seemed to them a callous disregard of their self-worth and their many years of loyal service. In short, they felt devalued. Some blamed the stupid bureaucracy or Governor Dukakis for their predicament. Others felt that privatization would never happen or that they could wait out the Weld administration. They were counting on the legislature to oppose the closing and to protect the unions. Many adopted the attitude "We won't believe it until they put a padlock on the door." A lot of people were stuck in denial, buried "knee deep in the big muddy."

While sensitive client care and clinical integrity of the process remained the top priorities for administrators, appropriate planning for staff ran a close second. During the phasedown and closing process, significant efforts were made to avoid the necessity of staff layoffs. To begin with, Rae O'Leary persuaded Henry Tomes to place a hiring freeze throughout the system and to give first consideration to Met State employees for transfer. On November 26, deputy commissioner Stephen Day issued a memo to all area directors, which read in part:

> Consistent with the movement of patients from Metropolitan State Hospital to clinically appropriate settings, there is a resulting need to lower staffing levels within this facility. The coordination of these staffing reductions with the lowering of the hospital census poses unique obstacles which can best be addressed by the transfer of affected employees. While it may not be possible to avoid layoffs totally at Metropolitan State Hospital, it is the position of the agency that every avenue will be exhausted for accomplishing these reductions before proceeding to layoff activities.

> Utilizing the transfer language which already exists with union collective bargaining agreements, all DMH Areas will be required to provide priority consideration to Metropolitan State Hospital transfer requests. Accordingly, no positions are to be filled without full and fair consideration of appropriate Metropolitan State Hospital transfer requests.[86]

This memo started the ball rolling and set into motion a series of events arranged mostly by Jeff McCue and Maryellen LaSala. Their main objective was to develop a personnel work plan whereby the least number of employees would be laid off. They discussed their plan with labor union officials and solicited their feedback regarding staff bidding for jobs.[87]

Several staff meetings were held for the purpose of answering employee questions. An informational booth was set up to advertise employment opportunities and to assist with résumé writing. The Career Counseling Center in the Division of Employment Training held employee seminars on site. Hospital job fairs were also scheduled. As of December 11, 1990, there were fifty-seven requests for transfer on file, and forty-eight informational postings had been received. Somewhat later, a day-long seminar on retirement was offered by William Farmer of the State Retirement Board.

Meanwhile, Marylou Sudders appeared on the wards almost daily, her presence an important factor in calming tensions. She made it a point to visit all rotating work shifts at least twice each month to talk with staff and to answer their questions. Informal conversations and observations were as important as the formal ones. Sudders was ready to provide information, squelch rumors, listen to complaints, give moral support, soothe ruffled egos, and deal with people who were angry and upset. The staff needed to know what was happening in the community as well as the hospital. Even partial information, if it was true, was better than none. Bulletin boards, in locked glass cases, provided the latest information on the opening of community programs, movement of clients, current census data, and so on. Printed updates were occasionally distributed with the payroll.

A combination of fiscal carrots and market forces were employed to implement the reduction in force. Negotiations regarding a bonus incentive program and an early retirement option were under way. Employees who elected voluntary layoff received a lump sum cash payment of $2,268, based on their health insurance costs, an option that proved attractive to many workers. They were also eligible for unemployment compensation. In the interest of clinical continuity and stability, DMH granted an extended notice period for voluntary layoffs. An early retirement program soon became available. The bonus incentive program, however, was not approved. It was turned down by Peter Nessen, the secretary of administration and finance, who viewed the bonus idea as not cost effective.

On November 14, 1991, Rae O'Leary sent commissioner Eileen Elias a status report that stated,

> Our initial commitment to staff to avoid layoffs during the phasedown did not appear to be realistic when the hospital closure was being confronted. Now, however, our optimism is again increasing. We intend to make every effort to provide employment options to Met State employees who are interested in such options.[88]

In the end, most opted for them. The following data summarize employee attrition from the phasedown through the closing:

Transfers within DMH	365
Transfers to other state agencies	22
Mothball crew	27
Voluntary layoff	240
Retirements	40
Resignations	38
Laid off (no bumping option awarded)	17
Functional eliminations	27
Discharges	12

Of the 365 transfers, 153 staff were transferred laterally with the patients, and 68 were bumped into other facilities as a result of the functional eliminations. Of the 240 voluntary layoffs, 183 were processed after December 13, 1991, and 166 employees met the eligibility criteria for the insurance incentive. All vacation and incentive cashouts were completed on February 20, 1992. Only 17 employees were laid off. Only one grievance was filed, and that was an affirmative action complaint. When an early retirement plan was put into effect in July 1992, forty employees took advantage of it.

From Phasedown to Closure

As of June 19, 1991, the same day that Governor Weld's special commission released its report, the census at Met State was down to 207 clients. For all practical purposes, this concluded the phasedown. The next day Commissioner Elias, who had just been appointed, visited the hospital to announce to families and staff that it would be closed, a traumatic moment of truth. Because to this point no one had told them about the closing, this unenviable duty fell to Elias who broke the news as best she could. She spoke about the death of an institution and the grieving process that has to accompany it. One participant described her visit as a wake.

Movement of patients continued throughout the summer and fall of 1991. As of November 19, the census was down to 180 patients. By this time 324 employees had left, and the remainder of patients and workers would leave within the next two months. The other significant development was the opening of a DMH replacement unit at Cambridge Hospital. A contract was signed on December 16 to provide seventeen acute-care beds to accommodate Cambridge and Somerville patients.

As Metropolitan State headed for closure, there was an increase in petty theft as some wards were closed. This was stopped by moving all furnishings and equipment from the unit and sealing off the closed area immediately after the last patient had left. When all was said and done, the final displacement of the 382 patients was recorded as follows:

DMH inpatient transfers	163
DMH community placements	156
Admissions diversion	37
DMR community placements	14
Long-term-care placements	5
Other	7

On January 25, 1992, the last group of patients and staff was moved out and relocated. Six days later, with the hospital wards completely empty, Marylou Sudders

invited the trustees and a few special guests to lunch. Afterward she bid them farewell, packed her personal belongings, and locked the hospital doors. The previous day, she had sent a letter to all employees, paying tribute to them for their professionalism and their caring in a job well done. Sometime later, Commissioner Elias met with a group of mental health professionals. At the end of the meeting, Catherine Dunham, who had served under Dukakis, shook hands with Elias and congratulated her by saying, "You have achieved what we tried for so many years to accomplish, but we were unable to do."[89] It was a gracious gesture.

On that poignant note, the history of Metropolitan State came to an end. The skeleton crew then put the facility in mothballs. Vacant and boarded up, the hospital currently resembles a ghost town. Former patients seeking to gain reentry occasionally return. Over the past few years, the three adjoining municipalities, the state Division of Capital Planning and Operations, and the Metropolitan District Commission have reached a consensus with regard to the disposition of the 346 acres of abandoned property. There is something in the reuse proposal for each town: conservation land for Belmont, a nine-hole municipal golf course for Waltham, and affordable housing for the elderly in Lexington. The golf course will be designed to have the least impact on the natural environment, preserving wetlands and providing for minimum deforestation of Mackerel Hill. At this writing, legislation to this effect is pending before the General Court.

Evaluating Policy Implementation

As may be seen from this sweeping historical review of mental health care in Massachusetts, different eras are defined by different problems. From the start of the first state hospital in Worcester in the early 1830s until the Civil War, the problem was social control and institutional care. From the Civil War until the New Deal, the problem was growth and expansion of public asylums. From the New Deal until the New Frontier, the problem was skyrocketing admissions and warehousing of patients. From the New Frontier until recently the problem was deinstitutionalization and community programs. The defining issue of today's era is privatization and public managed care.

Once a state assumes responsibility for a public function, it cannot easily discard it. The policy conundrum of providing institutions of last resort makes disengagement that much more difficult. The obsession with state hospitals blinded participants to the protection of their own interests and distorted their understanding of the new realities that have emerged in the past several years. Other states, for example, Michigan and New Jersey, have attempted to close their mental hospitals, but they have not been successful.

In the effort to restructure mental health in Massachusetts, ideology did prevail, and the workings of the system in a managerial sense improved. Most important, the consequences of its implementation on community life were anticipated and dealt with responsibly. What had gone wrong with deinstitutionalization did not go wrong this time. The major policy achievements closely followed the classical implementation scenario. Policy goals were stated in such precise terms as "Four mental hospitals to be closed by 1993." Policymakers and implementers — the governor, the health and human services secretary, DMH, some of the mental health lobby — shared these goals, and the entire general public supported this policy. Power to control the implementation process was centralized hierarchically. The implementers were granted the technical authority and possessed the technical competence for carrying out the policy goals.

Crisis alone can empower. An early reckoning of the impact of budget reductions and

simplified management showed that the Elias strategy was working. The extremely tight time constraints permitted those in charge to decide on and implement the closure policy without prolonged debate. Policy goal attainment required bold leadership and the political will to stay the course. Previous administrations had faltered and stumbled for lack of such will. In a major restructuring of this kind, the commissioner is definitely on the hot seat. Eileen Elias took most of the heat and pressure. As she says, "Managing change in a public bureaucracy necessitates determination, tenacity, vision, strategic and systemic planning, and implementation."[90]

In both reducing spending and consolidating hospitals, the Weld administration achieved substantial success. In the first three years, the total savings were $62 million. Thirty-four million dollars were used to expand community-based services and $26.7 million to develop replacement units. Furthermore, the commonwealth avoided the expenditure of $43.7 million in capital resources that would have been needed to bring the closed mental hospitals into compliance with federal certification and accreditation standards. The Department of Mental Health generated $17.9 million in new revenues as a result of its initiatives and saved $11 million in state employee health insurance costs for a net state cost savings of $69 million. Unlike what occurred in previous efforts to deinstitutionalize, this time the resources followed the consumer.

Completing tracking studies of patients who had been discharged helped to assure that they did not slip through the cracks. According to DMH tracking data, from July 1991 to the end of 1992, a total of 963 patients were discharged or transferred from the three adult hospitals. Of this number, 312 were discharged to DMH-funded community residences, 274 were placed with their families, nonfamily members, or in independent living settings, 255 were transferred to another state facility, and 114 were moved to other treatment facilities. Only two patients were discharged to the street to become homeless persons. Replacement units for acute care were set up through contracts with general hospitals, which resulted in a significant drop in the length of stay. State hospitals had longer stays, while general hospitals had much shorter ones. Less than 6 percent of the state employees who worked in the system were laid off. Most of the others were absorbed elsewhere in the system or hired by private providers.

Much of the program duplication and overlap that existed within the system was substantially reduced so that the fiscal and management goals were substantially realized. However, as Barbara Leadholm and Joan Kerzner point out,

> The restructuring of the system has not come without a price. Along with the successes, there were some unavoidable disruptions in services. Hospital closures, consolidations, and privatization resulted in the dislocation of some staff as a result of layoffs and bumping, and particularly affected vendor-operated community clinics to which DMH clinical staff had historically been assigned. This practice was discontinued in June 1991 when the Department cashed out the state positions. The clinics (and subsequently, a number of clinical staff) were offered contract funds instead. Not unexpectedly, clients of these clinics and their family members resented the disruptions and the uncertainties regarding continuity of care.[91]

The apparent success of the Met State closure is instructive as the way to go. It provided the textbook school solution to the problem. The entire operation worked almost to perfection. From an insider's point of view, Doris Carreiro felt that the plan was executed superbly from start to finish. Scholars have usually applied three criteria to

evaluate policy implementation. They are efficiency, effectiveness, and equity. Using these criteria, I would give the implementers generally high marks for their performance. The transition team led by Rae O'Leary and Marylou Sudders deserves much of the credit for planning and implementation. It elicited trust and performed well.

The efficiency criteria attempt to evaluate quality of performance usually in relation to cost. Here the statistics generated by the Met State closure between fiscal years 1990 and 1994 reveal the following: state funding savings, $28.9 million; inpatient replacement cost, $2.3 million; community expansion cost, $7.1 million; revenue enhancement savings, $0.9 million; group insurance savings, $5 million; and capital cost savings, $16.7 million. These produced a total saving of $42.1 million.

The effectiveness criteria attempt to measure consumer and constituency satisfaction. After Met State and Danvers had been closed, the Division of Capital and Planning Operations, the state agency which oversaw the consolidation process, contracted with the University of Massachusetts to interview clients and families of these two hospitals. The purpose of the study was to determine whether the state's promise that clients would have "equal or better" care in their new settings had been fulfilled. A total of 86 clients were interviewed — 59 former Metropolitan State and 27 former Danvers patients. While most Met State patients had been placed into community group homes or apartments, most Danvers patients had been transferred to Tewksbury.

No client interviewed rated his or her current placement as "worse" than the prior hospital placement. In the case of the 59 former Met State clients in community settings, 69 percent rated their overall posthospital experience as "better" while 31 percent rated it as "equal" to their hospital care. In addition, a majority reported that they felt involved and satisfied with the transfer process. The 27 Danvers patients were less positive, with only 30 percent rating their new inpatient setting as "better," while 67 percent rated it as "equal." Most reported little or no involvement in, and lack of satisfaction with, the process of moving from one facility to another.[92]

Most family members indicated that the client's new placement was "better" than the state hospital in a variety of areas, including living space, facility cleanliness, opportunity for social activities, and privacy. Only a few family members indicated feeling that the closing of the state hospital where their relative had received care had a predominately negative impact on their family member. Many reported not being informed of the closing or that the client would be moved. Many also felt excluded from discharge planning for the hospitalized relative.[93]

The equity criteria deal with fairness in delivery of public services. Here the policy mandate in dispute worked better than most critics were willing to admit. For one thing, patients now spend less time in a restrictive setting. Formerly, they could spend anywhere from five months to five years at Met State in a deplorable environment. Closing hospitals was only part of the story. Changes in approaches to care was another important factor, involving looking at mental health from a broader perspective. The problem lay in seeing clients solely in terms of their acute status and not from a recovery and rehabilitation point of view. DMH needed to capture that model. Elias was a commissioner who understood recovery and rehabilitation. During her tenure she won praise from constituency groups for encouraging treatment in the least restrictive settings and for getting patients more involved in their own care. On the fairness issue, the restructuring went a long way toward eliminating the inequities of the two-tier system that had prevailed for so many years. No longer were patients discriminated against because they

were poor or disadvantaged. The practice of "creaming" was eliminated.

The policy jury is still out on the quality and consequences of privatization. Time will tell whether the quality of services has been enhanced. The most severe critique was provided by Robert Dorwart and Sherrie Epstein, who see privatization of mental health care as a fragile balance. They explain,

> This tension between whether human services should be supplied because of a public obligation or mission to serve community interests or because of a desire to sell a service in order to generate a profit is one that we believe to be at the heart of many current policy debates in mental health. Pressures toward increased competition and cost containment are likely to exacerbate the stress already building as protagonists wrestle with various options for financing and organizing mental health care.[94]

This stress became evident in June 1995 when a Department of Mental Health internal report of patient deaths and suicides was released on an information request. The data revealed that deaths in the mental health system had risen by 79 percent during the restructuring period from 1990 to 1994. When this information reached the public, it was used by some advocates and the media as evidence to support their position that the public managed-care initiative was detrimental to the seriously mentally ill.[95]

Commissioner Elias, called on to testify and to explain the statistics before the House Post Audit and Oversight Committee, a legislative watchdog group, explained that in 1992 the criteria for reporting client deaths were expanded to include a broader range of people having contact with DMH.[96] Even though the increase in the reports of deaths likely resulted from this expanded method of collecting data, neither the advocates nor the media accepted this explanation. Instead, they continued to use these data as proof that the restructuring initiative was linked to increased patient deaths and demanded the resignation of Commissioner Elias.[97]

To deal with the problem and to satisfy the Post Audit Committee's desire to get the facts from an unbiased source, DMH commissioned an independent team of researchers to investigate the matter further. More specifically, the researchers were asked to examine the reported increase in patient mortality and whether it was related to the restructuring and public managed-care initiative. The team's report revealed an actual decline in the rate of consumer deaths from 1991 to 1993.[98]

One can argue about the desirability and feasiblity of these policies, but they were not just rhetorical or ideological talk; they were in the mainstream of mental health policy and program development. The choice between privatization and state hospitals will continue to require a search for an appropriate balance among competing values where no final resolution is possible. With the amelioration of one problem, new difficulties will emerge, compelling public attention. The restructuring will at least permit a cost-benefit analysis to be debated in light of the Pacheco law. The important question is whether the taxpayers are willing to invest sufficient resources to provide for a broad range of services. Only if the reply is in the affirmative will a comprehensive community support system become a viable entity.

Whatever the possibilities for a new range of services, a few lingering questions remain. Is the state government shirking its responsibilities? Is it evading necessary duties? Is it relinquishing its oversight function? These are sobering thoughts for policymakers to ponder. In the final analysis, the managed-care concept can be made to work, but it depends largely on keeping people out of the hospital.

Epilogue

After the closure of Metropolitan State, Marylou Sudders became head of the New Hampshire mental health system, which was a career move for her. Meanwhile, the pressures on Eileen Elias continued to mount. Despite the tendency to oversimplify events, the media coverage had sparked a public controversy that would not subside. A few high-profile suicides added fuel to the fire. As a result, the Massachusetts Alliance for the Mentally Ill continued to beat the drums for Elias's removal. Under fire, Elias continued to defend her much maligned agency.

In January 1995 Gerald Whitburn was appointed by Governor Weld as the new secretary of health and human services. Whitburn came from Wisconsin, where he had been in charge of public welfare. Elias did not hit it off with her new boss, partly, it was said, because Whitburn wanted his own person in the job. So he leaked a story to the press that Elias had been asked to step down. She fought back and won a temporary stay that allowed her to leave on her own terms. Charles Baker saw to that. Nevertheless, Whitburn continued to press for her removal. On January 9, 1996, Elias announced that she would soon be leaving her post. Three days later, as fate would have it, Marylou Sudders was tapped to replace her as commissioner.

It may all have been a matter of personality, but Elias's abrasiveness and arrogance did not help her cause either. She could not be written off as a puppet of the Weld administration. Her forced departure added to the astounding parade of commissioners who have gone in and out of the revolving door of administrators. From the political perspective of governors, they are deemed expendable. Yet these exceptional civil servants are the unsung heroes and heroines who are often sacrificed on the altar of cynical politicians.

In November 1995 Governor Weld proposed a reorganization of state government in which the eleven secretariats are reduced to five. Moreover, the sixteen state agencies that once comprised the Executive Office of Health and Human Services are consolidated into a family services secretariat containing four separate departments. The Department of Mental Health is slated to be merged into a new Department of Public Health Services. Tinkering with organizational charts and reshuffling agencies may help to rationalize the bureaucracy, but the blurring of agency roles and regrouping them according to function can be viewed as another form of evasion. Ironically, Gerald Whitburn, who fired Elias, was forced out in June 1996. His ouster reinforced the notion that what goes around comes around.

One final comment. In an age of devolution, when control of health care policies and expenditures shifts from Washington to the states, pressures to contain costs and manage the delivery of mental health care will profoundly affect patients and caregivers alike. Steven Marin, the chief executive officer and chief psychiatrist at McLean Hospital, warns,

> As third-party payers and managed-care organizations are increasingly involved in determining where, how, and by whom mental health care is to be delivered, the federal government and the state are preparing to reduce their spending for such care, posing new threats to those insured under Medicaid and Medicare programs. Among the affected will be the most socially disadvantaged and severely ill patients in the Commonwealth —precisely those who are least able to protest and/or draw upon other sources of support.[99]

The lives of these vulnerable people haunt the ending of this system reform story. ❧

Notes

1. Clea Simon, "Who Has the Right?" *Boston Globe*, April 21, 1996.
2. This study relies on a wide array of sources — public documents, memoranda, newspapers, and personal interviews with the major participants including four former Met State patients and their family members. They provide us with insights into the main concerns and perceptions of those who were involved. As with all case studies, illuminating and useful as they may be for education and scholarship, the inability of the case writer to screen all relevant facts and the reliance on what participants choose to reveal means that some critical ones are often overlooked. Participant-observers may miss them as well. Even so, this approach at least takes into account the different ways in which the central actors saw the episode and their roles in it. Although none had any obligation to assist me, all were more than helpful. I was given many "leads" and explored each to its end.
3. See Joseph S. Slavet et al., "After the Miracle: A History and Analysis of the Massachusetts Fiscal Crisis," University of Massachusetts at Boston, May 1990.
4. Report of the Governor's Special Commission on Consolidation of Health and Human Services Institutional Facilities, "Actions for Quality Care," June 1991, i.
5. Interview with Carol Upshur, a health care expert who served on the governor's special commission, July 19, 1995.
6. Report of Governor's Special Commission, "Actions for Quality Care," iii.
7. Interview with Bernard Carey, September 22, 1995. See also working paper prepared for the Massachusetts Association for Mental Health by Joseph Finnegan and Donna Mauch, "Restructuring the Delivery of Human Services: Focus on Department of Mental Health," November 1990.
8. Interview with Donna Mauch, November 16, 1995.
9. See Eileen Elias and Marc Navon, "Implementing Managed Care in a State Mental Health Authority: Implications for Organizational Change," forthcoming.
10. For a detailed discussion and analysis of this opposition, see John Laidler, "Storm Calms over Danvers Closure," *Boston Globe,* January 15, 1995. See also Mark Leccese, "Too Much, Too Fast," *Boston Tab,* August 2, 1994.
11. Quoted in Leccese, "Too Much, Too Fast."
12. *Boston Globe,* September 19, 1993. This poll, conducted by KRC Communications Research, which surveyed 400 registered voters on September 9–10, had a margin of error of 5 percentage points.
13. Letter from mental health commissioner Eileen Elias to Department of Mental Health central office staff, June 24, 1991.
14. Report of the Senate Committee on Post Audit and Oversight, "A Review of DMH Policy Planning and Implementation during the Closing of Northampton State Hospital," January 1993.
15. Report of Governor's Special Commission, "Actions For Quality Care," 9, 58.
16. Interview with Charles D. Baker, April 19, 1995.
17. Report of Governor's Special Commission, "Actions for Quality Care," 58.
18. This and the following paragraph follow closely the argument developed in Robert C. Wood, *Remedial Law: When Courts Become Administrators* (Amherst: University of Massachusetts Press, 1990), 13–14. I thank Robert Wood for his permission to use this material.
19. See B. Shaw, "Knee Deep in the Big Muddy: A Study of Escalating Commitment to a Chosen Course of Action," *Organizational Behavior and Human Performance* 16 (1976): 27–44.
20. Interview with Philip W. Johnston, April 7, 1995.
21. For a detailed criticism of the Weld administration's mental health initiative, see Leccese, "Too Much, Too Fast"; see also the newsletter *AMI of Mass.,* no. 38 (Summer/Fall 1991): 5.
22. Interview with Katherine Olberg Sternbach, who was employed at DMH 1979–1990 and served as assistant commissioner of mental health under Henry Tomes, May 18, 1995.
23. Interview with Doris Carreiro, February 16, 1995.
24. Wood, *Remedial Law,* 16.

25. See "Pushing Privatization Too Far," *Boston Globe*, editorial, January 27, 1995.
26. For an excellent history of Worcester State Hospital, see Joseph P. Morrissey et al., *The Enduring Asylum: Cycles of Institutional Reform at Worcester State Hospital* (New York: Grune and Stratton, 1980).
27. For an excellent account of the harsh realities and religious bigotry that confronted the Irish in Boston, see Thomas H. O'Connor, *The Boston Irish: A Political History* (Boston: Northeastern University Press, 1995); see also Oscar Handlin, *Boston's Immigrants* (New York: Atheneum, 1970).
28. David J. Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic* (Boston: Little, Brown, 1971),132.
29. Ruth B. Caplan, *Psychiatry and the Community in Nineteenth-Century America* (New York: Basic Books, 1969), 180.
30. J. Michael Moore, *The Life and Death of Northampton State Hospital* (Northampton, Mass.: Historic Society of Northampton, 1995), 3.
31. David Mechanic, *Mental Health and Social Policy* (Englewood Cliffs, N.J.: Prentice-Hall, 1969), 54.
32. Gerald N. Grob, *Mental Illness and American Society, 1875–1940* (Princeton: Princeton University Press, 1983), 74–75.
33. John R. Sutton, "The Political Economy of Madness: The Expansion of the Asylum in Progressive America," *American Sociological Review 56* (1991): 669. My interpretation relies heavily on Sutton's account.
34. For a chronological evolution of the state mental health care system, see Lizabeth Watson, "Guide to Social Welfare Records," Massachusetts Archives, May 1991, 58–71.
35. Moore, *The Life and Death of Northampton State Hospital,* 12.
36. Watson, "Guide To Social Welfare Records," 23.
37. For a brief history of mental health services in Massachusetts, see "Comprehensive Plan to Improve Services for Chronically Mentally Ill Persons," vol. 1, December 1985, 4–7. My interpretation of the development of mental health policy and programs relies substantially on this source.
38. See Paul Lerman, *Deinstitutionalization and the Welfare State* (New Brunswick, N.J.: Rutgers University Press, 1982), 99.
39. Interview with Hubie Jones, August 23, 1995; see also Report of the Task Force on Children Out of School, "Suffer the Children," Boston, 1972, 5–6. In addition, see Peter B. Edelman, "The Massachusetts Task Force Reports: Advocacy for Children," *Harvard Educational Review,* November 1973.
40. Martha W. Weinberg, *Managing the State* (Cambridge, Mass.: MIT Press, 1977), 192.
41. Ibid., 193.
42. Ibid., 194.
43. Quoted, ibid.
44. See Jean Dietz, "Worcester State Hospital Hardly the Worst," *Boston Globe,* February 21, 1985.
45. *Commonwealth v. Wiseman* (1969) Mass. 251. The court order restricted the showing of the film "only to legislators, judges, lawyers, sociologists, social workers, doctors, psychiatrists, students in these or related fields, and organizations dealing with the social problems of custodial care and mental infirmity."
46. Statement by a former DMH employee who requested anonymity.
47. Interview with Joseph Finnegan, September 20, 1995.
48. Mauch interview.
49. Northampton Consent Degree, Civil Action 76-4423-F (ordered December 7, 1978).
50. Jean Dietz, "Mental Health Chief Defends Personnel," *Boston Globe,* February 19, 1982.
51. Report of the Blue Ribbon Commission on the Future of Public Inpatient Mental Health Services in Massachusetts, "Mental Health Crossroads," Boston, May 1981.
52. Interview with Catherine Dunham, December 1, 1995.
53. Interview with Rae A. O'Leary, December 28, 1994.
54. Interview with Barbara Hoffman, August 21, 1995.
55. Laidler, "Storm Calms over Danvers Closure."
56. For a similar critique of deinstitutionalization, see Colin Nickerson, "Reformers' Dream That Went Astray."

57. See Robert L. Okin, "Testing the Limits of Deinstitutionalization," *Psychiatric Services* 46 (June 1995): 569.
58. Quoted in Jean Dietz, "Requirements for a Mental Health Chief," *Boston Globe,* February 9, 1983.
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62. Joseph M. Harvey, "Patients Win Choice on Drugs," *Boston Globe,* November 30, 1983; see also Jean Dietz, "Bay State Ruling Provokes Debate," *Boston Globe,* December 4, 1983.
63. See "First Interim Report of the Special Senate Committee to Study the Impact of Deinstitutionalization of the Mental Health and Retardation Services in the Commonwealth of Massachusetts," 1984, 9.
64. Johnston interview.
65. Ibid.
66. See Michael S. Dukakis, "A Comprehensive Plan to Improve Services for Chronically Mentally Ill Persons," December 1985.
67. Jean Dietz, "Dukakis May Seek Millions for Mental Health Department," *Boston Globe,* December 3, 1985.
68. Governor Michael Dukakis, "Special Message on Mental Health," was reprinted in "A Comprehensive Plan to Improve Services for Chronically Mentally Ill Persons," 2–3.
69. Quoted in Jean Dietz, "Reactions Varied on New Mental Health Plan," *Boston Globe,* December 20, 1985.
70. Johnston interview.
71. These data are from the annual reports for Metropolitan State Hospital for the years 1931 and 1932. The reports, which run consecutively until 1969, are available at the Massachusetts Archives.
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81. Carreiro interview.
82. O'Leary, "Metropolitan State Hospital Phase-Down Project," 2–3.
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84. Memo from board of trustees to Met State Hospital employees, November 27, 1990.
85. Interview with Alan Greene, October 20, 1995.
86. Memo from Stephen L. Day to all area directors, November 26, 1990.
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