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United States Department of the Interior
National Park Service

National Register of Historic Places Multiple Property Documentation Form

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This form is for use in documenting multiple property groups relating to one or several historic contexts. See instructions in *Guidelines for Completing National Register Forms* (National Register Bulletin 16). Complete each item by marking "x" in the appropriate box or by entering the requested information. For additional space use continuation sheets (Form 10-900-a). Type all entries.

A. Name of Multiple Property Listing

Commonwealth of Massachusetts State Hospital and State School System

B. Associated Historic Contexts

1. The Organizational Framework: 1830-1940
2. Methods of Care and Treatment: 1700-1940
3. Noted People Involved in the System: 1830-1940
4. Architecture and Landscape: 1840-1940

C. Geographical Data

See continuation sheets

[X] See continuation sheet

D. Certification

As the designated authority under the National Historic Preservation Act of 1966, as amended, I hereby certify that this documentation form meets the National Register documentation standards and sets forth requirements for the listing of related properties consistent with the National Register criteria. This submission meets the procedural and professional requirements set forth in 36 CFR Part 60 and the Secretary of the Interior's Standards for Planning and Evaluation.

Judith B. McDonough — 12/8/93

Signature of certifying official Judith B. McDonough, Executive Director — Date

Massachusetts Historical Commission, State Historic Preservation Officer

State or Federal agency and bureau

I, hereby, certify that this multiple property documentation form has been approved by the National Register as a basis for evaluating related properties for listing in the National Register.

for Patrick W. Andrus — 1/21/94

Signature of the Keeper of the National Register — Date

E. Statement of Historic Contexts

Discuss each historic context listed in Section B.

See continuation sheets

[X] See continuation sheet

Overview Cover Sheet

A. Name of Multiple Property Listing
Commonwealth of Massachusetts State Hospital and State School System

B. Associated Historic Contexts: See Registration Form
C. Geographical Data: See continuation sheets
D. Certification: See registration form
E. Statement of Historic Contexts: See continuation sheets
F. Associated Property Types: See continuation sheets
G. Summary of Identification and Evaluation Methods: See continuation sheets
H. Major Bibliographical References: See continuation sheets

I. Form Prepared By: Candace Jenkins, Preservation Consultant, with Betsy Friedberg, National Register Director, and Douglas J. Kelleher, Preservation Planner, Massachusetts Historical Commission, 80 Boylston Street, Boston, Massachusetts, 02116

C. GEOGRAPHICAL DATA

The geographical area encompasses fifteen state-owned hospital and school campuses within the Commonwealth of Massachusetts.

E. STATEMENT OF HISTORIC CONTEXTS

I. Introduction

Concern for the disadvantaged, including the poor, the sick, the mentally disturbed or handicapped, and the disadvantaged or wayward youth, has been recognized as a responsibility of the public sector in Massachusetts since its early seventeenth century settlement period. For two hundred years, until the mid-nineteenth century, the charge for their care rested primarily with the towns in which they resided through locally elected overseers of the poor, and in some cases, through specially established poor farms. Lock-ups served for the criminally inclined. Gradually, the towns' duties in this regard became unwieldy and largely unfulfilled, due in part to the pressures of immigration and rapidly increasing numbers of unsettled poor. Thus, the state stepped in, influenced by vocal, liberal reformers to create an extensive, humane, and nationally renowned system to care for its varied classes of dependent citizens.

Over the course of one hundred years, from 1830 to 1930, the Commonwealth gradually assumed full responsibility for the disadvantaged, and created a remarkable public institutional system, noted for both its extent and its innovations. At least thirty-one facilities were constructed across the state including thirteen hospitals for the insane, three schools and one farm for the mentally retarded, four reform schools for wayward juveniles, three almshouses for the poor, four sanatoria for tubercular patients, and three specialized institutions for alcoholics, for crippled children, and for laboratory research. Several were the first of their type in the nation, or exerted national influence, reflecting Massachusetts' pioneering leadership role.

The Commonwealth was generous in constructing these facilities, with the exception of the almshouses, underscoring its commitment to provide the best available care for those who were unable to care for themselves. Hospitals and schools constructed in the nineteenth century were often designed by well-known architects and still evidence an exceptional quality of construction and attention to architectural detail. Although twentieth-century facilities were often designed by less prominent architects, and began to rely on standardized plans, they too are well constructed. Many campuses are enhanced by well-landscaped grounds and/or hilltop sites providing fine views of the surrounding countryside, although few landscape

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architects or engineers have been identified. Most also encompass several hundred acres of wetlands, wooded areas, and agricultural fields that remained in active use until the 1970s.

The extent of the State Hospital and School System in Massachusetts provides an unusually complete picture of the changing role of state-sponsored institutional care in the United States. Along with Pennsylvania and New York, the Commonwealth of Massachusetts was on the forefront of institutional reform and theory. One scholar has defined Massachusetts' role thus:

> The Bay State had pioneered in nineteenth century welfare. Its policies had helped to legitimate the state mental hospital in the early part of the century. Massachusetts had also established the first Board of State Charities in 1863 and a State Board of Health six years later. The cultural and intellectual leadership of its citizens reinforced its political significance, and where Massachusetts led other states traditionally followed (Grob 1983: 82).

Extensive campus networks that integrate buildings and landscapes in large-scale rural settings remain as testimony to the ideals of the system in the nineteenth century, and its eventual failure by the mid-twentieth century. In particular, the campuses included in this nomination embody the central role that ideal asylum environments played in nineteenth and early twentieth century treatment programs. The Boston Psychopathic Hospital of 1912 stands apart as an urban facility devoted to research and acute care that pointed the way toward future directions for psychiatry. The integrity of a few campuses has been permanently compromised, but most remain as clear manifestations of the state's social conscience.

As a whole, the system meets criteria A, B, and C of the National Register of Historic Places, and is significant on the local, state, and national levels. The significance and integrity of individual campuses are evaluated on their separate nomination forms. The following narrative establishes the framework for that evaluation by examining the following key contexts and their relationship to the National Register criteria. Those contexts are The History of Public Involvement: Its Organizational Framework (criterion A), Methods of Care and Treatment (criterion A), Important People Involved in Creation and Maintenance of the System (criterion B), Physical Developments: Architecture and Landscape (criterion C), and Potential for Pre-historic and Historic Archaeological Significance (criterion D). This narrative is weighted toward facilities and programs for the insane, reflecting their dominance within the state system.

The overall period of significance for the Massachusetts State Hospital and School System extends from 1830 when its first facility

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was constructed, to ca. 1940, when the institutional system was near its peak size and several statewide reviews of its utility were initiated. Nationally, 1940 is seen as the end of the era when institutional care was accepted as the best available response to problems like insanity. After World War II, criticism of institutional care intensified, as it was seen "to disregard the rights of sick and dependent persons by isolating and subjecting them to cruel abuse" (Grob 1983: 5, 6).

At the same time, this "ineffective" care was absorbing approximately one-sixth of the state budget (DMD 1930: 6), creating a forerunner to our present health-care crisis.

The result supported the 1970s policy of deinstitutionalization, which radically reduced patient populations, and left campuses vacant and deteriorating. The individual hospital and school campuses included in this nomination evolved gradually during the nineteenth and early twentieth centuries, responding to increased state involvement, as well as to changing theories of care and treatment. Thus, buildings and landscapes from a broad time period will generally contribute to their significance, although those that date from the initial founding of the particular campus are often of primary importance.

II. History of Public Involvement: Its Organizational Framework

The history of public involvement in the care of disadvantaged citizens arises from a context of changing social/political attitudes and realities, accompanied by advances in scientific medical theory. It encompasses major shifts in responsibility from the local level in the eighteenth century, to the state level in the nineteenth and early twentieth centuries, to the federal level in modern times.

The Colonial period response to the issue of dependency was profoundly different from that of the post-industrial period. It did not differentiate between various types of misfortune but encompassed all under the heading of poverty; it accepted misfortune as part of the natural order and did not attempt to eradicate its causes; it did not establish a specialized institutional framework but dealt with the problem on a personal and local level. Stable family and community structures provided sufficient socializing influences to balance individual problems and defects.

A profound shift in attitude occurred in the early years of the new republic, for which social historians such as David J. Rothman and Gerald N. Grob have identified many causes. These include rapid population growth accompanied by a sharp jump in the rate of immigration, great improvements in transportation networks leading to increased mobility, and rapid industrialization and urbanization.

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These trends were coupled with the rise of Enlightenment and Utopian philosophies that emphasized the power of human reason and the basic improvability of mankind.

All of these physical and philosophical changes tended to disrupt the homogeneity, parochialism, and religious determinism of the established social order that had hitherto provided for local support of the disadvantaged, supplemented by limited state remuneration for those without legal residence in any town. The unanimous national response to individual need and its perceived effect on social stability in the early and mid-nineteenth century was to create ideal "asylum" environments to shelter, cure, and/or reform those citizens who could not cope with what was viewed as an increasingly complex and corrupt society. The goal of institutional proponents was "to secure social stability through individual rehabilitation" (Rothman 1971: 217), and to improve the quality of life for those most in need (Taunton Lunatic Hospital; 2nd Annual Report 1855). The ideal asylum environments had much in common with ideal Utopian communities of the period.

Eastern Massachusetts was on the forefront of change in all the areas discussed above. Thus, it is not surprising that active advocacy for improvement in the living conditions of the disadvantaged began in the earliest years of the nineteenth century with the establishment of numerous private charitable institutions like the Boston Female Asylum for Orphans (1800), the Boston Dispensary (1801), the Massachusetts General Hospital and its psychiatric subdivision, McLean Asylum (1811), and the New England Asylum for the Blind (1829). Many of the same social reformers and philanthropists involved in these institutions began to petition the state to expand its role in the 1820s.

The first major step toward full-scale state involvement in charitable endeavors came in 1821 with a report to the General Court by Josiah Quincy on the subject of pauperism. Examining the post-Revolutionary period 1791-1820, Quincy found that the settled poor (those having legal residency in a town and thus having claim to its support) had remained at a fairly constant level, while the unsettled poor (those without legal residency and thus dependent on remuneration from the state) had increased fivefold (Sanborn 1876: 17). Quincy recommended that the subject of the poor be put under the annual supervision of the legislature, taking for granted "that the present system of making some public, or compulsory provision for the poor, is too deeply riveted in the affections or the moral sentiment of our people to be loosened..." (Sanborn 1876: 18). No concrete action on Quincy's report was taken by the state until 1852, when three state almshouses were established and quickly filled to overflowing.

In 1829, eight years after Quincy's report on poverty, the legislature

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was again asked to consider the condition of the state's dependent citizens. This time Horace Mann brought forth the issue of humane treatment and accommodations for the insane, who were then kept in local poorhouses or jails if not at home and were frequently chained and otherwise mistreated. Mann was appointed chairman of a committee to investigate "the practicability and expediency of erecting or procuring, at the expense of the Commonwealth, an asylum for the safe-keeping of lunatics and persons furiously mad" (Sanborn 1876: 39). At the same time, towns were directed to provide statistics on their insane to the Secretary of the Commonwealth (Hurd 1916: 586).

This time, the Legislature was immediately convinced of the need to care for such a population, and appointed three commissioners to select a site and erect a hospital for 120 insane persons. The committee chose the large central Massachusetts city of Worcester, whose geographic location offered equal access to all citizens of the Commonwealth. The fact that it was the hometown of Governor Levi Lincoln may also have been a factor. Thus, the state's first insane asylum, which was one of the first in the nation, was completed in 1832 adjacent to the developing city center.

A decade later, Mann's findings were amplified, and the inadequacies of a 120-bed state facility revealed, by Dorothea Dix, who visited local poorhouses and jails throughout the Commonwealth. Many of the insane she found in those facilities had spent some time at Worcester, but had been returned even when they showed improvement, due to lack of local funds and/or to make room for others at the already overcrowded asylum. The nationally known Dix delivered an eloquent Memorial to the State Legislature in 1843. Her moving testimony resulted in immediate expansion of the Worcester asylum to 320 beds, and in establishment of two new asylums within the decade. In her address she stated:

> I come to present the strong claims of suffering humanity. I come to place before the Legislature of Massachusetts the condition of the miserable, the desolate, the outcast. I come as the advocate of helpless, forgotten, insane, and idiotic men and women; of beings sunk to a condition from which the most unconcerned would start with real horror; of beings wretched in our prisons, and more wretched in our almshouses. And I cannot suppose it needful to employ earnest persuasion, or stubborn argument, in order to arrest and fix attention upon a subject only the more strongly pressing in its claims because it is revolting and disgusting in its details...I proceed gentlemen, briefly to call your attention to the present state of insane persons confined within this Commonwealth, in cages, closets, cellars, stalls, and pens! Chained, naked, beaten with rods, and lashed into obedience (Dix 1843: 2).

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These strong words were backed up with the hard data of specific examples. Among her findings were an idiot who had been chained in a small stall in Lincoln for 17 years; an insane man in Granville who was losing use of his limbs due to the closeness of his confinement; a woman at Danvers who was tearing her skin off due to the filthy conditions in which she existed; a naked skeletal woman kept for years in a small lightless and airless closet beneath the cellar stairs at Newburyport; a man at Wayland crippled from the effects of confinement and unrelieved cold; and a young woman at Newton who was confined naked in a stall where she was at the mercy of profligate men and boys. Generally, Dix observed that these conditions arose from ignorance on the part of local caretakers rather than sadism, arising from the general belief that the insane and retarded lacked human emotion and feeling.

The hopeless and inhumane conditions of the insane at most local facilities stood in sharp contrast to the comfort, care, and enlightened understanding offered at Worcester. Dix's detailed observations clearly defined the value of the asylum approach and the comparative haven it offered. She stated:

> I do not know how it is argued that mad persons and idiots may be dealt with as if no spark of recollection ever lights up the mind. The observation and experience of those who have had charge of hospitals show opposite conclusions (Dix 1843: 10).

The scope of state welfare efforts was greatly expanded when two additional committees were appointed by the Legislature in 1846 to study the question of state facilities for the care of "idiots" and the reform of juvenile offenders. The former, headed by Samuel Gridley Howe, resulted in the Massachusetts School for Idiotic and Feeble-Minded Youth (South Boston, 1848-52/Waltham, 1887), which is seen as the initial step toward public involvement in the care and training of the "feeble-minded" nationwide (Wallace 1941: 7-9). The latter, strongly influenced by Theodore Lyman, resulted in the Massachusetts State Reform School (Westborough, 1848). Both of these institutions were the first state-operated facilities of their type in the nation.

State involvement in the charities continued to expand over the next thirty years to include two additional hospitals for the "insane" (Taunton, 1851; and Northampton, 1855), three almshouses for the poor (Bridgewater-now Mass. Correctional Institution, Monson, and Tewksbury of 1852), and two establishments for adolescents: the Nautical Reform School (Marion, 1859; now Mass. Maritime Academy), and the Industrial School for Girls (Lancaster, 1854; now MCI). All were run by independent Boards of Trustees who reported to the Governor and Council. Additionally, the state cooperated with the three

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counties--Suffolk, Essex, and Middlesex--that had established facilities for "idiots and lunatics not furiously mad," in compliance with a state law of 1836. (Tthe Suffolk facility, known as the Boston Lunatic Asylum at South Boston, 1839, was eventually taken over by the state in 1908.)

By 1863, the system had become extensive and complex enough to require some type of coordination, so the legislature established the Massachusetts Board of State Charities (Chapter 240, Acts of 1863) and charged it with supervision of the whole system of public charitable and correctional institutions. This board developed from the 1854 Commission on Lunacy (DMD 1930: 3).

Typically, its mission was to gather data, define issues, and establish public policy, rather than to regulate. As the first of its type, and one of the most influential in the nation (Grob 1983: 40, 50, 79), it epitomized the optimistic liberal outlook of early reformers and institutional managers. Two statements by Dr. Samuel Gridley Howe (1801-1876), its chairman from 1865 to 1874, illuminate contemporary thought in Massachusetts. In the Board's Annual Report of 1867 he said:

> ...the purpose of charity in New England has been to diminish the number of the helpless, to make them sounder, stronger, more hopeful and self-reliant. Justice, no less than mercy, has been in the thoughts of our people; a justice not satisfied with almsgiving, but seeking zealously to establish a Social condition in which alms would be less and less needed.
>
> Painful as the sights of woe in many of our charitable institutions must be, they are made more tolerable by the thought that in America --the home of the poor man-- we are in the way to throw off and neutralize much of the misery handed down to us from older countries and less hopeful times.
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> In 1870, he continued in this vein saying, that "longer acquaintance with the condition of the dependents strengthens the belief that the existence of whole classes of defectives, of paupers and of criminals, is not among the essentials, but the accidents of a highly civilized state; and that the number and condition of those classes is largely under human control."

Thus one can see that early and mid-nineteenth century reformers believed passionately in the eventual eradication of poverty, crime, and disease, both mental and physical, and in the ultimate perfectibility of society. In this they were closely allied with contemporary Utopian thinkers, many of whom resided in Massachusetts.

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Two additional "insane hospitals" at Worcester (1870; NR 1980) and Danvers (1873; NR 1984) were established under the sixteen-year tenure of this innovative Board.

Chapter 291 of the Acts of 1879 consolidated the state's approach to public welfare by merging the Board of State Charities with the State Board of Health (est. 1869) and several institutional boards that had remained semi-autonomous up to that point. These included Boards of Trustees of the State Reform School (Lyman School, Westborough, 1848/84), and the State Industrial School (Lancaster Industrial School for Girls, 1854; now MCI), as well as the Boards of Inspectors of the State Primary School, the State Almshouse, and the State Workhouse (formerly the almshouses at Monson, Tewksbury, and Bridgewater respectively; the latter now part of MCI). During the seven-year tenure of the Board of Health, Lunacy, and Charity, only the Westborough Insane Hospital was established, in 1884, incorporating the early buildings of the Boys' Reform School, which was moved a few miles eastward.

By the end of this board's tenure, there was a marked change in attitude, reflecting the national mood of pessimism about the ability of institutions to cure mental problems, reform criminal behavior, or eradicate poverty. It was also noted that the consolidation of Charities and Health was unsuccessful because the board "had to scatter its forces in so many directions." Typically, Massachusetts was one of the first states to experiment with a centralized administrative structure to maximize efficiency and accountability in the face of a growing state welfare function. Influenced by the size and strength of its professional medical community, it was also one of the few states to reject central political control at the turn of the century (Grob 1983: 211, 233). At this time, Massachusetts was noted as a pioneer in the development of wise legislation for the insane by a 1884 national study entitled "Legislation on Insanity" (DMD 1930: 3).

The responsibilities of the multi-faceted Board of Health, Lunacy, and Charities were reapportioned when the Board of Health was re-established by Chapter 101 of the Acts of 1886 and the Boards of Insanity and Charity were separated by Chapter 433 of the Acts of 1898. Between 1886 and 1898, three innovative institutions were established under the auspices of the Board of Charity and Insanity: the Massachusetts Hospital for Dipsomaniacs and Inebriates at Foxborough (1889; the nation's first public hospital specifically for alcoholics, separating that class from the general insane population), the Medfield Insane Asylum (1892; the state's first facility erected specifically for chronic cases of insanity), and the Templeton Colony of the Fernald School (1899; the state's only facility specifically for chronic cases of retardation). Additionally, Monson was converted to the Massachusetts Hospital for Epileptics (1895).

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Establishment of these specialized institutions reflects the ferment of late-nineteenth century psychiatry, and its growing belief in the possibilities of scientific progress. This led to experimental programs for some classes of the insane such as alcoholics and epileptics, whose disease had a known--and thus more treatable--physical basis. It also led to segregation of chronic patients in institutions where the goal was to enhance the quality of their lives rather than to return them to society. The concurrent determination to hold maximum patient populations at 2,000 per institution attempted to limit the negative impact of rising populations on the hospitals' ability to treat and care for patients. A fourth institution, the Rutland State Sanatorium (1895; the nation's first public hospital for tubercular patients), established by the Board of Health, reflected advances in scientific understanding of the causes of physical disease.

One of the primary tasks of the new Board of Insanity was to complete the transition of care for the insane that had begun in 1830 from the local to the state level. State responsibility, which resulted in transfer of insane inmates from local poorhouses to state asylums, was mandated in 1900 with funding provided in 1904 (Grob 1983: 86; Chapter 451 Acts of 1900). Towns took this opportunity to reclassify the senile aged as insane, thus greatly increasing the state burden of aged chronic patients who generally remained within the system until their deaths. The state developed two large rural campuses at this time to provide accommodations for the anticipated influx of new chronic patients. These were the State Colony for the Insane at Gardner (Chapter 451, 1900; now MCI) and Grafton State Hospital (Chapter 434, 1901).

Similarly, the Legislature transferred responsibility for the care and support of indigent feeble-minded children to the state in 1908, resulting in the establishment of a second state school at Wrentham (Wallace 1941: 69). Epileptics were also remanded to state care in 1908 (DMD 1930: 3), following up on the 1895 initiative to convert the former Almshouse and State Primary School at Monson to the Massachusetts Hospital for Epileptics. As a result of this massive expansion of the system, the Board of Insanity conducted a systemwide review in 1904-1905 to establish uniform standards of capacity that could be impartially applied to avoid overcrowding at any of the campuses (DMD 1926: 104-107).

During the twentieth century, the State Board of Insanity was reorganized several times, then renamed the Massachusetts Commission on Mental Diseases by Chapter 285 of the Acts of 1916, the Massachusetts Department of Mental Diseases by Chapter 350 of the Acts of 1919, and finally the Massachusetts Department of Mental Health by Chapter 486 of the Acts of 1938. Similarly, the State Board of Health was renamed the State Department of Health by Chapter 792 of the Acts

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of 1914, and the Department of Public Health by Chapter 350 of the Acts of 1919. The same Act of 1919 created the Department of Public Welfare out of the former State Board of Charities. Chapter 350 of the Acts of 1919 established a Division of Juvenile Training within the Welfare Department to oversee the state reform schools. Chapter 638 of the Acts of 1969 created the Department of Youth Services and mandated closure of the state reform schools.

Separate acts of this period also changed the names of the individual institutions from lunatic or insane asylums to state hospitals, and from schools for feeble-minded youth to state schools. These changes in name reflect psychiatry's new focus on scientific understanding of mental diseases and the desire for institutions to evolve from ideal places of retreat to ones of cure.

These administrative and departmental refinements reflected the ever-increasing size and expense of the state institutional system after full responsibility for the mentally ill and retarded was assumed in 1900-1908. They also created an increasingly unwieldy bureaucratic structure, at least partially controlled by political rather than medical objectives, which helped to dilute the zeal and idealism of earlier institutional managers. Institutions added during this period included: four state hospitals aimed primarily at chronic care at Grafton (1902), Gardner (1902; now MCI), Norfolk (1914; now MCI), and Waltham/Lexington (Metropolitan State Hospital; 1930); a clinic for acute cases of insanity (Boston Psychopathic Hospital; 1912); two state schools at Wrentham (1906) and Belchertown (1922); a boys' reform school at Shirley (1908; now MCI); three tuberculosis sanatoria all established in 1907 at Lakeville, North Reading, and Westfield; a school for crippled children at Canton (1904); and a research laboratory at Jamaica Plain (1904). Additionally, several colonies for tubercular patients were created at the state hospitals. In 1929-1930, facilities controlled by the Department of Mental Diseases were valued at $27 million and absorbed one-sixth of the state budget. Annually, they cost over $8.5 million to maintain, with another $2.25 million expended for new construction (DMD 1930: 6).

III. Methods of Care and Treatment

The care and treatment of dependent citizens, including the physically and mentally ill, as well as the young and the destitute, can be seen to evolve through several stages beginning with the general acceptance and grouping together of these conditions under the general heading of "poor" in the Colonial period. This was followed in the early nineteenth century by classification of misfortunes, and an initial optimism about the possibility of effecting change and/or cures through a program of Moral Treatment. This strategy included removal of the afflicted one from an increasingly complex society to an ideal physical and social environment created within the boundaries of an

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asylum. The hopeful tenets of Moral Treatment, with slight refinements, were extended from the "insane" to the "idiotic," the poor, and the juvenile delinquent by mid-century. Early asylums offered great improvements in the lives of their inmates, and so enjoyed widespread public approval and support.

As reality tempered optimism in the second half of the nineteenth century, doubts began to grow about the possibility of curing or eradicating these conditions, especially insanity. One of the first to publicly voice the new pessimistic attitude was Pliny Earle, whose widely read essays on "The Curability of Insanity" (or perhaps more properly, the incurability) in the 1870s refuted favorable early statistics on cures. Tewksbury's establishment as a facility for the chronic, or long-term, pauper insane in 1866 was the first institutional response to the problem.

The change in attitude was partially related to the maturing of the system and the overcrowding of its facilities, which undermined the close patient-staff relations of the earlier years. Limits on patient populations grew from 250 per institution in the 1850s, to 600 in the 1870s, to 1,000 by 1900, and to 2,000 in the 1910s. Another factor was a marked increase in chronic cases, especially the aged and senile, for whom there was no hope of cure. Both of these factors were directly related to the state's assumption of full responsibility for care of the mentally ill and retarded in 1900-1908. A third was the failure of psychiatry to keep up with the scientific advances of general medicine, which was beginning to establish meaningful relationships between causes, symptoms, and cures for a variety of diseases.

All of this resulted in an increased emphasis on the custodial or parental functions of institutions, especially insane asylums, which were briefly glorified at the turn of the century. In its annual report of 1886, the State Board of Lunacy and Charity explained that asylums had a broader mission than to simply effect cure:

> The utility of our hospitals and asylums must not be tested by holding them to any impossible standard in this respect. The protection of the community from the harm and loss which the insane inflict, if left at large; the protection of the insane themselves from great sufferings of various kinds; the relief to families that would otherwise be burdened beyond their strength, by the care of insane relatives; these and other benefits which our Massachusetts hospitals and asylums confer, are an evidence of their great utility, both past and present
>
> (Grob 1983: 41).

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Acceptance of a custodial role is clearly seen in the increasingly complex bureaucracy and proliferation of campuses (Context I), and in the rise in acceptable population limits with accompanying changes in building form (Context IV).

Some of the pessimism surrounding insanity was allayed by advances in medical theory that provided new treatment strategies for mental illness with a known physical basis. Establishment of the Massachusetts Hospital for Dipsomaniacs and Inebriates at Foxborough in 1889, the Massachusetts Hospital for Epileptics at Monson in 1895, and three tuberculosis sanatoria in 1907 reflect this trend. Psychiatry's growing belief in the possibility of scientific progress also helped to recreate a limited sense of optimism and to refocus energies from care back to treatment. In Massachusetts, this trend is epitomized by establishment of the Boston Psychopathic Hospital (1912) as an acute care facility based on innovative German models. Community outreach programs, including traveling clinics and social workers, were instituted throughout the state hospital and school system, following the Psychopathic Hospital's successful lead. The mental hygiene movement, with its emphasis on prevention through education and early intervention, attempted to counteract the rapid growth of the system.

The Depression, which forced many families to give up care of dependent members to the state while substantially reducing institutional budgets, and World War II, which drained both staff and funds, seriously depleted an already foundering system. Thus, by the mid-twentieth century, institutional care began to be seen as an outmoded and expensive practice that disregarded patient rights and subjected them to abuse, the very conditions that asylums were founded to counteract. This perception, coupled with development of psychoactive drugs, provided a rationalization for the policy of deinstitutionalization. At its best, that policy has returned patients to responsible community life. At its worst, it has contributed to the conditions that Mann and Dix fought against in the early nineteenth century, with the destitute and mentally disturbed living on the streets without hope or care.

a. Eighteenth-century Background

During the colonial period, Massachusetts thought of and treated dependent citizens in a manner typical of other provincial governments. As has been mentioned, there was no attempt at classification, even into the broad categories of poor, physically ill, or mentally ill. All were considered poor, with men and women, young and old, housed together. Neither was there any attempt to effect cures, since poverty and illness were considered to be natural components of the hierarchical social/religious order. Thus, the poor and ill were cared for by family or friends where possible, or by the

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town when these supports were lacking or the recipient was too unruly or "furiously mad." Large towns erected poorhouses or acquired existing farmhouses to shelter the poor, the ill, the orphan, the "insane," and the "idiotic," together. Smaller towns often auctioned these dependent citizens to the lowest bidder to care for as they saw fit. This system was accepted and deemed adequate until what David Rothman terms "the boundaries of colonial society" began to break down under the pressures of immigration, industrialization, improved transportation; and the rise of a rationalist Enlightenment philosophy stressed the improvability of all men.

Obviously these "boundaries" broke down at different times, varying from town to town and state to state. Massachusetts in general, and its coastal section in particular, was on the forefront of intellectual, social, technological, and economic change in the early nineteenth century. Its capital city, Boston, was a major point of entry; it was the birthplace of the Industrial Revolution in American; it quickly adopted improved modes of transportation such as arrow-straight turnpikes in the period 1800-1810, canals in the 1810s, and railroads in the 1820s and 1830s; and finally, it was home to many early Enlightenment reformers and Utopian thinkers. Thus, it is not surprising that Massachusetts was also on the forefront in developing laws, institutions, and treatment programs for the physically and mentally ill throughout the nineteenth and twentieth centuries.

b. State Care of the Insane: 1830-1940

The "insane" were the first class of dependent citizens to receive specialized institutional treatment from the state when the Worcester Insane Asylum opened in 1830. That facility, and others constructed in the mid-nineteenth century, including Taunton (1851) and Northampton (1855), were run according to the principles of "Moral Treatment." This reflected the influence of European physicians such as Phillipe Pinel, who began to advocate kind and sympathetic treatment of the insane in the late eighteenth century and achieved some success in effecting cures. Pinel's ideas, published in America by 1811, emphasized removal of the insane to ideal asylum environments in rural settings, and the imposition of a regular schedule of sleep, labor, meals, moral instruction, and recreation, as well as gentle treatment, eschewing chains and corporal punishment (Zimmer 1981: 1-2).

This philosophy fit well with the dominant American belief that the increasingly open and fluid nature of their society was responsible for an increase in insanity, and that such problems could be cured within an ideal asylum or institutional setting. The hegemony of Moral Treatment at this time also reflects the status of medical knowledge, which did not yet relate etiology, symptomatology, and physiology (Grob 1983: 12). Moral Treatment's emphasis on ideal

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physical and social environments resulted in exceptional buildings accompanied by extensive agricultural and designed landscapes at nineteenth-century asylums.

Pliny Earle, the nationally noted theorist and Superintendent at the Northampton Lunatic Hospital, described Moral Treatment thus in his Annual Report of 1866:

> Moral Treatment, as the term is generally understood, includes some agencies which might more strictly be called hygienic, as their curative influence is primarily exerted upon the body. The mental or moral influence is secondary. It includes all agencies, the direct and immediate operation of which is upon either the intellect, the passions, the propensities, or the moral and religious sentiments. Practically, in a hospital, everything in the management of patients other than the administration of medicine, the nursing of the sick, and the use of the bath, is considered as moral treatment. Then internal polity of the house, the regular hours, the extension of privileges, the imposition of restraints, all the details of what is called discipline, are included under this head, no less than those other agencies which will demand more special notice, as manual labor, religious worship, intellectual employment, and recreation and amusement, in their diversified forms (11th Annual Report 1866).

At Taunton, they explained the purpose of Moral Treatment and revealed its strong religious basis by saying that the aim of treatment was "to renew, to revive, to recreate that soul, whose original creation was God's greatest work" (2nd Annual Report 1855) Taunton, which is the oldest extant insane asylum in Massachusetts, provides a clear example of the limits of Moral Treatment and the problems caused by growing numbers of incurable, chronic patients throughout the system. Like other early asylums, Taunton was quickly filled to capacity, indicating general popular support and acceptance. However, its very success spawned the seeds of failure, as it was quickly recognized that the "old, helpless, and demented" tended to accumulate (2nd Annual Report 1855), and that the numbers of those who could be cured and released did not equal those who desired admittance. By 1860, the Trustees and Superintendent were asking what was to be done with the growing number of chronic patients. Sending them back to overburdened families, local poorhouses, or lock-ups was considered inhumane. The short-term answer was to move chronic pauper patients to Tewksbury. The longer-term answer, realized over the next hundred years, was to enlarge the system and the hospitals within it, gradually refocusing attention from active cure to reactive maintenance.

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Earle, who was one of the early proponents of Moral Treatment, was also one of the first professionals to vocally express doubt in its ability to consistently effect cures. He did this through a series of lectures and widely circulated essays in the 1870s on the "The Curability of Insanity," which refuted favorable early statistics. Through retrospective studies, Earle demonstrated that cures had been calculated on the ratio of recoveries to cases discharged rather than admitted, that readmissions had been ignored, and that recoveries of a single patient were often counted several times (Grob 1983: 39).

As Moral Treatment, with its reliance on an environmental/social/religious approach, was gradually seen to be limited in its application, other methods with a more physical basis were explored. The Westborough Insane Hospital of 1884, for example, based its treatment program on homeopathic principles that emphasized rest, nutrition, massage, and hydrotherapy. Other less innovative institutions relied more heavily on available drug therapy to control "excitable patients" without recourse to physical restraint. Drugs available in the second half of the nineteenth century included elixir of iron and bark to promote strength, bromide of potassium to control epileptic seizures, and an array of sedatives of varying strengths such as morphine, opium, belladonna, chloral hydrate, paraldehyde, sulphonal, calomel, hyoscyamin, stramonium, and varatrin. An 1875 report to the Massachusetts Legislature noted the importance of medication in treatment of the insane as well as the wide disparity of use among the various state institutions, with some spending three times as much on drugs as others (Grob 1983: 13-14).

Physical restraints, including straitjackets, muffs, straps, handcuffs, cribs, and isolation rooms, were used on about 5% of patients nationwide as demonstrated by data from the 1880 U.S. Census. The issue of restraints was always controversial, with their use generally seen as undesirable but sometimes necessary when patients threatened harm to themselves or others (Grob 1983: 17-18). Soon after opening, Taunton did away with its strong rooms, or small windowless cells, for "excited" patients, preferring instead to offer sympathy and individual treatment, demonstrating their distaste for restraint and its implied cruelty (1st Annual Report 1854).

Ever-increasing patient populations made this approach difficult, if not impossible. Patient employment, which offset the monotony of institutional life, often calmed "excitable" patients without recourse to drugs, and provided some sense of normalcy, routine, and self-esteem, was an important therapeutic tool from the beginning. Out-of-doors tasks were favored because the experience of nature combined with the health-promoting qualities of fresh air and sunlight were considered especially therapeutic. Male patients were generally assigned to farm, construction, and maintenance work while women accomplished household tasks such as sewing and cleaning, supplemented

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by tending kitchen gardens and greenhouses. At Grafton, farmwork was encouraged for women, too. Many of the better-staffed and funded institutions erected special workshops. Patient labor did provide some economic benefit, but few suggested that as its primary value, or that patients be required to earn their keep (Grob 1983: 23-34). The following descriptions of the value and purpose of work at Grafton are typical: "...patients have been encouraged to work wherever possible...with profit both to themselves and the institution" (27 Annual Report 1904).

"In carrying out such a work as this it should always be borne in mind that the improvement of the individual is the prime end sought, and that the occupation is a purely subordinate means to an end. Work of this sort would be a remedial measure, prescribed in the treatment of disease" (31st Annual Report 1908). "...this out-of-doors crew was largely recruited from patients who have formerly sat around the house and done very little or nothing at all....it has relieved the wards of some of its noisy and turbulent women, and in most instances with marked benefit to the patients. The measure of success in this work has not been so much the amount of labor accomplished as the numbers of patients who have been taken out and led back into habits of industry" (32nd Annual Report 1909).

A popular method of managing patients was through increasingly refined systems of classification, primarily based on external behaviors or symptoms. Annual Reports for all of the institutions cite classification efforts. Classification by type kept similar patients together, which tended to reduce conflict and the attendant need for discipline, medication, or restraint (Grob 1983: 22-23). Medfield (1892) is an especially good example of the classification and isolation of various types of patients within a single institution. Original plans show that separate buildings were provided for "quiet," "excited," "untidy," and "epileptic" male and female patients. The 1880 Federal Census included seven categories of mental illness, all based on symptoms, which included mania (affecting 38% of patients), dementia (28%), melancholia (19%) epilepsy (9%), monomania (2%), paresis or tertiary syphilis (2%), and dipsomania (1%) (Grob 1983: 8).

The late nineteenth century's growing reliance on drugs, restraints, work therapy, and symptomatic classification all reflect the fact that the causes of insanity were not yet understood. For example, the role of heredity had been observed for many years, but the failure to understand it is demonstrated by the following statement from the asylum at Taunton:

> Could we trace it closely enough, I think we should find this hereditary taint in the blood far more potent in the production of insanity than all the array of alleged causes which makes so much show in tables. It is a leprosy,

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> poisoning life at the very fountain, which, concealed in one generation, breaks out in the next (21st Annual Report 1874).

The impossibility of establishing a scientific psychiatric classification system based on etiology was recognized by Pliny Earle in 1886:

> In the present state of our knowledge no classification of insanity can be erected upon a pathological basis, for the simple reason that, with but slight exceptions, the pathology of the disease is unknown .... Hence, for the most apparent, the most clearly defined, and the best understood foundation for a nosological scheme for insanity, we are forced to fall back upon the symptomatology of the disease --- the apparent mental condition, as judged from the outward manifestations (Grob 1983: 35).

Creation of specialized hospitals for alcoholics at Foxborough (1889), and for epileptics at Monson (1895; reassignment of former Almshouse and State Primary School) reflect classification as well as psychiatry's desire to work with populations whose insanity had a demonstrable physical and treatable basis. Foxborough was the first of its type in the nation, while Monson was third after Ohio (1892) and New York (1894) (DMD 1930:4).

Increased numbers of chronic insane, especially the aged and senile, made a substantial contribution to the pessimism that pervaded asylums in the late nineteenth century. During the period 1880-1886, more than 12% of the state's asylum population was over 60 years of age (Grob 1983: 10). Many institutions tried to avoid this burden by requesting permission to transfer chronic cases elsewhere, or at least to segregate them within separate wards or buildings at their own institutions.

The assignment of the chronic pauper insane to Tewksbury in 1866 was the first instance of a purely chronic care facility in Massachusetts, followed by conversion of the original Worcester Asylum to the Asylum for the Chronic Insane in 1877 after the new Worcester Lunatic Hospital (NR 1980) was completed. The Medfield Insane Asylum of 1892 was the first state hospital established specifically for chronic cases. Soon thereafter, in the early twentieth century, three separate colonies for quiet, chronic insane patients were built at Westborough, and Grafton was established as the Worcester Farm Colony in 1901 with four large colonies, all for chronic cases. Gardner (now MCI) was established in 1900 as the State Colony for the Insane.

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This major increase in chronic care facilities in the early twentieth century reflected the state's full assumption of responsibility for the insane in 1900, and the transfer of insane and senile aged inmates from local poorhouses to state hospitals in 1904. At Grafton the mission of chronic care was described thus:

> ...while not ending in recovery, such limited improvement sometimes takes place as greatly contributes to the capacity of the individual to appreciate the enjoyment of living. A careful and painstaking attention on the part of nurses is necessary, if we are to detect and fan into flame these flickerings of reason (29th Annual Report 1906).

A rural setting that allowed the maximum of personal freedom, with opportunities to enjoy nature and work out-of-doors, was considered crucial to successful chronic care. The colony form of Grafton and Gardner State Hospitals was specially developed to meet this objective.

Another problem that began to affect mental hospitals in the late nineteenth century was difficulty in finding and keeping well-trained nurses and attendants because of low wages and prestige, long hours, and the arduous, sometimes dangerous nature of the work. Some established training schools to alleviate this situation. The first in the country opened in 1882 at McLean Hospital in Belmont, a private asylum associated with Massachusetts General Hospital (Hurd 1916: 609). The second in Massachusetts opened in 1889 at Danvers State Hospital (NR 1983). By 1895, more than thirty such schools existed nationwide (Grob 1983: 20), including several in Massachusetts.

Many hospitals also began to segregate staff and patient living quarters at this time by building separate dormitories for nurses and attendants, as well as single-family houses for superintendents and doctors. This not only created more pleasant living arrangements for staff, but also provided more space for patients in the ward buildings. Nevertheless, many institutions cited problems in securing suitable employees, and in 1906, the Massachusetts State Board of Insanity stated that: "It has been barely possible at times during the past year to procure respectable persons enough to do absolutely necessary work in caring for patients and safeguarding against danger" (Grob 1983: 20).

In the early twentieth century, state legislation increased wages and lessened hours. During World War II, however, almost all of the institutions included in this nomination reported operating with about 50% of their staff positions unfilled (Gov/Council 1945).

With Moral Treatment discredited, no viable substitutes in sight, increasing numbers of incurable chronic cases, and constant staff

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shortages, the institutional treatment of insanity came more generally into question by the turn of the century. At this time, psychiatrists began to divorce themselves from the asylums within which their speciality had developed, further tarnishing the institutional image. Psychiatric thought turned from management and administration of patients in an institutional setting toward a scientific understanding and potential cure of mental disease through such varied disciplines as neurology, cellular biology, pathology, psychotherapy, and mental hygiene. The hopeful turbulence of the time is summed up in a statement by New York neurologist Bernard Sachs: "The past of psychiatry has been full of discouragement; the present is involved in a maze of uncertainty; but the future is full of hope" (Grob 1983: 110).

The two major vehicles for modernizing psychiatry in the early twentieth century were research institutes and psychopathic hospitals, both of which were pioneered in New York in 1895 and 1900 respectively (Grob 1983: 127, 136). In Massachusetts, these changes are most apparent at the nationally influential Boston Psychopathic Hospital of 1912, now the Massachusetts Mental Health Center. Established specifically to treat acute cases of insanity, it was based on the model of innovative German psychiatric clinics and was intended to produce "an earlier and more intelligent method of treatment which will reduce hospital admissions by cure or prevention" (4th Annual Report). It also evidenced the period's growing social mission and emphasis on prevention, which focused on mental health rather than mental illness. The American Medical Association described the new approach thus in 1913:

> The psychopathic hospital in a community is bound to be one of the most concrete sources of enlightenment as to psychopaths, and every society for mental hygiene, for sex hygiene, for the amelioration of alcoholism, for eugenics, should make it part of its business to help start a psychopathic hospital with its outpatient service in every community in which there is any hope for awakening social sense (Grob 1983: 140).

Cure was to be effected through scientific research into the causes of insanity, while prevention was encouraged through development of outpatient and social service departments. Elmer E. Southard, who had been appointed as the first state pathologist in 1909, also served as the first director of the Boston Psychopathic Hospital. Thus, research institute and psychopathic hospital were combined in Massachusetts in an illustrious facility noted for the exceptional quality of its staff and its close ties with the Harvard Medical School (Grob 1983: 137-140). Massachusetts hospitals were said to be the first in the country to establish scientific laboratories (DMD

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1930: 5). Hospitals throughout the system at this time followed the lead of Boston Psychopathic by developing outreach clinics and social service departments. In 1922, Massachusetts established the nation's first mental hygiene program for pre-schoolers, and physicians were required to pass an examination in psychiatry before they could be licensed in that speciality (DMD 1930: 5).

Scientific progress led to development of several controversial intervention therapies for chronic patients in the 1920s, 1930s, and 1940s. Their experimental nature led to extensive debates about whether psychiatrists should wait until conclusive data were available, or whether treatment should be extended without delay to patients who were otherwise without hope of any type of non-institutional life. These treatments included: fever therapy, which was sometimes successful in treating paresis or tertiary syphilis; insulin, metrazol, and electroshock therapy, which seemed to alleviate the symptoms of schizophrenia; and pre-frontal lobotomies, which calmed violent personalities (Grob 1983: 293-305).

By 1930, the total population in Massachusetts institutions had reached 23,680, including 18,300 mentally ill, 1,230 epileptics, and 4,150 feeble-minded. Its expenses absorbed one-sixth of the state budget (DMD 1930: 6). Nationally, chronic patients occupied almost 80% of the available beds in mental hospitals by that time (Grob 1983: 197). That they needed care far more than treatment was an unglamorous fact that was sometimes ignored by doctors, politicians, and the public.

Attempts had been made to accommodate these growing numbers in the nineteenth century by increasing acceptable limits for patient populations from 250, to 600, to 1,000. Nevertheless, exhaustive studies in the early twentieth century documented severe overcrowding throughout the system. Unlike other states, Massachusetts instituted a final limit of 2,000 because "a large hospital militates against individual observation and treatment of patients" (DMD 1926: 108). Overcrowding was resolved through establishment of Metropolitan State Hospital in 1927-1930, and through enlargement of many other campuses, most notably Northampton. Many construction programs of the 1930s were funded by the Works Progress Administration and other Federal relief programs.

Despite these physical improvements, and renaming of the old asylums and lunatic hospitals as state hospitals, they were popularly and professionally associated with psychiatry's past failures. Disassociation of psychiatric progress and prestige from the hospitals, coupled with the increasing chronic populations and decreased funding, led to their perception as backward warehouses where patients were abused and confined against their will by the mid-twentieth century. Thus, by the 1940s:

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> . . . there was general agreement that too many patients had become 'institutionalized' and hence were destined to spend the rest of their lives as pitiful guests dependent on public largesse; that brutality and neglect were endemic; that deteriorating physical plants and inadequate care were common; that lethargy, neglect, and overcrowding had reduced mental hospitals to the status of inadequate poorhouses" (Grob 1983: 199).
>
> Once viewed as the harbingers of progress, mental hospitals were now portrayed as monuments to human degradation, brutality, and indifference (Grob 1983: 318).

The national population at state and county mental hospitals peaked at 559,000 in 1955. After that time, a national public policy of deinstitutionalization was promoted by the availability of new psychoactive drugs and psychiatric therapies, by alleged violations of patient rights and the perceived ill effects of long-term institutional care, by the deteriorating condition of the physical plants, and by the shift of fiscal responsibility from the state to the federal level. The latter became particularly important in the 1960s when the Joint Commission on Mental Illness and Health recommended a national policy of no new construction at mental hospitals, and federal grant programs encouraged the shift of aged patients from hospitals to nursing homes (Grob 1983: 317-319). A recent report of the Governor's Special Commission on Consolidation of Health and Human Services Institutional Facilities noted that:

> 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 (Special Commission 1991: i).

c. State Care of the Mentally Retarded: 1848-1940

The inhumane living conditions of "idiots" was brought to the attention of the state by Samuel Gridley Howe, a reformer previously noted for his work with the blind, deaf, and dumb. He was successful in securing a small appropriation in 1848 to teach ten "idiotic" children in an experimental program that quickly expanded into the Massachusetts School for Idiotic and Feeble-Minded Youth. This was the first public institution for the feeble-minded in the United States, followed by schools in Syracuse, N. Y., in 1851, Lakeville, Conn., in 1852, and Elwyn, Pa., in 1853. By 1892, nineteen public institutions had been founded with populations ranging from twenty-five to more than 800, for a total of 6000 patients nationwide. The 1890 U. S. Census counted 95,571 feeble-minded persons; only 420

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of the 3,000 counted in Massachusetts at that time were receiving institutional care (Wallace 1941: 45-46). Massachusetts established three schools including Wrentham (1906-07) and Belchertown (1915-20). As was the case with insane asylums, national organizations developed as the public institutions became more common. These included the Association of Medical Officers of American Institutions for the Feeble-Minded, and the American Association for the Study of the Feeble-Minded, both established in 1876 (Wallace 1941: 47, 67).

Treatment programs at these schools for the feeble-minded were based on the tenets of Moral Treatment combined with special teaching methods developed by Edouard Seguin. Seguin, who began instruction of "idiots" in Paris in 1837, was the first to theorize that idiocy was caused by an arrested development of the brain occurring before, during, or after birth. More importantly, Seguin developed a system of painstaking physiological training of the senses, which "might restore them to society and life." Seguin's Treatise on Idiocy, published in 1846, sparked international interest in the subject and was still held in high esteem one hundred years later. Seguin's ideas were also instrumental in development of the Montessori teaching methods in the early twentieth century. Thanks to Seguin's genius, treatment of "idiots" was initially more successful than treatment of the "insane," resulting in placement of the Massachusetts School under the Board of Education in 1886.

The intent of the treatment program developed for "idiots" during the nineteenth century, and its moral rather than scientific basis, was summed up by Dr. Howe at the school's outset in 1848:

> "it is proposed] to train all the senses, to strengthen the power of attention, develop the muscular system, and some degree of dexterity in simple handicraft. To call out their social affections, to inculcate feelings of regard for others in return for love and kindness shown them, to appeal to the moral sense and to develop religious sentiment.
>
> It is to be hoped that part of them will gain useful knowledge, most of them become cleanly, decent and industrious, and that all of them will be better and happier from the efforts on their behalf (Wallace 1941: 10).

By 1875, Howe defined "idiocy" as:

> ...the condition of a human being in which, owing to some morbid cause in the bodily organization, the faculties and sentiments remain dormant or undeveloped, so that the person is incapable of self-guidance, and of approaching that degree of knowledge usual with others of his age.

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> He had also defined three classes of persons with imperfect cerebral organization based upon their ability to use language: "idiots" who could use no words by age 12; "simpletons" or "imbeciles" who could use nouns only; and "fools" or "morons" who could construct simple sentences.
>
> Other factors that Howe considered important to classification were physical examination of form, weight, and dimensions; habits and general temperament; and color perception (Wallace 1941: 22).

The treatment programs developed in the nineteenth century combined study, manual training, and recreation in a highly structured and supervised routine. The abilities of small children were developed through the Seguin and Kindergarten methods, while older children were assigned to graded classes in reading, writing, geography, and history, and also participated in occupational therapy programs. Trained adults who were employed at the hospital during the day at farming, kitchen and laundry work, sewing, etc., attended evening programs in music, gymnastics, dancing, basketry, etc. The importance of industrial training and physical exercise to the overall program were described thus in 1892:

> We do not expect to make skilled artisans of new pupils. The finished work is a secondary consideration, the mental discipline secured the accurate doing is the desired result. Nearly all our pupils receive systematic physical training. Mental awakening generally follows increased physical development" (Wallace 1941: 43).

There is also frequent mention of the relationship between productive labor and self-esteem in the annual reports for the state schools.

The Massachusetts School entered the twentieth century expanding its innovative programs rapidly and retaining its national and international stature. Many of the new programs reflected the national mental hygiene movement with its emphasis on mental health.

A school department with graded classes was opened in 1892 (Wallace 1941: 42). Teaching clinics for Tufts and Boston University Medical School students were instituted in 1903, expanding the program initiated in 1884 with Harvard (Wallace 1941: 32, 61). A formal parole or vacation system was adopted in 1912 along with the new position of field or social worker to supervise pupils with outside placements. At the same time, an out-patient clinic was established, further strengthening community ties. By 1915 monthly clinics had been started in Worcester, Fall River, New Bedford, and Haverhill, and that year the school held a total of 32 clinics involving 743 patients (Wallace 1941: 92). Patients' general health needs were treated more

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scientifically in a small campus hospital as methods and products developed by the State Board of Health, such as diphtheria antitoxin, were employed in 1915, and tuberculosis tests were introduced in 1920 (Wallace 1941: 90, 100). More complete profiles of the patients' mental condition were also made available through the use of new psychological tests such as the Binet-Simon and the Intelligence Quotient (Wallace 1941: 82; 104). Dental Clinics, held by Tufts University, were established in 1917 (Wallace 1941: 94). The first women physicians--Drs. Anna M. Wallace and Edith Woodill--were appointed in 1907 (Wallace 1941: 68). X-ray examination of the brain was introduced as a diagnostic tool in 1920 (Wallace 1941: 100).

At the same time, several issues arose that deflected some of the state schools' energy away from their primary educative purpose, and toward custodial care and management. They arose from a growing societal fear of increased deviancy, as science illuminated the role of heredity and began to link feeble-mindedness with crime, pauperism, and immorality. A governor's commission was appointed by Chapter 59 of the Acts of 1910 to investigate "the increase of criminals, mental defectives, epileptics, degenerates, and allied classes" and to make recommendations for the protection of the Commonwealth and its citizens. Among the commission's recommendations were provision for permanent custodial care of defective delinquents and the prohibition of marriage and reproduction for such classes. Dr. Walter K. Fernald, who headed the Massachusetts School and was a national leader on these issues, was appointed the chairman of the commission. These concerns expanded the mission of the state schools to acceptance of chronic, pauper, delinquent, epileptic, and physically disabled cases who were not considered suitable for training, but who were nevertheless in need of proper care. Thus, the early twentieth century was a period of major growth at public institutions for the feeble-minded as illustrated by the Massachusetts School, where applications for admission rose from 142 in 1889 to 484 in 1911 (Wallace 1941: 75-78), and by the founding of a second school at Wrentham in 1907.

In Massachusetts, the need to provide permanent care for some chronic patients was recognized by the 1870s. A farm school for adult males was established at Dover in 1880, with a much larger successor at Templeton in 1899. The farms were designed to provide a useful and happy living situation for adult males trained at the main school, with programs based primarily on closely supervised exercise and farmwork in a healthy out-of-doors environment; the idea was based on colonies for epileptics in Germany and New York. The other campuses were developed with separate wards for adult chronic patients as well. In 1905, the British Royal Commission on the Care and Control of the Feeble-Minded provided the following glowing report on Massachusetts facilities, showing particular admiration for the Templeton Colony:

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> This is a most interesting institution, embodying in itself the whole history of American methods of dealing with the feeble-minded from its earliest beginnings in the training school for the idiot to its latest development the colony (Templeton) for the permanent custodial care and employment of defectives unfit for free life. Its superintendent is Dr. W. E. Fernald, who is not only one of the greatest authorities in the United States of America on the medical aspect of the care of mental defectives, but is an institutional manager of great energy, enthusiasm, resource, and capacity (Annual Report, 1905).

Annual reports of the period cite the need to care for mentally deficient patients who had been assigned to the state reform schools and insane asylums, but also recognize the problems that might be caused by these individuals. In the 1901 report it said:

> Attention is called to the large number of admissions over 14 years of age of both sexes, from Mental Hospitals, Girls' Industrial School at Lancaster, and Lyman School for Boys. Many received or admitted show an increased proportion where the moral deficiency is greater than the mental defect. Many problems of this type came from the Children's Aid Society, Society for Prevention of Cruelty to Children, and from police courts. Many of the above had been placed out repeatedly without success. They are a perplexing problem in the School. They must be isolated in special buildings which will be required for proper classification (Wallace 1941: 59-61).

Chapter 796 of the Acts of 1913 provided for segregation and care of defective delinquents in the state's criminal facilities, but this was apparently not enforced, and they continued to be placed at the state schools until 1922, when provisions were made at Bridgewater (Wallace 1941: 96, 107).

The Massachusetts School reports also stress the need to provide permanent institutional protection for adult females and to segregate adult male and female patients within the institution. By 1901, when chronic female patients of child-bearing age numbered 200, it was stated:

> The principal department of the Massachusetts School for the Feeble-Minded is the custodial department, and the protection of feeble-minded women its most important office.

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> Public opinion now requires the segregation of adult males and females of the higher grades of feeble-mindedness to prevent marriage of such individuals, and resulting increase of mental defect in the community. The purchase of 50 acres of added land in Waverley is advised on which the new buildings may be built (Wallace 1941: 59-61).

In 1909, Dr. Fernald further stated:

> It has been recently said that practically all high-grade indigent feeble-minded women become mothers of illegitimate children, many of them soon after reaching the age of puberty; that most of the children of feeble-minded women are feeble-minded; that the histories of these feeble-minded women and their feeble-minded children are practically the same. Their birth, poverty, helplessness, ruin and bearing of illegitimate children form parts of an endless chain, a recurring sequence. By means of it the State is continually supplied with degenerate human beings (Wallace 1941: 74).

The question of sterilization arose in the 1920s and 1930s, and while the procedure was generally favored, the Massachusetts state schools were not considered to be the appropriate place. In 1933 it was noted that 27 states had passed laws to allow sterilization (Wallace 1941: 126, 142).

The results of the growing patient population are seen in several ways. One is in the establishment of additional schools in Massachusetts at Wrentham (1906-1907), and at Belchertown (1915-1922), and in all of the other New England states during that period. By 1933, with a waiting list of 1,829 at the parent institution at Waltham, renamed as the Fernald School, discussions about the necessity of a fourth school began (Wallace 1941: 141). The other result is the major building campaign that transformed the Waltham campus between 1895 and 1925, expanding its capacity from 600 patients to over 1,000.

Public concern about the hereditary nature of mental defects, mental disease, and criminality, and the links between them encouraged scientific research in the early twentieth century. Research included studies of the hereditary nature of Mongoloidism and spastic paralysis, and of diseased brain conditions undertaken by the Neuro-Pathological Laboratory of Harvard Medical School (Wallace 1941: 91). In the 1920s, research began to show the relationship between diseases of the ductless glands, such as the thyroid and endocrine, and feeble-mindedness (Wallace 1941: 101). By the 1930s, research was exploring the relationship between mental deficiency and psychosis, and ways to distinguish between them in diagnosis (Wallace 1941: 142). At this time, Dr. Greene, Superintendent of the Fernald School, began

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advocating for a full-time research staff, stating:

> There is nowhere in the world an accumulation of material, records, facts, and types of cases for such work as there is to be found here.
>
> The etiological factors of mental defect are of deep interest; also eugenic studies and the problem of psychoses. These alone would constitute a program to fill the entire time of such a department (Wallace 1941: 151).

In 1937, Dr. Paul I. Yakovlev was appointed Director of Clinical Research at the Fernald School (Wallace 1941: 155). His work was described thus:

> clinic and bio-chemical routines as well as pathological, histological and microscopic studies, X-ray, etc, are being carried on; research is directed to both laboratory and clinical symptomatology and an attempt to get at etiology -- the hereditary and environmental factors and diagnoses and thus provide a scientific basis for therapy and prevention of mental defect (Wallace 1941: 159).

The impact of the national Mental Hygiene movement is seen in Chapter 277 of the Acts of 1919, which formally divided the state into districts and established out-patient clinics served by psychiatrists from the state institutions. Traveling clinics consisting of a psychiatrist, psychologist, and social worker were also instituted. These clinics helped to fulfil the provisions of Chapter 318 of the Acts of 1919, which called for free clinics and a registry of the feeble-minded (Wallace 1941: 102-103). The traveling clinic examined 1,564 patients in 1922, and found 1,271 to be feeble-minded. It was recommended that 489 stay in grade school, 803 attend special classes, 68 be institutionalized, and 885 attend manual and industrial training classes (Wallace 1941: 109). By 1931 it was noted that facilities for special classes in public schools were available (Wallace 1941: 131).

In the 1938 annual report of the Fernald School, Superintendent Dr. Ransom Greene articulated the current philosophy of the institution. Although he professed to be a believer in tradition, his words demonstrated the vastness of change that had occurred since the mid-nineteenth century:

> I wish to pay tribute to all the predecessors of the position which I now hold, in that they have always been more concerned about principles than standards and their primary interest has been the possibility of ameliorating the burden to society of those for whom they and we have to care, and in addition determine, if possible, how future generations may protected

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> or relieved from such a burden....
>
> The problem as a whole is far from simple; it involves primarily medical knowledge and, not secondary, but in addition, problems of education, sociology, psychology and legal affairs....The principles involved have been not only that of ameliorating the burden and immediate stress of the individual but the problem as a whole from the standpoint of welfare of our communities and relieving them of this burdenfor future generations....This has been the aim from the time of Dr. Howe, Dr. Sequin, Dr. Jarvis and Dr. Fernald. We are making progress along these lines....We have reached the stage in the last year where we have been able to start on a definite research program....the ends for which we aspire are based on purely the principles exemplified by the founder of such an institution as this, Dr. Samuel Gridley Howe." (Wallace 1941: 156-57).

The contrast between Howe and Greene is great. While Howe stressed individual improvement, and the responsibility of society to help "defectives" achieve their personal best, Greene stressed the responsibility of the schools to relieve society of the burden they caused.

d. State Care of the Poor: 1852-1940

The poor were cared for in local poorfarms and lock-ups until 1854, when three state almshouses were opened at Bridgewater, Monson, and Tewksbury. These almshouses, which were almost immediately filled to overflowing, probably did little more for the poor than provide basic shelter and food although their Annual Reports indicate that there were limited attempts at Moral Treatment through Sunday religious services and work programs. The poor received less attention than the insane, the idiots, or juvenile delinquents because they were seen as responsible for their condition, rather than as victims of society. Many were also foreign-born, lacking the support of other groups.

A Memorial History of 1880 described the origins of the Almshouses thus:

> the State Almshouses of Massachusetts are unlike any other charitable institutions of the country, in that they were established and supported by the State government, and even here they were originally intended as mere temporary expedients to meet a pressing emergency. The immediate cause of their establishment was the large influx of foreign immigration, following the period of general famine and great distress which prevailed through Ireland in the year 1847, and populated the manufacturing towns of the State beyond their

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> capacity to provide, filling the town almshouses to overflowing and burdening the towns with a large and insupportable pauper dependence. Petitions for relief poured into the legislature of 1852 from every side, and the State Almshouses were the result (Marden 1880: 158).

Perhaps because the almshouses were built as a temporary measure, or because classification of the poor became increasingly refined, the almshouses were quickly turned to specialized functions, which remained directed at the poor. Monson became the State Primary School in 1873; Bridgewater (now MCI) became the State Workhouse in 1873; and Tewksbury, the last of the three to remain an almshouse, became the State Hospital in 1900.

e. State Care of the Sick: 1852-1940

Although the symptoms of various diseases were recognized throughout the nineteenth century and some were treated at the poorhouses, no specialized state institutions were developed to treat them until the end of the century. The first was the Massachusetts Hospital for Dipsomaniacs and Inebriates, established at Foxborough in 1889, responding to state legislation of 1885 that recognized alcoholism as a disease; it was replaced by a colony at Norfolk (now MCI) in 1912. Patients were treated in a similar fashion to those in insane hospitals, although they were less confined. The value of labor, gymnastic exercise, and a regular schedule were especially emphasized, as were therapeutic baths. The intended effect of the treatment was described in the Annual Report of 1894:

> These exercises make the mind more alert, train the muscles and the willpower over the muscles, and so over the man. By the muscular exercise the effete matter and poisonous accumulations in the body, the results of prolonged use of alcohol, are thrown off and replaced by new tissues in the body and brain. The bath acts as a most powerful stimulant, especially to the nervous system.

In 1895, the first of four state sanatoria was developed at Rutland. The initiation of a program to treat tuberculosis at that time reflected Robert Koch's 1882 breakthrough in isolating the tubercle bacillus and demonstrating its causative role. Treatment of tuberculosis at the turn of the century relied as much on prevention as it did on cure and was thus allied with the mental hygiene movement. Most Western nations developed complex networks consisting of hospitals for advanced cases, sanatoria for mild cases, and dispensaries to diagnose new cases, combined with active public education. Treatment in the hospitals and sanatoria consisted of long-term bedrest, nutritious meals, and exposure to as much fresh air as the patients condition could withstand. Rutland's opening was

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followed by establishment of other state sanatoria at Lakeville, North Reading, and Westfield in 1907, by the creation of a county hospital system, and by the addition of tubercular colonies to several of the existing "insane asylums," most notably Westborough and Tewksbury.

Accompanying the growing interest in the detection, diagnosis, and treatment of disease, the state established a research and production (of vaccines and antitoxins) facility at Jamaica Plain in conjunction with Harvard University. Originally known as the Bussey Institute, it is now the Institute of Labs.

f. State Care of Juvenile Delinquents: 1847-1940

Juvenile reform schools sprang from the same general movement to classify the poor that produced orphanages in the early nineteenth century. Their founders believed that by separating children from the corrupting influences of inadequate parents or other adults, and placing them in an ideal and disciplined environment, they could greatly improve their chances of becoming productive citizens. Specialized houses of refuge began to be established by private charities in the early nineteenth century to reform disobedient children. They took in juvenile offenders who had been convicted of petty crimes, wandering street arabs picked up by local constables, and willfully disobedient children turned over by their parents. By 1857, the movement was broad enough to hold a national convention of refuge superintendents in New York, at which time it was estimated that seventeen institutions existed with a combined population of over 20,000 (Rothman 1971: 209). Typically, the earliest institutions established for the care of wayward juveniles in Massachusetts were private charities in Boston, including the Boston Female Asylum of 1800, and the Boston Asylum for Indigent Boys of 1814.
The Commonwealth of Massachusetts established three juvenile reform schools in the mid-nineteenth century and a fourth in the early twentieth century. The first step in this process was appointment of a committee in 1846 to consider the need for a "State Institution for the Reformation of Juvenile Offenders." A Resolve of April 1846 authorized construction of a State Manual Labor School. The Massachusetts State Reform School at Westborough was established the following year, with Theodore Lyman supplementing the $10,000 state appropriation with his own money and serving as president of the Board of Trustees until his death in 1849. The institution was renamed the Lyman School for Boys in his honor. Contemporaries noted this as the first state-operated juvenile reformatory in the United States (Sanborn 1876: 71). It was described in the 1854 National Magazine as

> the first enterprise in our country whereby a state, in the character of a common parent, has undertaken the high and sacred duty of rescuing and restoring her lost children, not so much by the terrors of the law as by the gentler influences

of the school (Allen 1985: 317).

In 1855, the State Reform School for Girls, renamed the State Industrial School for Girls in 1860, was established in Lancaster as a counterpart to the boys' institution. The State Nautical Reform School at Marion was established in 1859 as an adjunct to the Lyman School, providing programs for older and more hardened boys. This followed the traditional practice of apprenticing especially troublesome boys to ship captains, thus subjecting them to the exacting discipline of a long voyage (Rothman 1971: 230). The Massachusetts Industrial School for Boys was established at Shirley in 1908. Lancaster and Shirley have been transferred to the Department of Corrections, while Marion has evolved into the Massachusetts Maritime Academy.

The familiar tenets of Moral Treatment provided the basis for the programs offered by reform schools nationwide. Managers of these institutions sought to instill moral values and respect for authority through establishment of rigid routine and enforcement of consistent discipline. Optimism was particularly high because the inmates were young and impressionable. The New York House of Refuge summed up this attitude, stating that "the minds of children, naturally pliant, can, by early instruction, be formed and molded to our wishes" (Rothman 1971: 213). The daily routine offered by reform schools included prayer, work, exercise, and limited educational instruction (Rothman 1971: 225-226, 228). By the turn of the century, rigid mass discipline was tempered by recognition of the role that individual love and affection play in a child's development (Rothman 1971: 220). Architecturally, this is reflected in the change from congregate to dispersed campus plans characterized by moderately scaled "family"-oriented cottages (see Lyman School).

The program and goals offered by the Lyman School were typical of the national trends documented by Rothman. The stated goal was to keep the boys "disciplined, instructed, employed, and governed" until age 21 or until they were reformed, placed with a family, or sent to prison if incorrigible. The program involved instruction in "piety and morality, and in such branches of useful knowledge as shall be adapted to their age and capacity, as well as in manual labor and the arts and trades." The result of the instruction was "to secure to the boys the benefits of good example and wholesome instruction, and the sure means of improvement in virtue and knowledge and thus the opportunity of becoming intelligent, moral, useful and happy citizens of this Commonwealth" (2nd Annual Report 1850). Mid-twentieth century reports indicate that the institution's programs continued to include a mix of academic and vocational training (Governor and Council Report 1945). All of the four reform schools have been converted to other uses in accordance with the passage of reform legislation in 1969.

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IV. Noted People Involved in the System: 1830-1940

a. Early Advocates

Dorothea Lynde Dix (1802-1887) was one of the most influential humanitarian reformers in nineteenth-century America, devoting most of her energies to the "insane." Writing in 1916, scholar Henry Hurd stated, "this remarkable woman contributed more to the general awakening of the country to the needs of the insane than all other agencies combined." Her most important contribution was to stimulate public awareness and involvement. She was born in Hampden, Maine, but soon moved to her grandmother's Boston home in 1814. Her career began in 1816, at age 14, when she became involved in teaching, opening a day school in Worcester that year. In 1827, she came under the influence of Dr. William Ellery Channing, the eminent Boston Unitarian minister and humanitarian, when she was engaged as his children's tutor. Her involvement with the insane began when she was teaching Sunday School to women inmates at the East Cambridge jail on March 28, 1841, and discovered several insane women in unheated cells. She spent the following year investigating care of the insane in jails, asylums, and poorhouses throughout Massachusetts, and documented her shocking findings in a January, 1843, Memorial to the Legislature of Massachusetts. Her work was instrumental in expanding Massachusetts' facilities for the insane with two new asylums in the 1850s at Taunton (1851) and Northampton (1855). She also attracted noted psychiatrist Pliny Earle to the latter institution. From 1843 to 1861, she expanded her efforts to most of the eastern United States and Canada, and in thirty-two cases was directly responsible for construction of public insane asylums. In 1861 she was appointed superintendent of women nurses by Secretary of War Cameron, a position she held throughout the Civil War. She returned to advocacy for the insane in 1865. In 1882, declining health caused her to retire to an apartment at the New Jersey State Lunatic Asylum at Trenton, the first hospital established as a direct result of her efforts. She died there on July 17, 1887, and was buried at Mt. Auburn Cemetery in Cambridge, Massachusetts (Johnson 1904: III; Muccigrosso 1988: 399-403).

Theodore Lyman (1792-1849) was an author, politician, philanthropist, and member of an old, wealthy, and illustrious Boston family. He graduated from Harvard in 1810 and studied in Europe until 1819. From 1820-1825 he served in the state legislature as a member of the Federalist party, actively campaigned for and supported President Jackson in the late 1820s, and served as mayor of Boston from 1832 to 1835. Lyman's later life was devoted to philanthropy. His involvement as president of the Board of the Boston Farm School, a private charity devoted to "morally exposed" children, introduced him to the issue of reform schools. One of his major achievements was establishment of the nation's first state reform school at Westborough in 1846, supplementing the $10,000 appropriation with his own money,

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and serving as president of the Board of Trustees. Lyman donated an additional $22,500 to the school before his death in 1849, and left a $50,000 bequest in his will. The school was named the Lyman School for Boys in his honor (Johnson 1904: VII; Malone 1935: IV, 518; see form for Lyman School).

b. Hospital Administrators/Physicians

Pliny Earle (1809-1892), whose career spanned the period 1840-1892, was one of the most eminent psychiatrists of the nineteenth century, with an unusual knowledge of both American and European asylums and an extensive body of publications to his credit. He was born in Leicester, Massachusetts, and educated at the Friend's School in Providence, where he taught and served as principal from the time of his graduation in 1828 until 1835. In 1837 he earned a medical degree from the University of Pennsylvania, followed by a year in Parisian general hospitals and a second year touring European insane asylums. Returning to the United States, he was appointed Superintendent of the Friend's Hospital for the Insane at Frankford, Pennsylvania in 1840, and Superintendent of the Bloomingdale Asylum for the Insane in New York City in 1843. From 1845 to 1853, he returned to Europe to continue his study of asylums there. In 1853 he opened a private psychiatric practice in New York, was appointed visiting physician to the New York City Insane Asylum, and continued to lecture and publish. During the Civil War (1862-1864) he served at the Government Hospital for the Insane at Washington. Influenced by Dorothea Dix, his last appointment was at the Northampton Lunatic Hospital, where he served as Superintendent and Physician in Chief from 1864 until 1885 and remained in association until his death. It was here that he wrote his famous essays on "The Curability of Insanity" in the 1870s. Earle was co-founder of the American Medical Association, the American Medico-Psychological Association, the Association of Medical Superintendents of American Institutions for the Insane, and the New England Psychological Society (Johnson 1904: III; Malone 1935: III, 595-96; see form for Northampton State Hospital).

Dr. Walter E. Fernald (1859-1924) was the third superintendent of the Massachusetts School for the Feeble-Minded, serving for 37 years, from 1887 until his death in 1924. The following year, Chapter 293 renamed the institution as the Walter E. Fernald State School in his honor. He was a native of Kittery, Maine, and a graduate of Bowdoin Medical School. As the British Commission had noted in 1905, Fernald was a renowned authority on mental retardation with many publications to his credit. These included the History of the Treatment of the Feeble-Minded (1895), Some of the Methods Employed in the Care and Training of Feeble-Minded Children (1894), Feeble-Minded Children (1887), Care of the Feeble-Minded (1904), and Imbeciles with Criminal Instincts (1909). A eulogy published in the 1924 Annual Report of the

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Fernald School described Dr. Fernald's distinctions and achievements in greater detail.

> His achievements as an educator have been far-reaching. He recognized the first step in education of the feeble-minded was to make them happy; that the feeble-minded, like other persons, are happy only when they are doing something for which their capacity fits them. He arranged a 24-hour program in which the child is doing all the time, whatever its capacities demanded. This school became in a real sense a university. During the past year individuals and delegates were sent from 28 states and 13 countries and 4 provinces in Canada. He gave lectures to medical students, to teachers of special classes, public health nurses, physicians taking post-graduate work in pediatrics, psychiatry, etc. As an organizer he standardized everything he undertook, whether in erecting a building, clearing a field of stones, etc. His scientific standing was widely recognized. In 1912 he received the honorary degree of Master of Arts at Harvard. He was widely sought as a lecturer on mental disease and criminology. Twice President of the Association for the Study of the Feeble-Minded, in 1915 and 1924, he was at the time of his death, President of the Massachusetts Society of Psychiatry and the Boston School of Occupational Therapy. He was a leader in the National Society of Mental Hygiene. He was the originator of the ten-point system for testing and classifying of the feeble-minded. He proved the psychological tests alone were not enough. He secured practically every piece of legislation that had anything to do with these subjects for the last 30 years.

Samuel Gridley Howe (1801-1876) of Boston was an educator and "champion of peoples and persons laboring under disability." He graduated from Brown in 1821, received a medical degree from Harvard in 1824, then spent six years as a surgeon in the Greek War for Independence. Returning to the United States in 1831, he was engaged to run the newly incorporated Massachusetts School for the Blind, which he started in his father's house with six pupils. His successful forty-four-year directorship resulted in establishment of the noted Perkins Institution for the Blind. At the same time, Howe started an experimental school for the training of "idiots," which resulted in establishment of the Massachusetts School for Idiotic and Feeble-Minded Youth at South Boston in 1848. This was the first state-run facility of its type in the nation. Howe served as Superintendent from 1848-1875. The indefatigable Howe also supported Horace Mann in his crusade for better public schools and normal schools, helped Dorothea Dix in her efforts on behalf of the insane, agitated for prison reform, and was involved in the abolitionist movement. He also served as the chairman of the pioneering

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Massachusetts Board of State Charities from 1865-1874, where he had the opportunity to fully articulate his views on public charity (Johnson 1904: V; Malone 1935: V, 296-297; see form for Fernald School).

Edouard Seguin (1812-80) was the first to develop a comprehensive and widely accepted system for training of "idiots" in the early nineteenth century. He was born in Clemecy, France, to a family of distinguished physicians. During his medical training he became interested in psychiatry, and especially the study of "idiots." He established a training school in 1839, and in 1844 received the approval of several medical bodies and academies including the Paris Academy of Sciences. His training method was based on the premise that the "idiot's" brain was not diseased, but arrested in its growth. His chief work, the Traitement Moral, Hygiene et Education des Idiots, was published in 1846. A few years, later he emigrated to the United States and became involved in various schools and institutions throughout the country, including the new Massachusetts School for Idiotic and Feeble-Minded Youth at South Boston (1848). In 1866, he published a second book, Idiocy and Its Treatment by the Physiological Method, which especially influenced the development of English and American treatment methods (Johnson 1904: IX; Malone 1935: VIII, 559-60; see form for Fernald School).

c. Architects/Designers

Elbridge Boyden (1810-1898) designed the fine Renaissance Revival-style main building at the Taunton State Hospital for the Insane in 1851. This remains as the oldest extant insane asylum in the system, and as an excellent example of the influential "Kirkbride" plan. Boyden was born in Somerset, Vermont, trained with Athol house carpenter Joel Stratton, and studied the published works of Asher Benjamin. He moved to Worcester, Massachusetts, in 1844, where he started his own architectural practice. He no doubt became familiar with the state's first insane asylum of 1830, which was in the center section of that city. Mechanics Hall of 1854 is one of his best-known works. Others include the Bannister House (Harvard St. 1844), the East Worcester (1863) and Cambridge Street (1869) Schools, the Cathedral of St. Paul (1869), and the Webster Street Firehouse (1893). He also designed the Worcester County Superior Courthouse in Fitchburg (1871) and prepared a landscape plan for Falmouth Heights (1870). Boyden also worked throughout the midwest and had plans published in national magazines and pattern books such as those by A. J. Bicknell (Jenkins 1992: 5-6; Worcester Survey).

Brigham & Spofford: Charles Brigham (1841-1925) and **John C. Spofford** (1854-?), who were in partnership after 1888, designed the Massachusetts Hospital for Dipsomaniacs and Inebriates at Foxborough in 1889. Mr. Brigham, who had previously been in partnership with

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John Sturgis from 1866-1886, was a charter member of the Boston Society of Architects. Brigham & Sturgis designed the Boston Museum of Fine Arts at Copley Square (1876) and the Church of the Advent (1880), also in Boston. Mr. Spofford began his career as a draftsman with Brigham & Sturgis. Brigham & Spofford are noted for their public institutional commissions, including the rear wing of the Massachusetts State House (1889-95), the Memorial Hall at Belfast, Maine, the City Hall at Lewiston, Maine, and several public buildings in Fairhaven, Massachusetts, including the Town Hall (1894), High School (1905), and Library (Withey 1970: 76-77, 565-66; Mass. State House HSR 1984).

Elias Carter (1783-1864) and **James Savage** designed the original building at the Lyman School for Boys (now Westborough State Hospital) which is the oldest extant component of the Massachusetts Hospital and School system. Apparently self-trained as an architect, Carter was born in Brimfield and spent most of his career in nearby Worcester. He is particularly noted for his fine Greek Revival-style mansions, including the Governor Levi Lincoln House (1834). Other works include the Second Unitarian Church (1828), the Union Church (1835-1837), and the City Insane Hospital, all in Worcester. Elsewhere he designed a church at Templeton (1811), the First Parish Church at Mendon, and the Insane Hospital at Concord, New Hampshire (Withey 1970: 112; Worcester Survey).

George Clough (1843-1916) was responsible for early construction at the new Lyman School for Boys and for remodeling the old campus for use as Westborough State Hospital. Clough was born in Blue Hill, Maine, studied architecture in the Boston office of Snell & Gregerson, and established his own practice in that city in 1869. He is perhaps best known for his service as the Boston City Architect from 1875 to 1885. Some of his most notable works include the Boston English and Latin Schools (1877), the Suffolk County Courthouse (1886), St. Mark's Church in Brookline (1892-96), and the Soldiers' Home in Chelsea (Withey 1970: 127).

Amos P. Cutting (d. 1896), as a partner in the firm of Cutting & Holman, designed a major addition to the Lyman School (now Westborough State Hospital) in 1876. Cutting was a native of New England and maintained a practice in Worcester. His work, particularly churches, was noted as scholarly and correct. He designed the Franklin-Wesson House in Worcester in 1874 and the New Hampshire State Library at Concord in 1889. Cutting died in Los Angeles (Withey 1970: 157; Worcester Survey).

Stephen C. Earle (1839-1913) designed buildings at both the Lyman School and Westborough State Hospital in 1889-1890. Earle was born in Leicester, Massachusetts, and studied architecture at M.I.T. He opened a practice in Worcester after the Civil War, and soon went into

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partnership with James Fuller, with whom he designed the Church of All Saints. From 1872-1875, he practiced in Boston, then returned to Worcester. From 1892 to 1903, he practiced with Clellan W. Fisher, designing St. Matthews Episcopal Church (1888) and the Worcester Art Museum (1897) as well as many other public and private commissions. Earle is especially noted for his skill in the Queen Anne style, which is employed for the buildings at Westborough and the Lyman School (Withey 1970: 186-187; Worcester survey).

John A. Fox (1835-1920) designed the Administration Building and several others at the Tewksbury State Hospital during its conversion from an almshouse in the 1890s. In 1902 he was selected as architect for the Gardner State Colony for the Insane (now a prison and not included in this nomination). Fox was born in Newburyport and was educated at Dorchester High School. He trained with the civil engineering firm of Garbett & Wood and was later a draftsman with Ware & Van Brunt. He designed several institutional buildings including the Boston Museum (1870), the New Theatre at Brockton (1873), and the Provincetown Town Hall (1886). Mr. Fox was a charter member of the Boston Society of Architects (Withey 1970: 217-218).

Kendall, Taylor & Co. was a well-known Boston firm at the turn of the century that specialized in hospital design. Not surprisingly, **Henry H. Kendall** (1855-1943), **Albert S. Kendall** (1883-1941) and **Bertrand E. Taylor** (1855-1909) designed buildings at several state hospital and school campuses including Worcester, Monson (1910), Westborough (1897, 1902), Wrentham (1907), Mass. Mental Health Center (1910), Belchertown (1920s), and Taunton (1930s). Henry Kendall was born in New Braintree, studied architecture at M.I.T., and trained in the office of William G. Preston. From 1879-1889 he served as Assistant to the Supervising Architect of the Treasury. Albert Kendall, who was Henry's son, graduated from Harvard in 1905 and trained in his father's office, soon becoming a partner. Mr. Taylor was born in St. Johnsbury, Vermont, trained in the Boston office of Ober & Rand, and attended classes at M.I.T. Other partners in this firm included **Edward F. Stevens** (1860-1946) and **George Dutton Rand**. Rand, practicing as part of the firm Weston and Rand, designed the Worcester Lunatic Hospital in 1870. In addition to their Massachusetts state hospital and school work, the firm designed buildings at the New Hampshire Hospital for the Insane, Hitchcock Hospital at Hanover, Massachusetts; the City, Homeopathic, and Corey Hill Hospitals at Boston, and the Newton City Hospital (Withey 1970: 339-340, 590).

Jonathan Preston (1801-1888) designed the main building at Northampton Lunatic Hospital of 1855. He was noted as one of the most accomplished Boston architects of the mid-nineteenth century. He designed several notable buildings such as the original Massachusetts Institute of Technology (1864) and the companion Museum of Natural History (1864) in Back Bay with his son William G. Preston. He is

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also credited with the Church Green Building (1873) in Boston (Withey 1970: 486; Boston Survey).

William Gibbons Preston (1844-1910) designed numerous early buildings at the Fernald School, the Lyman School, and the Industrial School for Girls. The son of architect Jonathan Preston, he was educated at Harvard and the Ecole des Beaux-Artes in addition to training in his father's office. Some of his notable buildings include the First Corps of Cadets Armory (1891-1897), the Hotel Vendome (1871), the Chadwick Leadworks (1887), and the International Trust Company Building (1906), all in Boston; the Central Exchange Building in Worcester (1895); and the Cotton Exchange Building and First Presbyterian Church, both in Savannah, Georgia (Withey 1970: 487; Boston Survey).

Gordon Robb designed Metropolitan State Hospital in 1927-1930 as well as buildings at several other state campuses including Taunton and Northampton. His Met State buildings served as models for 1930s expansion throughout the system. Little is known about this architect other than the fact that he maintained an office in Boston from 1925-1930, 1932-1940, and 1944-1959 (COPAR Directory of Boston Architects 1846-1970).

William Pitt Wentworth (1839-1896) designed the Medfield Insane Asylum in 1892 as the state's first "cottage"-plan hospital; it exhibits a highly unusual mirror-image site plan. Wentworth was a native of Vermont who was educated in New York City. He returned to New England where he practiced in Boston for thirty years. Wentworth was especially noted for his church and hospital designs. Other works included the Church of the Messiah in Woods Hole, Massachusetts (1888); the Flower Memorial Church in Watertown, New York; the Washington Home in Boston; and several residences in Cambridge (Withey 1970: 644; AABN Obituary 4/18/1896: 22; Falmouth Survey).

V. Physical Developments: Architecture and Landscape (1830-1940)

Massachusetts developed an extensive system of at least thirty-one state hospitals and schools during the one-hundred-year period from 1830-1930. These included thirteen hospitals for the mentally disturbed, three schools and one farm for the mentally retarded, four juvenile reform schools, three almshouses, four tuberculosis sanatoria, one hospital for alcoholics, one hospital for crippled children, and a laboratory/research facility. One third were located in or near the Boston metropolitan area to serve the state's major population center, while the remainder were dispersed across the state to provide equal access to citizens of the southeastern, northeastern, central, and western sections.

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Development of this multi-faceted asylum system obviously responded to the needs of dependent citizens. It can also be seen within a broader context in which a wide range of institutions was being created to both serve and symbolize the values of a new nation in the post-Revolutionary period. These included capitol buildings, post offices, courthouses, custom houses, naval hospitals, etc. In The Federal Presence, Lois Craig notes that public buildings and institutions reveal society's intentions and reflect changing notions about the proper extent of the public domain (Craig 1978: xiv-xv). The vast numbers and variety of institutional buildings created in the nineteenth century provide clear evidence of the growing importance of the public domain. Asylums are just one type of institution that arose and proliferated after the Revolution to serve an increasingly complex society.

Nineteenth-century treatment methods for dependent citizens relied heavily on physical setting, so institutions were located in rural or at least semi-rural areas to provide a sense of tranquility. This also helped to avoid dissention from neighbors while keeping acquisition costs as low as possible. When three of the four earliest facilities (pre-1850) were engulfed by urban expansion in the second half of the nineteenth century, they solved the problem in two ways. The Worcester Insane Asylum developed an extensive farm colony at nearby Grafton in the early twentieth century, while the Boston Lunatic Hospital and the Massachusetts School for the Feeble-Minded sold their cramped South Boston quarters and moved to the suburbs in 1895 and 1887, respectively.

Generally the state looked for well-drained hilltop sites with good farmland and an adequate water supply that were somewhat removed from population centers but in proximity to a railroad line. The sites were developed with either a massive centralized "Kirkbride" structure or, from the 1880s through 1920, with dispersed "cottages" serving patient, staff, administrative, and support functions. The first cottage-plan state institutions in Massachusetts were the new Lyman (Reform) School of 1884, the new Massachusetts School for the Feeble-Minded of 1887, and the Medfield Insane Asylum of 1892. Colony-plan campuses like Templeton (1899), Gardner (1900; now MCI), and Grafton (1901) are a subset of the cottageplan. Devoted to chronic care in a rural, agricultural setting, they consist of loosely grouped satellite colonies united under a common administration.

Nineteenth-century campuses were often designed by the best architects of the period, and they still evidence an exceptional quality of construction and attention to architectural detail. As construction increased by the turn of the century, less prominent architects were usually employed. By the 1910s and 1920s, standardized designs began to appear in response to the ever-increasing size of the system.

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Chapter 451 of the Acts of 1900 directed the state to take responsibility for all mentally ill citizens, relieving towns of any responsibility. Similar legislation in 1908 affected the retarded and epileptic. As a result of this massive expansion of the system, the Board of Insanity conducted a system-wide review to establish uniform standards of capacity that could be applied to each campus to avoid overcrowding. Capacity was computed on the basis of fresh air supply, ability to introduce air without causing drafts, and amount of floor area necessary to avoid confrontations between patients. The factors taken into account included methods of ventilation, heating,and lighting, type of building (especially the extent of outside walls and windows), the dimensions of rooms and height of stories, the character or classification of the patients, and constancy of their presence.

That standard, developed in 1906, specified fifty feet per patient in day rooms, an equal amount in dormitories, and 100 square feet in rooms used continuously by the sick in bed or other classes, with the exception that in buildings where the patients are all quiet, clean, able-bodied, and out-of-doors most of the day, the day space has been reduced to 30 square feet (Department 1926: 105).

Later, the standard was modified to thirty square feet per patient in day rooms, 50 square feet in dormitories with the exception that 100 square feet be used in rooms occupied by the newly admitted and acutely sick classes, by tubercular, adult epileptic or disturbed patients, by patients who are both noisy and untidy, and by patients suffering from acute physical disease, the 100 square feet to be either in rooms occupied both night and day or 50 square feet in day rooms and 50 square feet in dormitories (Department 1926: 108).

Standardization of design was first implemented at Metropolitan State Hospital of 1927-1930, and then through expansion at other hospitals for the mentally ill. Metropolitan State Hospital represented the final evolutionary step in the mental hospital form, by combining the economies of the congregate plan with the greater intimacy of the cottage plan. The use of similar campus plans and buildings at the Wrentham State School (1906) and the Belchertown State School (1922) also reflect the move toward standardization.

In all cases and throughout the period of significance, the grounds around the buildings were generally landscaped with specimen trees, flower gardens, and meandering paths to encourage out-of-doors activities. Support buildings, including powerplants, workshops, and barns, were located in peripheral areas with the whole surrounded by agricultural fields and woodlands. The agricultural land provided important
opportunities for patients to work, develop habits of industry, and acquire self-esteem, while providing limited economic support for the institution. Many campuses include one or more pre-existing

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farmhouses or barns. These were reused for institutional purposes to save money and to allow quicker occupation of the site.

a. Insane Asylums

Moral Treatment, which was the dominant philosophy of institutional managers during much of the nineteenth century, relied heavily on creation of an ideal physical environment. Thus, great emphasis was placed on a tranquil natural setting, appropriate architecture, and to a lesser extent, landscape refinements. While Americans could and did look to Europe for models of treatment, they found little to guide them in the area of architectural design since Europeans tended to reuse monasteries, forts, or prisons (Rothman 1971: 135). Lacking this supply of existing large-scale institutional buildings, Americans were forced to develop their own. In so doing, they scrutinized one another efforts closely and engaged in heated debates about the proper form, either congregate or dispersed, that hospitals should take to achieve the goals of Moral Treatment.

Local poorfarms, which generally resembled contemporary two-story, wood-frame, rectangular-plan farmhouses, appear to have served as the model for the earliest asylums erected in Massachusetts and other states. Asylum builders generally employed masonry rather than wood as a more durable and fireproof construction material, however, and frequently followed classical tradition in extending the central structure with symmetrically designed lateral wings and end pavilions. The best example of this early form in the Massachusetts system was Elias Carter's Worcester Asylum, which was designed for 130 in 1830, expanded to 320 in the 1840s, and demolished in the 1970s. As shown in early engravings, it consisted of a four-story rectangular block flanked by three-story lateral wings that were extended by two-story wings in the mid-1840s. Stylistically, it retained the flat planar quality of the Federal period while adding fashionable Greek Revival style accents such as a two-story pentastyle Doric portico. Late nineteenth-century city atlases show that it had sprouted additional wings by that time.

Dr. Thomas S. Kirkbride, head of the prestigious Pennsylvania Hospital for the Insane from its opening in 1840 until his death in 1883, was the first to develop an institutional model acceptable to the majority of his colleagues. Described in his influential textbook of 1847, On the Construction, Organization, and General Arrangements of Hospitals for the Insane, with some Remarks on Insanity and its Treatment, the congregate "Kirkbride" hospital represented a refinement of the Worcester type, compressing and adding wings to create a large, highly centralized building consisting of an administrative core flanked by numerous stepped-back patient wings. The core housed kitchen, storerooms, reception areas, business and medical offices, chapel, library, and living quarters for the superintendent and medical

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officers, while the wings included rooms for nurses and attendants as well as patients. New wings could be added as needed, and their division into wards allowed for classification and separation of patients by behavioral symptoms as well as sex. Taunton (1851) and Northampton (1855), both of which were constructed to house Kirkbride's limit of 250 patients and expanded in the late-nineteenth century, provide good examples of this additive, centralized quality.

Kirkbride's treatise was based on 26 propositions concerning construction and administration. Together, it was believed that these propositions would produce an ideal physical and behavioral environment that would counteract the deficiencies of society at large while providing a model for its reform. He specified that hospitals for the "insane" should be built in the country, where they could be set on grounds of at least 100 acres to provide an abundance of fresh air, that they should be of fireproof masonry construction with slate or metal roofs, that they should be organized with a central administrative core flanked by wings with "excitable" patients housed in the outermost sections, and that they should be composed of eight wards housing a maximum total of 250 patients separated according to sex and class of mental illness. Details were considered as well, including the proper location of heating/ventilating ducts, the best type of plaster, and the optimal room width and ceiling height. He and others believed that insanity would eventually be understood and cured through solution of technical problems such as these.

"Kirkbride" hospitals received the official endorsement of the influential Association of Medical Superintendents of American Institutions for the Insane from 1851 to 1888 (Deutsch 1949: 211-212). They were built in all of the states throughout the nineteenth century, dominated architectural discussions at least through the 1870s, and represented the initial triumph of the centralized congregate system of organization. Even examples dating from the turn of the century followed Kirkbride's ideas closely with the exception of his 250-patient limit, which had been raised to 600 in 1866 and 1,000 by 1900. These buildings were widely adopted because they embodied prevailing psychiatric theories such as:

> separation of patients from the community; creation of a new therapeutic environment; the importance of classifying patients; the dominant and controlling role of the psychiatrist/superintendent; and reassurance to the family and community that patients would be cared for in a secure moral and medical environment that would promote their comfort, happiness, and even recovery (Grob 1983: 12).

The Commonwealth of Massachusetts, demonstrating currency with national ideas, erected four "Kirkbride" hospitals at Taunton (1851), Northampton (1855), Worcester (1870; NR 1980), and Danvers (1873; NR

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1984). All four were designed by well-known architects, and all except Worcester remain in near-original form despite years of neglect, displaying Kirkbride's tenets including setting, plan, and use of fireproof materials. Worcester, portions of which still stand despite a devastating fire in 1991, well illustrates the effectiveness of nineteenth-century fireproof construction.

Taunton, the oldest extant "insane" hospital in the state, is the most important of these four due to its age and its exceptional architectural quality. Designed by Worcester architect Elbridge Boyden in an early use of the Renaissance Revival style, it is a three-story, red-brick building trimmed with cast-iron Corinthian pilasters supporting a cast iron cornice. Its long central section is organized with pedimented central and end pavilions surmounted by Baroque domes that appear to have served ventilating as well as decorative purposes. Typically, a dining/kitchen ell is attached to the rear of the central pavilion while patient wings extend back from the end pavilions. These wings, in turn, are extended laterally and then joined to freestanding end pavilions by elegant curved, glazed second-story walkways. The outer wings are shown on the original plans for the building but were not constructed until 1875 and 1909. Boyden (1819-1896) was a nationally recognized architect with domestic designs published in contemporary pattern books. One of his best known Massachusetts buildings is Worcester's Mechanics Hall (NR), also designed in the Renaissance Revival style.

Northampton offers a contrast to the rich architectural sophistication of Taunton in its rather naive handling of the Gothic Revival style. It nevertheless closely follows Kirkbride's plan and siting principles. It was designed by Jonathan Preston (1801-1888), a well-known Boston builder/architect who went on to practice with his son William Gibbons Preston (see Fernald School, Waltham). Worcester (NR 1980) and Danvers (NR 1984), which are similar institutions designed in the High Victorian Gothic style, are constructed of granite with red brick trim and red brick with granite trim, respectively. Designed for the new patient limit of 600, they are substantially larger than their predecessors. Worcester is important as the first hospital designed by the firm of Weston and Rand, later succeeded by Rand, Taylor, Kendall, and Stevens, architects of numerous twentieth-century state hospital and school buildings. Danvers was designed by noted Boston architect Nathaniel J. Bradlee (1829-1888) as an adaptation of an unbuilt 1867 design for an insane asylum at Winthrop.

Danvers, the last of Massachusetts' great congregate "Kirkbride" hospitals, was followed by the Westborough Insane Hospital of 1884. As Westborough was a reuse of the old congregate Lyman School building (see Reform Schools), it falls somewhat outside the congregate/dispersed argument. Nevertheless, the 1880s renovations

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did create one immense congregate structure, larger than any of the preceding "Kirkbride"-design hospitals, fully illustrating the abandonment of the original 250-patient limit for asylum buildings.

All subsequent hospitals and schools followed some variant of the dispersed cottage plan, which consisted of relatively small-scale freestanding buildings where patients were separated and classified as they had been under the old ward system. The new plan came into favor because it allowed a more personal level of care and treatment by helping to reduce density within buildings as hospital populations increased rapidly. The rise of cottage hospitals is closely linked with the need to provide comfortable long-term accommodations for chronic patients. McLean Hospital in Belmont, Massachusetts, designed in 1875-1891, represents the "first full-fledged cottage plan mental hospital in America" (Zimmer 1983: 7). The trustees of this noted private institution specifically chose the cottage plan to distinguish themselves from state institutions. The chairman of the building committee described their intent thus during the facility's early planning stages in 1875:

> I think you are aware that we do not intend following the present fashion of State Asylums, such as are now building at Worcester and Danvers in this state, at Buffalo etc. in others, but on the contrary to avoid both the structural appearance and the economical methods, which are, probably, all right in them --- but to adopt to a liberal extent what may be called a domestic plan, in distinction to that of a public institution (Zimmer 1983: 4).

The therapeutic intent of the proposed plan, and its relation to the principles of medical classification, was described by Superintendent Cowles in 1882:

> The proposition for new buildings was to erect a number of cottages surrounding a large one for administrative purposes, and thus allowing the placing of patients similarly affected in a house by themselves, where they might have their own degrees of mental disease. Also much benefit was anticipated from the use of the beautiful grounds, and from the pleasant drives possible in all directions (Zimmer 1983: 7).

The earliest and most noteworthy of the state's cottage-plan hospitals is the Medfield Insane Asylum, erected in 1892, concurrently with McLean. Designed by Boston architect William Pitt Wentworth (1839-1896), the hospital follows a unique and complex plan of mirror-image wards facing onto a central green that contained a chapel, a congregate dining room, and power plant. The hospital campus, which resembles that of a college, seems to have been inspired by the homey vision of New England town commons. In this case, and

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most others, the individual buildings took the place of the old ward system, more fully classifying and separating patients into behavioral categories such as "quiet," "untidy," "excited," and "epileptic." Given the linkage between rising chronic populations and development of the cottage plan, it is not surprising that the state's first cottage-plan insane asylum was devoted to chronic care.

During the late-nineteenth and early twentieth centuries, all of the monolithic congregate hospital campuses were expanded with smaller-scale buildings for patients and staff, adding a dispersed component to their characters. Additionally, isolated colonies for the quiet, chronic insane began to be erected at several hospitals at the turn of the century, including Medfield, Danvers, and Westborough. At Tewksbury, which served as the state pauper hospital, including cases of both physical and mental disease, colonies for tubercular patients were added. This architectural development is a direct reflection of the changing patient population, which included increasing numbers of the aged and senile.

Colony-plan campuses developed as a variant of the cottage plan in response to Chapter 451 of the Acts of 1900, which directed the state to take responsibility for all insane persons. That piece of legislation provided for establishment of the State Colony for the Insane to house the expected influx of chronic cases. Gardner has since been converted to a state prison.

Grafton State Hospital remains as the most intact of the colony-type campuses. It was established in 1901 as a rural conjunct of the old Worcester Insane Asylum of 1830 which had itself been relegated to the status of a chronic-care facility in 1877. Developed in the early twentieth century, Grafton consisted of four sub-colonies, united under one administration. Each colony was characterized by freestanding wards of varying size, staff housing, and support buildings. Many were designed for quiet patients in a rustic Craftsman-style mode, featuring natural fieldstone basement stories with shingled or clapboarded upper stories and overhanging bracketed roofs. Larger-scale masonry structures, reminiscent of the old "Kirkbride" buildings, were erected for "excited" patients.

The Commonwealth's last facility for the "insane" was the Metropolitan State Hospital of 1927-1930 in Waltham, which consciously combined the economies of congregate-plan hospitals with the greater individuality of dispersed plans. Designed by Gordon S. Robb, another little-known Boston architect, it is important because its Colonial Revival style buildings responded to the need for standardization and served as the model for post-1927 additions to most other hospital campuses. Its Y-plan infirmary and use of hopper sash designed to prevent escapes were particularly influential. It is unique in that almost all of its buildings were constructed during the late 1920s and early 1930s,

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creating an architectural unity unknown at other hospitals with the possible exception of Medfield.

All of the state's nineteenth-century hospitals include buildings from throughout their history, as they were expanded to meet ever-growing patient populations, often many times the size of those originally projected and provided for. Typical additions include patient wards, dormitories for nurses and attendants, single-family houses following contemporary suburban designs for doctors and administrators, chapels, powerplants, laundries, workshops, and farm buildings. Cemeteries are often included as well. Generally, wards are constructed as additions to the main complex or adjacent to it, staff residences are scattered in the front and to the side, while support and farm buildings are located in peripheral areas, often to the rear. Many campuses received large H-plan admissions buildings in the 1950s and 1960s as the result of a 1954 systemwide analysis of needs.

b. Schools for the Mentally Retarded

The state erected three schools for the mentally retarded, all on the "cottage" plan. The first was the Massachusetts School for the Feeble-Minded, established in South Boston in a mid-nineteenth century wood-frame building of domestic appearance (photographs at Mass. State Archives). When the school moved to Waltham in 1887, William Gibbons Preston of Boston and an unknown landscape architect were hired to give it form. The campus was laid out with reference to the natural contours of the site, and original wards faced south to allow the patients as much sun as possible. Preston's buildings and succeeding ones are handsome examples of the Queen Anne and Romanesque Revival styles characterized by red brick construction, rockfaced sandstone trim, wide-arched entries, and fieldstone foundations dug and assembled by adult male patients as part of their work therapy programs.

Wrentham (1906-1907) and Belchertown (1915-1922) represent a standardization of building and site planning. Both are characterized by a tight rectangular site plan developed with similar cruciform patient wards and stuccoed staff cottages. Buildings are designed in the Craftsman and Colonial Revival styles. Both were designed by Kendall & Taylor, who specialized in hospital design and were the state's most frequently employed early twentieth-century firm.

The Templeton Colony of the Fernald School was established in 1900 as a unique facility devoted to the care of chronic male adults who had been trained at the parent institution. It was developed with four dispersed sub-colonies, established around the nuclei of existing farmsteads. Some of the finest late-eighteenth and early nineteenth century dwellings in the system remain here. New buildings were designed in a rustic mode by noted architect William Gibbons Preston.

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Both the colony plan and rustic buildings were similar to those at Grafton State Hospital, one of the state's primary chronic facilities for the insane. Templeton includes 2,600 acres of hilly agricultural fields and woodland, reflecting the facility's strong emphasis on supervised exercise and farmwork in a healthy out-of-doors environment.

The state schools were developed with the same building types as the insane asylums, including administration buildings, patient wards, staff dorms and houses, support buildings, and farm groups. Both schools and hospitals considered farm work to be an integral part of patient work therapy programs as well as a prudent economic measure, often keeping their budgets in the black. Special, less restrictive dormitories were often erected for patients who worked on the farm. Schools differed from insane asylums in that they had special classroom buildings, and more frequently employed patients in construction, particularly the erection of foundations from fieldstone found on the site and the laying out of roads.

c. Reform Schools

Only the Lyman School for Boys was included in the survey upon which this nomination is based (see Methodology). Thus, discussion will be limited to its initial development on the eastern shore of Lake Chauncy in Westborough (1848), and its subsequent move to the lake's western shore in 1884. The original Lyman School of 1848 was designed by Elias Carter and James Savage in a transitional Greek Revival/Italianate style. Constructed of brick with granite and terra cotta trim, it is a rather severe structure with a three-story central core flanked by two-story wings that extend backward (see Lyman School for description, early plans, and engravings; see Westborough State Hospital for photos). Carter (1783-1864), an early Worcester architect with numerous public buildings to his credit, including insane asylums, was particularly noted for his elaborate Greek Revival-style mansions. The school was expanded in 1876 by the Worcester firm of Cutting and Holman. Soon thereafter, this large congregate-plan building was declared unfit for a school due to its size and jail-like appearance, despite the fact that the commissioners had originally specified that it should be substantial but not ornate, and <u>not</u> look like a jail.

The jail-like appearance of the original Lyman School is consistent with the character of reform schools or houses of refuge nationwide. Rothman describes the contemporary New York House of Refuge thus:

> The institution's architecture was as monotonous as its timetable. Boys and girls occupied separate buildings, each structure of bare brick and unvarying design; as the refuge expanded, adding more wings, the repetition and uniformity

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increased. The buildings were usually four stories high, with two long hallways running along either side of a row of cells. The rooms, following one after another, were all five by eight feet wide, sevenfeet high, windowless, with an iron-lattice slab for a door and flues for ventilation near the ceiling....On the first floor of each wing was a huge tub for bathing, sizable enough to hold fifteen to twenty boys; on the fourth floor were ten special punishment cells" (Rothman 1971: 226).

Massachusetts created a separate facility for girls at Lancaster in 1854 (now MCI).

The New York facility was one of several visited by the Lyman School commissioners when they were developing plans. However, they seem to have been influenced primarily by Samuel B. Woodward, superintendent of Worcester State Hospital, who advised that:

> The building should have a central edifice of three stories including a high basement, mostly out of the ground, and two parallel wings, running back, with or without a colonnade front. The stories should be of medium height, in this climate; the lower and upper not less than 10', the middle 12', with a high and capacious attic to serve the purpose of ventilation. In the basement of the center building may be located the office of the managers, the kitchen, laundry, storerooms and rooms for the furnaces, and dining rooms the inmates. In the second story, the schoolrooms, dining rooms for the manager and his family, chaplain and teachers, chapel, apartments for the officers. In the upper story may be the single and associated dormitories, clothing rooms and storerooms for articles made. The wings may be two stories high, with capacious attics. In them may be lodging rooms, storerooms and workshops.....The Commissioners will doubtless build of stone or brick. The former is preferable...(2nd Annual Report of the Massachusetts State Reform School).

As shown in a frontispiece engraving in the First Annual Report of the Massachusetts State Reform School (see Lyman School form), the school building did include a three-story central section with a colonnaded porch, flanked by four-story towers, with two-story wings extending to the rear. Plans and sections of the building reveal that many of Woodward's ideas on internal arrangement were heeded as well.

In 1885 the school moved to the opposite shore of Lake Chauncy and erected a new campus, known as the Lyman School, on the cottage-plan then coming into vogue. This was the first cottage-plan campus in the Massachusetts state system, and one of the first in the nation.

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George Clough (1843-1916), formerly city architect for Boston, and Stephen Earle (1839-1913) of Worcester were cited as architects for some of the earliest buildings designed in the Queen Anne/Romanesque Revival style. Reform Schools operated on the familiar Moral Treatment program and included the same building types as the insane asylums and schools for the retarded already discussed.

d. Almshouses

The Commonwealth established three almshouses at Bridgewater, Tewksbury, and Monson in 1852 "as temporary expedients to meet a pressing emergency" (Marden 1880: 158) caused by the unprecedented influx of Irish immigrants at that time. According to all sources examined, the original almshouse structures were considered inadequate at best. All were identical wood-frame structures consisting of four-story central cores, flanked by U-plan three-story wings that extended back to a depth of 125 feet around central courtyards. Typically, the central cores served administrative purposes, including chapels on the upper stories, while the wings contained patient dormitories. The almshouses appear to have been modeled on the original 1848 Lyman School structure described above (see Westborough State Hospital), but because they were constructed of wood, they were considered drafty firetraps that were difficult to heat. Tewksbury was described thus:

> The main building has a frontage of 200', is four stories high, with wings extending backward from both ends to the depth of 125', and is almost identical in every respect, to the main buildings at Monson and Bridgewater, having indeed been constructed from the same plans and specifications. The center of the front of the main building is occupied by the Superintendent and officers as living apartments, and the entire capacity of the wings, with the exception of the sewingand dining rooms, is devoted to sleeping dormitories for the inmates (Marden 1880: 158).

Within a decade of establishment, the almshouses were converted to specialized functions as the poor were more closely classified. Bridgewater became the State Workhouse, receiving the criminal poor and insane, and Monson became the State Primary School, receiving pauper children (see form). Tewksbury remained the State Almshouse, but with an increasingly large department for harmless, chronic insane of the pauper class established in 1866. The original almshouse buildings do not survive at Tewksbury or Monson, and it is unlikely that the original Bridgewater structure survives either (now a state prison, Bridgewater was not included in the survey on which this nomination was based). All that remains of the almshouses are a landscape feature at Tewksbury and a portion of a possible foundation at Monson.

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e. Sanatoria

Like the almshouses, the four sanatoria erected by the state survive poorly if at all, probably because their buildings were also of wood-frame construction. The first, at Rutland (1895), was by far the most elaborate, consisting of eleven buildings of varied plan, elevation, and probably function, arranged in an arc, and connected at the rear by an enclosed passageway. Rutland was sold by the state in 1966 and demolished soon thereafter. The other three, erected at Westfield, North Reading, and Lakeville in 1907, were similar, but substantially smaller, simpler institutions than Rutland. They generally consisted of a central administration building flanked by closed wards for advanced cases and open pavilions for new cases. All three of these sanatoria have been substantially rebuilt so that none retain significant portions of their original design. Tubercular colonies were developed at some of the state hospitals as well, most notably Tewksbury. Most have disappeared with the exception of two small cottages at the Danvers and Medfield State Hospital campuses. Finally, the counties developed a parallel system of hospitals, primarily to treat tuberculosis, but they were not included in the present study, which focuses on state-owned facilities.

f. Landscape and Land Use

The majority of institutions included in this study--whether they originated as insane asylum, training school, reform school, or almshouse--include large amounts of open space. The only exception is the Massachusetts Mental Health Center in Boston. There are several reasons for this. The most important is found in the tenets of Moral Treatment, which provided the philosophical underpinnings for care of all types of dependent citizens in the nineteenth century. As discussed in the Care and Treatment Context, early reformers believed that mental illness and deviancy were caused by rapid changes in the nation's social structure. Thus, treatment focused on creation of an ideal physical, moral, and social environment, set apart from the corrupting influence of society.

Landscapes at these institutions fall into three distinct categories: designed pleasure grounds, working agricultural lands, and undeveloped natural acreage including woods and wetlands. The areas immediately surrounding patient and staff housing usually fall into the first category. They were often landscaped with broad lawns, specimen trees, flower beds, and meandering paths with ornamental light fixtures to provide a pleasant atmosphere for patients to enjoy the outdoors. The presence of greenhouses, the evidence of historic photographs, and citations in annual reports, indicate that these pleasure grounds once played a much more important role in campus aesthetics than they do today. Many buildings were sited on hilltops to take advantage of views of the surrounding countryside or in

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proximity to each other to form sheltered quadrangles where patients could congregate. Northampton is an especially good example of the former, while Tewksbury provides an excellent illustration of the latter. Many of these landscapes have been compromised by poorly sited new buildings, introduction of paved parking areas, and lack of maintenance resulting in scrub growth and loss of original plantings.

Peripheral areas fall into the other two categories. Those that were suited to it, were devoted to agriculture, providing both therapeutic and economic benefits. These are typical New England vernacular landscapes characterized by cultivated fields and pastures, sometimes defined by stone walls. Large-scale agricultural activities were discontinued in the 1970s throughout the system, and many of the fields and pastures are reverting back to woodland. A small number of campuses are protected by agricultural preservation restrictions and/or leasing to local farmers. The remaining acreage has remained in its natural state as woodland or wetland, fulfilling its ecological role while providing a buffer from surrounding land-uses, as well as room for expansion. All three types of landscapes are important components of each campus and should be taken into consideration when new construction is planned.

Dr. Thomas Kirkbride, who so influenced mid-nineteenth century asylum design, provided specifications for landscapes as well as buildings. He firmly believed that asylums should occupy large rural sites with adequate gardens and pleasure grounds (Deutsch 1949: 208-210; Pennsylvania 1856 Appendix: 7-9). He expounded on the importance of landscapes in early annual reports (1842, 1843) of the Pennsylvania Hospital for the Insane:

> The importance and utility of having the grounds about a hospital for the insane highly cultivated and improved, and everything in perfect order, is much greater than is generally supposed. It exercises a beneficial influence on all patients and on their friends. The good taste of many enables them to appreciate all such things in detail, many are pleased with them as a whole, and even those who are not capable of realizing their beauties, still have an indistinct recollection of something pleasant in connection with them...It should never be forgotten, that every object of interest that is placed in or about a hospital for the insane, that even every tree that buds, or every flower that blooms, may contribute in its small measure to excite a new train of thought, and perhaps be the first step toward bringing back to reason, the morbid wanderings of a disordered mind (Pennsylvania 1883: 50).

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Rothman describes asylum settings thus:

> the institution itself, like the patients, was to be separate from the community....the institution was to have a country location with ample grounds, to sit on a low hillside with an unobstructed view of the surrounding countryside. The scene ought to be tranquil, natural, and rural, not tumultuous and urban (Rothman 1971: 137-138).

This description fits most of the campuses included in this nomination, especially the early ones, where the dominant "Kirkbride" building was inevitably set on the highest ground. An early description of Northampton State Hospital demonstrates the parallels between Massachusetts asylums and the national model:

> The hospital stands on a commanding elevation nearly on the center of the farm, fronting the east. It is protected on the North and Northeast by a dense grove, but has on the East and Southeast an extensive open lawn, over which is an unobstructed view of Northampton and the Holyoke range of mountains, of the broad meadows bordering on the Connecticut River and the town of Hadley on the opposite banks and beyond, and higher up the hillside of Amherst and its college buildings (Annual Report 1858).

Few of the hospitals' Annual Reports mention landscape architects. The only state hospital known to have employed a noted practitioner is Boston State, where the landscape was designed by Arthur Shurtleff. Boston State was a city facility at the time, however, and the present campus unfortunately bears little or no evidence of his hand. Other campuses are greatly enhanced by pastoral landscape designs. These include Taunton, Northampton, Tewksbury, Medfield, and Metropolitan State (R. Loring Haywood, landscape engineer). Foxborough was laid out by Boston landscape architect, Joseph H. Curtis (1841-1928).

Landscape issues, unlike designers, are frequently mentioned in annual reports and include statements such as the following. At Northampton, it was noted that the trustees had "visited several similar institutions ... and consulted a gentleman of taste and experience in this department who has examined the grounds, and aided them by his suggestions and advise" (1st Annual Report 1856). When the Fernald School moved from Boston to a more spacious Waltham campus in 1887-1888, it was reported that the buildings would not be laid out in "checkerboard" fashion, but that siting would follow the natural contours of the land (1st Annual Report 1888). In this case, the trustees may have been influenced by concurrent developments at the nearby private McLean Hospital, where Frederick Law Olmsted was providing similar advise (Zimmer 1983: IV 2-6) and Joseph Curtis was providing the actual design. Annual reports for all of the campuses

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provide abundant information on landscape improvements ranging from plantings to road layout to grading activities.

Rural settings and large campuses provided more than an aesthetic therapeutic benefit. They also provided opportunities for healthy out-of-doors work. Manual tasks were considered to be crucial components of a well-ordered patient's day, with productive work inculcating habits of industry while providing both self-esteem and physical well-being. Agricultural work played an important role in the routine of male, and in some cases female, patients until the 1970s when it was discontinued systemwide. Westborough State Hospital retains an especially well-preserved agricultural landscape, with historic uses documented by an early twentieth century map showing the division of woodlands, wetlands, and fields. Evidence of agricultural uses prior to purchase by the state also remains in the form of forestation patterns, old stone walls, and former carriage roads lined by old overarching trees. Other campuses with especially important agricultural landscapes include Northampton, Danvers, Medfield, Templeton, Grafton, Wrentham, and Belchertown.

The integrity of campus landscapes, including viewsheds, are presently being compromised by several factors. The "designed" zones are affected primarily by introduction of new buildings and paved parking lots into former lawn areas, and by lack of maintenance. This reduces recreational areas and the sense of tranquility that was such an important part of early treatment programs. This is especially a problem at the state schools. Careful siting of new construction that considers original spatial layout, circulation systems, and topography could lessen further impact. At the hospitals, neglect of landscape features and introduction of parking lots are the greatest problems. In almost all cases, the "rural/vernacular" zones are affected by neglect that has resulted from disuse over the last twenty to thirty years. Outbuildings are generally in deteriorated condition and fields are beginning to revert to woodland.

g. Historic and Pre-historic Archaeological Potential

Prehistoric and historic archaeological resource potential is present in nearly every state hospital property included in this nomination. Each of these resource areas has the potential to contribute strongly to the significance of properties where archaeological survivals can be documented and their integrity remains intact. Both prehistoric and historic resources are present on campuses in a wide range of environmental zones ranging from the coastal lowlands of eastern Massachusetts to uplands surrounding the Connecticut River Valley in the western portion of the state. With prehistoric resources this ecological diversity and broad spatial distribution enable the study of a wide range of research issues on both a regional and local level. Historic resources, on the other hand, represent a relatively

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consistent plan of development over the entire area throughout the history of state hospital development. Potential archaeological resources on each of the state hospital properties can contribute greatly to a variety of research problems in each of these fields. Their wide distribution enhances their importance by providing a data framework within which the information potential for each hospital can be extrapolated on the state and regional level. Archaeological remains at many of the state hospitals may be especially significant since many of the properties are located near wetlands and include large areas with development clustered during hospital construction. Since many areas near wetlands remain undeveloped, site integrity for surviving prehistoric sites may be high. Since adaptive reuse of many pre-existing farms was also common with the state hospitals, the integrity of surviving historic archaeological resources may also be high, particularly near surviving pre-existing structures and where field patterns remain unchanged.

Prehistoric resources present on state hospital properties have the potential to further document patterns of prehistoric occupation in towns where these patterns are poorly understood. Surviving sites can contribute much-needed information in towns where prehistoric site inventories are underreported and where systematic site examinations are lacking. Most state hospital properties exhibit locational characteristics including well-drained, level to moderately sloping areas in close proximity to wetlands, all favorable characteristics for prehistoric site locations. Generally speaking, site inventories in the eastern portion of the state are more well represented than in the central and western portion of the state. This pattern likely represents actual regional population trends, but also probably includes levels of reporting. Collecting activity has historically been greater in eastern Massachusetts than in the western portion of the state. This trend, combined with increased densities of historic period land use and development in eastern Massachusetts, may be partially responsible for varied levels of reporting statewide. Underreporting is clearly a problem in eastern Massachusetts; however, as one goes west, this problem increases. The distribution of state hospital properties is present in a pattern that will enable a study of this problem on a statewide level, with regionally comparative results over a wide area.

The regional pattern described above is also true with regard to systematic site investigations. While site densities and inventories are greater in eastern Massachusetts, relatively few of the known sites have been systematically studied making intersite comparisons difficult if not impossible. Systematic site examinations have increased greatly over the last 20 years; however, the majority of this work has been concentrated in eastern Massachusetts, where expanded development has led to a greater number of archaeological surveys. Central and western Massachusetts clearly lags behind the

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eastern part of the state in the number of systematic site examinations performed. Potential prehistoric sites on many of the state hospital properties in these areas can help improve our sample of systematically studied sites within the region. This sample will contribute to a comparative database from which numerous prehistoric research topics can be addressed.

The fifteen state hospitals included in this nomination are located along wetlands included in most of the major river drainages in Massachusetts, including and east of the Connecticut River. In western Massachusetts, the Northampton State Hospital, Monson State Hospital, Belchertown State Hospital, and Templeton Colony are all located along tributary streams of the Connecticut River. In central Massachusetts, the Tewksbury State Hospital, Lyman School for Boys, and the Westborough State Hospital are all located along the Shawsheen, Concord, Sudbury and Assabet River tributaries, which generally flow north to the Merrimack River. The Grafton State Hospital is also present in the central Massachusetts locale along tributary wetlands of the Blackstone River Drainage, which flows to the south. In eastern Massachusetts, the Metropolitan State Hospital, Massachusetts Mental Hospital, Medfield State Hospital, Fernald State School, and Wrentham State School are each located within the bounds of the Charles River Drainage. The Foxborough State Hospital is located along the interior Neponset River drainage and the Taunton State Hospital along the Millers River/Taunton River drainage.

As a result of this distribution, both politically and in terms of riverine drainage basins, potential prehistoric sites in the state hospitals are present in a sample that allows for statewide comparisons of site densities, reporting and subsistence/settlement studies based on their location within specific riverine basins. River basins have traditionally been used as a sociopolitical unit for regional comparisons of prehistoric settlement patterns and technological studies. Potential prehistoric sites on state hospital properties in this nomination may present a sample within which this type of study could be made or tested on a statewide or regional level. Information may be present indicating the degree to which sites within drainage basins are similar or the extent to which settlement and subsistence patterns crosscut drainages with similarities over wider physiographic zones, such as the coastal lowlands or central Massachusetts uplands.

Prehistoric resources on the various state hospital grounds may further document the relationship of Native American core/periphery zones on a statewide basis. Most Native American core areas focused on the coast and major riverine locations, with peripheries including the much less documented tributary streams and interior wetlands. Many of the state hospitals are included in tributary wetlands of major drainages, which may further enable clarification of the nature

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and diversity of this relationship.

The wide distribution of potential prehistoric sites on state hospital properties may also enable the study of such topics as trade, which would be difficult with a single site or drainage. The ecological and regional diversity of properties in this nomination indicate a wide range of resources and cultural items that would have been available to prehistoric peoples on a regional but not necessarily local level. Systematic archaeological studies can identity these materials and items, their source areas or potential manufacturing points, and can suggest hypotheses for the methods of distribution or potential trade systems.

Potential historic archaeological resources on State Hospital property included in this nomination may contribute data on a variety of research topics from the 17th through 20th centuries. This data results from pre-existing use of the properties through and including State Hospital operations.

Nearly every property has the potential to contribute information on rural farmsteads, including actual agricultural operations and related residential use of the farms. A pattern exists with most state hospitals whereby campuses were selected at the sites of one or more pre-existing farmsteads. This selection is directly related to therapeutic work for patients, the claimed self-sufficiency of the hospitals, and the fact that pre-existing farms often offered a ready-made facility for residence and/or administration while the main hospital facility was being constructed. Pre-existing farmsteads have been documented at every facility except at the Massachusetts Mental Hospital, which is located on a small panel of land in a densely built-up urban setting. Earlier farmsteads are expected but not verified at the Metropolitan State Hospital and Northampton State Hospital. Structural remains of farmhouses and outbuildings could provide information on the physical layout of rural farms and the extent to which they follwed the pattern of other farms in the local area, region, or state. This data could also define the extent to which the pattern of farm buildings was influenced by the specific function of the farm, such as husbandry versus agriculture or dairying activities. Production of specific crops or the extent to which they were grown may have also influenced the pattern of farm buildings by requiring structures for storage or residence for farm laborers.

Detailed analysis of occupational-related features associated with farmsteads no longer extant and those still standing can contribute information on the social, cultural, and economic lives of farm residents, their families and by comparative analyses and extrapolation, how their lives compared with life on farmsteads in other areas of the state. These features can provide information on the day-to-day lives of inhabitants on rural farmsteads including

their eating habits, clothing, and overall status of life at the time they lived in. Trash areas can also provide technological information relating to the extent to which then-current farming trends were employed and the presence of other manufacturing activities on farms.

Extant pre-existing farmsteads and those that survive archaeologically can also provide data on the extent to which adaptive reuse of earlier farms was important in the state hospital system. Adaptive reuse has been recognized at several state hospitals including those in Wrentham and Westborough. Archaeological survivals should exist in these areas to indicate potential modifications to residential and agricultural structures during their change from private to institutional use. Archaeology can also help document the extent to which patients were employed in building modification and the degree to which these modifications followed standard accepted trade practices of the time. Archaeological survivals indicating adaptive reuse can be a useful tool in defining the extent to which institutional life was similar to or different from more civilian life at the time.

Subsistence farming or the degree to which pre-existing farmsteads and the state hospitals were selfsufficient is another topic that could be studied with potential archaeological survivals on state hospital properties. Analysis of the contents of occupational-related features, particularly trash deposits, can indicate the extent to which farms and the state hospitals grew and/or manufactured items they needed for their survival. A comparison between state hospitals might also indicate the extent to which different hospitals cooperated with each other by providing specialized items or products each needed for their operation. A certain level of cooperation has been recognized within the state hospital system whereby farm colonies at different hospitals were organized to support certain hospitals with agricultural and dairy products.

Occupational-related features or trash areas at the state hospitals can contribute data on the lives of patients and staff at the hospitals, possibly indicating how those lives changed through time and how they related to or compared with life in society in general. On some campuses, refuse deposits may have originated with pre-existing farms and been reused over time.

These deposits may contain stratigraphic evidence of first private, then institutional use, possibly for similar activities. General patterns of consumption between the private and institutional sectors could be analyzed as they changed through time or varied between specific groups at particular points in time. Patients and staff may have lived lives quite different from one other or overlapped in areas such as subsistence. Patterns of consumption involving food, clothing, entertainment, etc. may have also varied or been similar between institutions. Archaeological survivals have the potential to

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identify these trends through comparative analysis of refuse deposits between the hospitals.

Potential historic archaeological resources at the state hospitals also offer a rather unique opportunity to study the state almshouse system in the 19th century. State-owned almshouses predated the state hospitals in Monson and Tewksbury. These facilities represented two of the three state-owned almshouses in operation at the time. A town-owned poor farm was present on the Belchertown campus. Archaeological survivals, including structural remains and refuse deposits, can help document the living conditions in 19th century poor farms, possibly identifying differences or similarities between state versus town care for the poor. These resources can also help document the extent to which poor farms were self sufficient as reported at the time. Archaeological survivals associated with the state almshouses can also contribute to studies of ethnicity with specific groups such as the Irish, who immigrated to the United States in large numbers after the famines in Ireland in 1847. During that period, local town-owned almshouses or poor farms were filled to capacity, resulting in many immigrants being sent to the state almshouse in Monson. A similar pattern may exist for the almshouse in Tewksbury. This pattern may also hold for other ethnic or racial groups such as French Canadians and Polish, who also immigrated to the United States in large numbers in the mid 19th through the early 20th centuries.

One final note on why historic archaeological survivals on the state hospital properties are significant. Patients were sent to the various state hospital because they could not survive in everyday life. State hospital patients included alcoholics, the chronically insane, poor, handicapped, or generally disadvantaged and medically sick youth and adults. These types of individuals have rarely been brought together at a single location where they lived,worked, and were treated as a group. Archaeological survivals at the state hospitals have the potential to offer a unique look at these behaviors and conditions apart from the remainder of society. A systematic study that produces archaeological data representative of the various types of patients at the state hospital could be of major importance in the field of historic archaeology. Most patients at the state hospital represent groups in whom where opportunity and interest for their study are often absent or lacking. Archaeological survivals at the various state hospitals present the potential to study groups of individuals and a particular spectrum of our society that has often been forgotten or hidden. Archaeology can help document aspects in the lives of individuals and groups for which other documentation is not available.

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VI. Current Status

The system thus developed has remained remarkably intact even though it has been grossly underutilized over the past twenty years, leaving many buildings vacant and deteriorating. The vacant status of the state's four Kirkbride buildings at Taunton, Northampton, Worcester, and Danvers is a matter of special concern, especially after a major fire destroyed much of Worcester in 1991. The few major losses that have occurred include the original Worcester Asylum of 1830, the original South Boston facilities of Boston State Hospital (1839) and the Fernald School (1856), all of the original wood-frame Almshouse buildings (1852-54) at Bridgewater, Monson, and Tewksbury, all but fragments of the Tuberculosis Sanatoria at Lakeville, North Reading, and Westfield (1907), and most of the farm complexes and chronic colonies throughout the system. Factors affecting the integrity of the remaining system include neglect, incompatible reuse (generally as prisons), and extensive new construction and rehabilitation (generally at the State Schools).

The present nomination comes at a crucial time in the history of the system. Having peaked at a total patient population of 35,000 in the 1940s, the hospitals, through the process of deinstitutionalization, had reduced that number to about 6,000 in the decades that followed, leaving all the campuses underutilized. Several campuses have recently been closed, others will in the future, and development and/or reuse is likely. The Massachusetts Historical Commission is working with the staff of the Division of Capital Planning and Operations (DCPO) to ensure that the historical and archaeological significance of the system, as documented in the present nomination, is taken into account in future redevelopment proposals. While National Register listing assures that the historic value of designated properties will be considered during the planning stages of any federally or state-sponsored project, it does not guarantee those properties' preservation. It is expected that many of the campuses will change in both function and appearance in the future, and that alterations to many buildings--including demolition of some--will occur. The MHC and the DCPO are currently developing a Memorandum of Agreement to guide growth and change at the Northampton State Hospital. This MOA may provide a framework for other campuses where closure has already occurred and for whom development is expected.

F. ASSOCIATED PROPERTY TYPES

I. Name of Property Type: First Property Type: Hospital/Campus Area

II. Description

a. Physical Characteristics. Hospital Campuses/Areas are located throughout the state and encompass large areas, ranging from hundreds

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F. Associated Property Types See continuation sheets

I. Name of Property Type _____

II. Description

III. Significance

IV. Registration Requirements

[X] See continuation sheet

[X] See continuation sheet for additional property types

G. Summary of Identification and Evaluation Methods

Discuss the methods used in developing the multiple property listing.

See continuation sheets

[X] See continuation sheet

H. Major Bibliographical References

See continuation sheets

[X] See continuation sheet

Primary location of additional documentation:

- [X] State historic preservation office
- [X] Other State agency
- [ ] Federal agency
- [ ] Local government
- [ ] University
- [ ] Other

Specify repository: Massachusetts Historical Commission
Massachusetts State Archives

I. Form Prepared By

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to thousands of acres in extent. These campuses are developed with either a massive centralized "Kirkbride" building and/or dispersed "cottages" serving administrative, patient, and staff functions. Support buildings, including powerplants, laundries, workshops, maintenance buildings, and barns, are grouped around the main buildings with the whole surrounded by large tracts of agricultural fields and undeveloped wetlands and woodlands. Within this general framework, great variety exists at the individual campuses. Developed over a span of 100 years from the 1840s to ca. 1940, they reflect changing taste in their architectural style, and embody changing ideas about treatment in their configuration. Some are designed by noted architects and are masterful examples of particular architectural styles. A few are characterized by a single group of buildings developed at one time. Most, however, include buildings from several periods of historic development. Some include, or consist of, well-developed isolated colonies. Most include substantial groups of farm buildings. The materials chosen for construction, whether wood or masonry, are related to architectural style, period of construction, and intended use. Scale is related to these factors as well. Noncontributing buildings in the form of large scale patient care facilities were added to many campuses after the period of significance (1830-1940).

In practice, most of the campuses have a two-part landscape that consists of a "designed" section where the buildings are clustered, and a "rural/vernacular" section that provides a buffer zone. The "designed" zones are characterized by vehicular drives and footpaths that are often lined by trees and/or ornamental light fixtures, by broad lawns, and to a lesser extent by ornamental plantings. Buildings are often arranged to create sheltered quadrangles. The presence of greenhouses, along with mentions in the annual reports, indicate that planting beds once played a much more important role in campus aesthetics than they do today. The "rural/vernacular" zones are typical of the New England landscape as a whole with their interspersed pattern of farmland, wetland, and woodland.

Refer to Statement of Historic Context: Physical Developments: Architecture and Landscape for more detailed information.

b. Associative Characteristics

Hospital Campuses/Areas are the major physical manifestation of the public health care system developed by the Commonwealth of Massachusetts from 1830 to ca. 1940. All examples will have intimate historical associations with the state's continuing attempts to care for varied classes of dependent citizens including the poor, the sick, the insane, the mentally retarded, and the juvenile delinquent. They are located throughout the state, and generally sited on rail lines, to provide equal access to care for all citizens of the Commonwealth.

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The earliest campuses (1850s-1870s) are dominated by a large-scale highly centralized "Kirkbride" buildings, surrounded by later small-scale "cottage" buildings. Later hospitals are built on the dispersed "cottage" plan. Hospital campuses encompass large amounts of open space to provide the "ideal setting" required by early treatment methods and to provide room for the agricultural activities that were part of patient therapy as well as campus economy. Boundaries should encompass all buildings and all land that were associated with the campus during its period of significance and retain integrity as discussed in Registration Requirements.

Refer to Statement of Historic Context: Physical Developments: Architecture and Landscape for more detailed information.

III. Hospital Campus/Area Significance

Hospital Campuses are the major physical manifestation of the public health care system developed by the Commonwealth of Massachusetts from 1830 to ca. 1940, and are described in the various historic contexts above.

a. Criteria

1. All examples will meet criterion A for associations with development of the state public health system, and of the community or region in which they are located. Refer Statement of Contexts: "The History of Public Involvement" and "Methods of Care and Treatment" for more detailed information.

2. Some examples will meet criterion B for integral associations with the productive lives and work of noted persons in public health field. Refer to Statement of Historic Section E: "Noted People" for more detailed information.

3. All examples will meet criterion C as examples of state-developed public health care facilities, and as groups of buildings that create distinguishable entities although their components may lack individual distinction. Some will be the examples of the work of master designers and/or possess high artistic value. The natural landscape that forms the setting for the buildings is important as an expression of early treatment methods. Refer to Section E: "Architecture and Landscape" for more detailed information.

4. Many examples will meet criterion D due to their potential to yield important information about the evolution of public health care either through study of extant buildings and landscapes, or through historic archaeological remains. There is also the potential to yield information about prehistory through archaeological investigation.

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Refer to Section E: "Information Potential" for more detailed information.

b. Criteria Considerations

The criteria considerations do not apply to this property type as a whole. Religious properties, usually chapels, are sometimes contributing and integral parts of campuses (A). Some buildings may be moved within a campus and remain as contributing components if they maintain appropriate historic relationships to other parts of the campus (B). Cemeteries are often contributing and integral parts of campuses, reflecting their self-contained nature, and possessing the potential to yield information about inmates (D). Some components of the campus that are less than fifty years old may be considered to contribute if they have demonstrated state- or national-level associations with one of the contexts (G).

c. Level of Evaluation

Evaluation of this statewide system most properly takes place at the state level. Where appropriate and possible, some campuses are also judged within a national context.

IV. Hospital Campus/Area Registration Requirements

Hospital Campuses/Areas must possess the physical and associative characteristics discussed above and in Section E to be considered eligible for National Register listing. The primary associative characteristic, and the key registration requirement, is integral connections with the Commonwealth of Massachusetts' development of an extensive public system to care for dependent citizens who were incapacitated by mental or physical health problems, by poverty, or by juvenile truancy, during the period 1830-ca. 1940. To be eligible for nomination to the National Register of Historic Places under this property type, a campus/area must have been developed as part of this system and possess sufficient physical integrity to convey that association.

Campuses must also retain integrity to their period of significance. Their physical condition and integrity is primarily being affected by the downsizing of the state public health care system, a process that began in the mid-twentieth century. Historic buildings are being affected by neglect, abandonment, and inappropriate rehabilitation. Historic campus landscapes are being compromised by several related factors. The "designed" zones are affected primarily by introduction of new buildings and paved parking lots into former lawn areas. This reducing recreational areas and the sense of tranquility that was so important to early campuses. This is especially a problem at the state schools. Careful siting of new construction that considers

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original spatial layout, circulation systems, and topography could lessen further impact. At the hospitals, neglect of landscape features and introduction of parking lots are the greatest problems. In almost all cases, the "rural/vernacular" zones are affected by the neglect that has resulted from disuse over the last twenty to thirty years. Former agricultural buildings are generally in deteriorated condition and fields are beginning to revert to woodland. Limited loss of land or minor historic buildings will generally not preclude registration. Limited amounts of new construction that respect the character of contributing buildings and landscapes will generally not preclude registration. Present-day ownership and use by the state is not required as long as other qualifications are met.

Several campuses, including Northampton, Danvers, Foxborough, and Metropolitan State, have recently been declared surplus by the Department of Mental Health.

a. Specific Integrity Factors

1. Location and Setting: Campuses will always possess integrity of location and setting. These are considered to be key integrity factors for this property type. Early treatment methods, especially Moral Treatment, relied heavily on creation of an ideal rural physical setting that would remove the afflicted one from an increasingly complex society to effect cures. Thus, the mental health institutions were located in rural or at least semi-rural areas to provide a sense of tranquility for patients, to avoid dissention from neighbors, and to keep acquisition costs for the state as low as possible. These latter considerations also apply to campuses developed for reasons other than mental health. Campuses were invariably large areas encompassing hundreds, and in some cases, thousands of acres in order to preserve an ideal self-contained setting within their boundaries. Agricultural components were included as measures of work therapy and campus economy. Setting refers to the campus itself rather than to its surroundings. Refer to Section E, especially "Methods of Care and Treatment," and "Architecture and Landscape" for more detailed information.

Factors that affect this type of integrity include modern hospital or non-hospital related development, the sale or leasing of all or part of the campus, and neglect of contributing landscapes. These factors may be sufficiently detrimental to integrity to preclude registration of this property type, or to exclude portions of the historic hospital campus.

2. Design, Materials and Workmanship: Campuses will always possess a high degree of integrity of design, materials, and workmanship. These are important integrity factors for this property type. Like setting, building design was an important component of early treatment methods.

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Design also refers to the relationships of buildings to one other within the campus landscape. Refer to Section E, especially "Methods of Care and Treatment," and "Architecture and Landscape" for more detailed information.

Factors that affect this type of integrity include the demolition, alteration, or moving of buildings, the addition of new buildings, the loss or alteration of landscape features including reforestation of agricultural land, and the loss of historic period acreage. These factors may be sufficiently detrimental to integrity to preclude registration of this property type, or to exclude portions of the historic hospital campus.

3. Feeling and Associations: All campuses must possess historic associations with the state public health care system. This is a key integrity factor. They must retain sufficient physical integrity as described above to be able to convey their relationships to and associations with the historic contexts described in Section E.

I. Name of Property Type: Second Property Type: Small-Scale Facilities and/or Individual Buildings

II. Description

a. Physical Characteristics

This property type includes facilities that consist of single buildings or small numbers of related buildings set on small amounts of land. In some cases, this configuration is original; in others, it results from major losses or changes to a larger campus (see property type I). Examples of the former include compact urban hospitals such as the Massachusetts Mental Health Center that were originally developed with a minimum of buildings and landscape features. In the latter case, the building(s) must include one or more major components of the original campus. Examples include a centralized "Kirkbride" building, an administration building and associated patient care or staff residence building(s), or an isolated colony. A single patient ward, staff residence, support or farm building would be unlikely to qualify. Individual examples will display great variety in location, setting, scale, materials of construction, architectural style reflecting their historic uses, and periods of construction.

Refer to Section E: Architecture and Landscape for more detailed information.

b. Associative Characteristics: This property type is an important physical manifestation of the public mental and physical health care system developed by the Commonwealth of Massachusetts from 1830 to ca.

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1940. All examples will have intimate historical associations with the state's continuing attempts to care for varied classes of dependent citizens including the poor, the sick, the insane, the mentally retarded, and the juvenile delinquent. Boundaries should encompass all buildings and land that was associated with the facility during its period of significance and retain integrity as discussed in Registration Requirements.

Refer to Section E: Architecture and Landscape for more detailed information.

III. Small-scale Facility and/or Individual Building Significance

This property type is an important physical manifestation of the public health care system developed by the Commonwealth of Massachusetts from 1830 to ca. 1940, and described in the various historic contexts that comprise Section E.

a. Criteria

1.. All examples will meet criterion A for associations with development of the state public health system, and of the community or region in which they are located. Refer to Section E: "The History of Public Involvement" and "Methods of Care and Treatment" for more detailed information.

2. Some examples may meet criterion B for integral associations with the productive lives and work of noted persons in the public health field. Refer to Section E: "Noted People" for more detailed information.

3. All examples will meet criterion C as examples of state-developed public health care facilities. Some will be the examples of the work of master designers and/or possess high artistic value. Refer to Section E: "Architecture and Landscape" for more detailed information.

4. A few examples may meet criterion D due to their potential to yield important information about the evolution of public health care either through study of extant buildings or through historic archaeological remains. Refer to Section E: "Information Potential" for more detailed information.

b. Criteria Considerations

Religious properties, usually chapels, are unlikely to meet the National Register criteria as examples of this property type (A). Moved buildings are unlikely to meet the National Register criteria as examples of this property type (B). No birthplaces are associated with this property type (C). Cemeteries are are unlikely to meet the

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National Register criteria as examples of this property type (D). A reconstructed building is unlikely to be considered as a significant example of this property type (E). No commemorative properties are associated with this property type (F). Properties that are less than fifty years old may be considered significant examples of this property type if they have demonstrated state- or national-level associations with one of the historic contexts (G).

c. Level of Evaluation

Evaluation of this statewide system most properly takes place at the state level. Where appropriate and possible, some campuses are also judged within a national context.

IV. Registration Requirements

This property type must possess the physical and associative characteristics discussed above and in Section E to be considered eligible for National Register listing. The primary associative characteristic, and the key registration requirement, is an integral connection with the Commonwealth of Massachusetts' development of an extensive public system to care for dependent citizens who were incapacitated by mental or physical health problems, by poverty, or by juvenile truancy, during the period 1830-ca. 1940. To be eligible for nomination to the National Register of Historic Places under this property type, a building(s) must have been developed as an important component of the state hospital and school system, and must possess sufficient physical integrity to convey that association.

The physical condition and integrity of this property type is primarily affected by the downsizing of the state public mental and physical health care system, a process that began in the second half of the twentieth century. This has led to building neglect and abandonment, to inappropriate rehabilitation, and to incompatible new construction. Present-day ownership and use by the state is not required as long as other qualifications are met.

a. Specific Integrity Factors

1. Location and Setting: These are not important integrity factors for this property type. Most examples of this property type will survive as key remnants of campus/areas, and thus by definition will lack integrity of setting. The few examples such the Massachusetts Mental Health Center, which were developed as urban research/treatment facilities, are not dependent on setting for their significance.

2. Design, Materials and Workmanship: This property type will always possess a high degree of integrity of design, materials, and workmanship. These are critical integrity factors in this property

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type. Building design was an important component of early treatment methods. Refer to Section E, especially "Architecture and Landscape" for more detailed information.

Factors that affect this type of integrity include the demolition, alteration, or moving of buildings.

3. Feeling and Associations: All examples must possess historic associations with the state public health care system. This is a key integrity factor. They must retain sufficient physical integrity as described above to be able to convey their relationships to and associations with the historic contexts described in Section E.

G. SUMMARY OF IDENTIFICATION AND EVALUATION METHODS

Identification: The Multiple Property listing for the Commonwealth of Massachusetts Hospital and School System is based on a 1984 survey of historical/architectural resources conducted by Candace Jenkins for the state Division of Capital Planning and Operations (DCPO). It was conducted as part of their systemwide campus planning study designed to identify surplus state properties. That study examined all state hospitals and schools managed by the Department of Mental Health (DMH); all facilities managed by the Department of Public Health (DPH); and all such surplus facilities under the management of DCPO. The purpose of the historical/architectural survey component was to assist DCPO in fulfilling their responsibilities under Section 106 of the National Historic Preservation Act (NHPA) and Chapter 254 of the Massachusetts General Laws (MGL). The survey used the general methodology and forms established by the Massachusetts Historical Commission (MHC).

Specifically, the survey began with a review of DCPO records including dates of campus establishment and component buildings, and an extensive slide collection. Five campuses were deleted because they had been established less that fifty years ago (Dever, Hogan, Gentile, Glavin, Shattuck). Four others were deleted because they had previously been listed in or voted eligible for listing in the National Register of Historic Places (Danvers, Worcester, Taunton, Shirley). One other was deleted because all historic buildings had been demolished (Rutland). Thus, the original list of thirty-one facilities was reduced to twenty (see Appendix A).

Those remaining twenty campuses were visited and photographed to determine their architectural significance and integrity and were researched (primarily through Annual Reports at the State Library) to determine their historical significance. Research identified eleven other facilities that were originally associated with the state hospital and school system but have been since demolished or transferred to other agency control, primarily the Department of

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Corrections. These were not visited or fully researched, but were included on a chronological list of hospitals and schools established between 1830 and 1930 (see Appendix B).

The 1984 survey resulted in a Narrative Overview, tracing the history of the system, a chronological list of the system, and standard MHC area inventory forms for the individual campuses. Preliminary National Register evaluation was undertaken and the significance of campuses was ranked on the local, state, or national level. In general, the system was found to possess a high level of historic/architectural significance and to retain a high degree of integrity.

Evaluation: In 1991-1992, Candace Jenkins prepared this multi-property nomination for the MHC. Initial evaluation meetings with MHC staff deleted Boston State Hospital from further consideration due to substantial loss of integrity. DPH facilities were deleted due to time and budgetary constraints. Taunton, which had previously been voted eligible but not nominated due to insufficient information, was added. The contexts developed for this nomination, including public health, represent a refinement of the Narrative Overview prepared for the 1984 survey. They were designed to consider the key issues that influenced development of the system as they relate to the National Register criteria. They were expanded with additional research to develop a national context and to add components that considered important people involved in the system, and the potential for archaeological resources (the latter completed by Leonard W. Loparto, MHC staff).

The remaining fifteen campuses were visited and rephotographed to determine any changes that had taken place since 1984 and to gather the more detailed building by building and landscape information required by the National Register. Limited additional research was undertaken as necessary. Interim meetings of the consultant and MHC staff considered issues such as integrity, boundaries, period and level of significance, appropriate levels of information, and supporting documentation. Property types were based on function and integrity. Registration requirements were developed on the basis of specific knowledge about the historic evolution and current integrity of the state hospitals and schools. Nomination forms, including district data sheets and accurate maps that identify all buildings and landscapes, were prepared.

In the future, this nomination may be amended with DPH properties and with former DMH properties that have been transferred to other agencies such as Corrections.

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MASSACHUSETTS STATE HOSPITALS AND SCHOOLS: 1830 - 1930
CHRONOLOGICAL LIST
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APPENDIX 1

DATE ESTABLISHED	NAME:HISTORIC/CURRENT	MAJOR ARCHITECT(S)	PLAN TYPE
1830	Worcester Insane Asylum demolished	Elias Carter	Congregate
1839/1895	Boston Lunatic Hospital Boston State Hospital disposition process	Kendall & Taylor Arthur Shurtleff (landscape)	Congregate (1839) Cottage (1895)
*1847/1885	Mass. State Reform School Lyman School for Boys, Westborough disposition process	Carter & Savage George Clough; Stephen Earle	Congregate (1847) Cottage (1885)
*1848/1887	Mass. School for Idiotic and Feeble-Minded Youth Walter E. Fernald State School, Waltham	William G. Preston	Cottage (1887)
*1851	Taunton Lunatic Asylum Taunton State Hospital	Elbridge Boyden	Kirkbride
1852	State Almshouse at Bridgewater Southeast Correctional Center		Congregate (1852)
*1852/1895	State Almshouse at Monson Massachusetts Hospital for Epileptics Monson Developmental Center		Congregate (1852) Cottage (1895)
*1852/1900	State Almshouse at Tewksbury Massachusetts State Infirmary Tewksbury State Hospital	John A. Fox	Congregate (1852) Cottage (1900)
1854	Industrial School for Girls Lancaster pre-Release Center		
*1855	Lunatic Hospital at Northampton Northampton State Hospital disposition process	Jonathan Preston	Kirkbride

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DATE ESTABLISHED	NAME:HISTORIC/CURRENT	MAJOR ARCHITECT(S)	PLAN TYPE
1859	Nautical Reform School Massachusetts Maritime Academy, Marion		
*1870	Worcester Lunatic Hospital Worcester State Hospital partial demolition	Weston & Rand	Kirkbride
*1873	State Lunatic Hospital at Danvers Danvers State Hospital disposition process	Nathaniel J. Bradlee	Kirkbride
*1885	Westborough Insane Hospital	George Clough; Stephen Earle	Congregate
	Westborough State Hospital	Rand, Taylor, Kendall & Stevens	Lyman reuse
*1889	Mass. Hospital for Dipsomaniacs & Inebriates Foxborough State Hospital disposition process	Brigham & Spoffard Joseph H. Curtis (landscape)	Cottage
*1892	Medfield Insane Asylum Medfield State Hospital	William Pitt Wentworth	Cottage
1895	Rutland State Sanatorium demolished		
*1899	Templeton Colony of the Fernald School	William G. Preston	Colony
*1902	Worcester Farm Colony Grafton State Hospital disposition process	Fuller & Delano	Colony
1902	State Colony for the Insane, Gardner North Central Correctional Institution	John A. Fox	Colony
1904	Mass. School & Home for Crippled and Deformed Children Mass. Hospital School, Canton		Cottage

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DATE ESTABLISHED	NAME:HISTORIC/CURRENT	MAJOR ARCHITECT(S)	PLAN TYPE
1904	Bussey Laboratory, Jamaica Plain Institute of Labs	W.S. Burke Stevens & Lee	n/a
*1906	Wrentham State Schhol	Kendall & Taylor	Cottage
1907	Lakeville State Sanatorium Lakeville Hospital		
1907	North Reading State Sanatorium Berry Re-hab Center		
1907	Westfield State Sanatorium Western Mass. Hospital	E.C. & G.C. Gardner	
1908	Industrial School for Boys MCI Shirley		
*1912	Boston Psychopathic Hospital Mass. Mental Health Center	Kendall & Taylor	Clinic
1914	Norfolk State Hospital MCI Norfolk		
*1915	Belchertown State School disposition process	Kendall & Taylor	Cottage
*1926	Metropolitan State Hospital, Waltham Belmont, Lexington disposition process	Gordon S. Robb Loring Heywood (landscape)	Hybrid

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APPENDIX 2

DATE ESTABLISHED	NAME:HISTORIC/CURRENT	MAJOR ARCHITECT(S)	PLAN TYPE

EOHS FACILITIES INITIALLY EXAMINED

* fully surveyed
NR listed in National Register of Historic Places
NRE voted eligible for National Register

DEPARTMENT OF MENTAL HEALTH

State Hospitals

*1711	Boston State Hospital		
1712	Danvers State Hospitals, NR 1984		
*1716	Medfield State Hospital		
*1717	Metropolitan State Hospital, Waltham		
*1718	Northampton State Hospital		
1719	Taunton State Hospital, NRE 1984		
*1720	Westborough State Hospital		
1721	Worcester State Hospital, NR1980		
*1729	Foxborough State Hospital		

Facilities for the Mentally Retarded

*1722	Monson Development Center		
*1723	Belchertwon State School		
*1724	W.E. Fernald State School, Waltham		
*1725	Wrentham State School		
1726	Dever State School, Taunton		

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DATE ESTABLISHED	NAME:HISTORIC/CURRENT	MAJOR ARCHITECT(S)	PLAN TYPE
1728	Hogan Regional Center, Danvers		
*1750	Berry Rehabilitation Center, North Reading		
1754	ICF/MR (Centile School Site), Springfield		
1756	Glavin Regional Center, Shrewsbury		
DEPARTMENT OF PUBLIC HEALTH			
	#2020 Institute of Laboratoreis, Jamaica Plain		
	#2021 Tewksbury Hospital		
	#2022 Lakeville Hospital		
	2023 Rutland Heights Hospital		
	#2025 Western Massachusetts Hospitals, Westfield		
	2026 Lemuel Shattuck Hospital		
	#2027 Massachusetts Hospital School, Canton		
DIVISION OF CAPITAL PLANNING, SURPLUS FACILITIES			
	*Lyman School for Boys, Westborough		
	Oakdale Residential Treatment Center, West Boylston		
	Lancaster Industrial School for Girls, NR 1976		
	*Grafton State Hospital		
ALSO SURVEYED			
	*Massachusetts Mental Health Center (see Boston State Hospital)		
	*Templeton Colony (see Fernald State School)		

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APPENDIX 3

DATE ESTABLISHED	NAME:HISTORIC/CURRENT	MAJOR ARCHITECT(S)	PLAN TYPE

SUMMARY OF ADMINISTRATION STRUCTURE

1854-1855	Lunacy Commission
1863-1879	Massachusett Board of State Charities - Chap 240/1863
1879-1886	State Board of Health Lunacy of Charity - Chap 291/1879
1886-1898	State Board of Lunacy & Charity (Health broken out by Chap 101/1886)
1898-1916	State Board of Insanity - Chap 433/1898
1919	State Board of Charity merged into Department of Public Welfare - Chap 350
1916	Massachusetts Commission on Metal Diseases - Chap 265