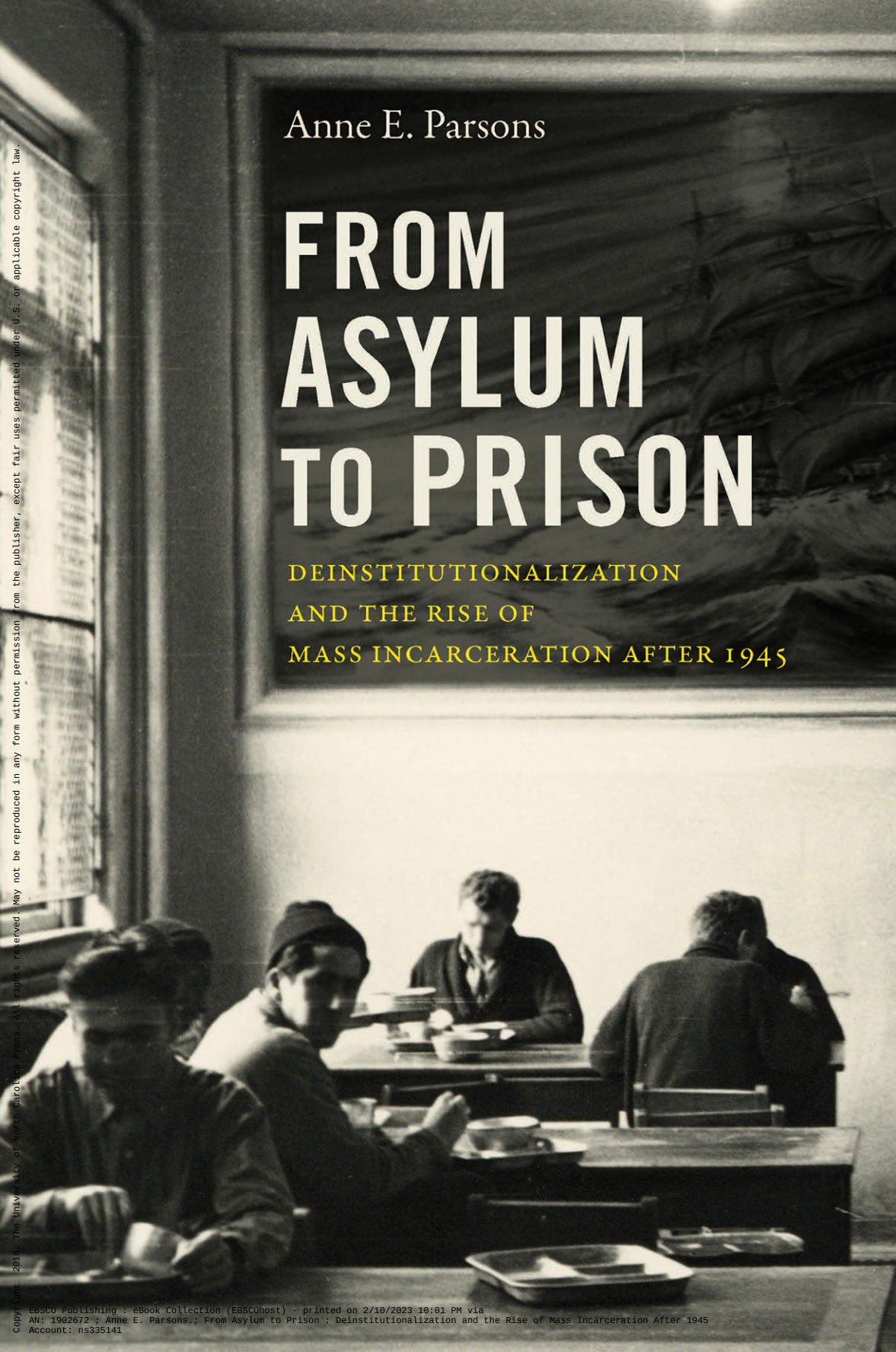
Anne E. Parsons

FROM ASYLUM TO PRISON

DEINSTITUTIONALIZATION AND THE RISE OF MASS INCARCERATION AFTER 1945



FROM ASYLUM TO PRISON

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DEINSTITUTIONALIZATION AND THE RISE OF MASS INCARCERATION AFTER 1945

Anne E. Parsons

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ABBREVIATIONS

ACLU	American Civil Liberties Union
AFSCME	American Federation of State, County, and Municipal Employees
APA	American Psychiatric Association
CO	conscientious objector
ECT	electroconvulsive therapy
NAMH	National Association for Mental Health
NARC	National Association for Retarded Children
NMHF	National Mental Health Foundation
PARC	Pennsylvania Association for Retarded Citizens
PMH	Pennsylvania Mental Health Inc.
SCI	State Correctional Institution
SPMI	serious and persistent mental illness

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INTRODUCTION

America's prisons have become our new asylums—only worse, because they're not equipped to handle the needs of people in psychiatric crisis.

—Ronnie Polaneczky, *Philadelphia Daily News*, 2014

In 1942 the Philadelphia police picked up George Elder for hitchhiking. A man of Cherokee and African American descent, Elder had taken to the road as a hobo during the Great Depression. During his trips around the country, he traversed twenty-five states. Yet now, at age thirty-five, his traveling days had abruptly ended. The authorities found Elder's expired draft card, learned he had refused to fight in World War II, and took him to court. Elder told the judge that he had refused to fight in the war because of the government's racist practices. "I said I was a pacifist who hated guns and wars. I was a conscientious objector and wouldn't shoot anybody. And I didn't want to fight for a country that treated Indians and black men like America [did]."[1] Not only did Elder refuse to fight, but he also demanded that the U.S. government reimburse him $346 for the injustices committed to Native Americans. Elder's radical request for reparations angered the judge, who sent Elder to two psychiatrists. The doctors diagnosed George Elder as paranoid schizophrenic, certified him legally insane, and committed him to the Philadelphia State Hospital at Byberry, one of the largest hospitals in the country. A white preacher tried to get Elder released in 1947; a Byberry staff member did the same in 1962. Both of these attempts failed, and Elder remained at the hospital for twenty-nine years.

In August 1970—amid efforts to reduce the number of people at Byberry—hospital administrators finally released the sixty-four-year-old Elder.

George Elder in the *Philadelphia Evening Bulletin*, June 19, 1971. (Photograph by George Nelson; Special Collections Research Center, Temple University Libraries, Philadelphia, Pa.)

He moved into a boardinghouse in North Philadelphia but had no job, lived on public welfare, and struggled with depression in his new home. After five months Elder returned to Byberry. He said that he was too old to live alone in a boardinghouse. News outlets—including the *Philadelphia Evening Bulletin* and *Ebony*—picked up his story. When a reporter asked him if he wanted to leave Byberry, he replied, "When I was younger somebody should have asked that. I was strong once. I could lift 100 pound bags all day. Now they've kept me here too long. I don't think I've got much further to go."[2]

The forces that shaped George Elder's long-term commitment to Byberry were characteristic of the transforming mental health system in postwar America. In the 1940s and 1950s, laws allowed states to commit people against their will, after which many people had few legal avenues to secure their release from institutions that served as carceral spaces—prisonlike in the way they held many marginalized people involuntarily. In the 1960s and 1970s,

deinstitutionalization—meaning the downsizing and closure of state-run mental hospitals—began to take hold. Community-based approaches in psychiatry, legal challenges to commitment laws, and activism around patients' rights led to the release of tens of thousands of people from inpatient mental health facilities. Yet these new mental health policies and practices did not guarantee people's rights to adequate social services outside the hospital walls. Many people like Elder struggled to survive after they left institutions.

Elder's confinement encourages us to think about how the carceral state shifted its focus from asylums to prisons during the second half of the twentieth century. If police picked up Elder for a misdemeanor today, they would most likely take him to jail. Rather than a mental hospital, he would stay in the jail's psychiatric ward. Thus, while confinement in mental health institutions plummeted between 1950 and 2000, the United States has shifted to a more punitive—but still institutional—approach to social disorder. The asylum did not disappear; it returned in the form of the modern prison industrial complex.

Mental health centers in prisons and jails grew at the very same moment that involuntary confinement in mental hospitals declined. Today, this new system of mass incarceration disproportionately affects people with psychiatric disabilities. Some of the largest mental health centers in the United States currently operate behind bars, and 40 percent of people diagnosed with serious psychiatric disorders face arrest over their lifetimes. In Philadelphia, nearly one-third of inmates have a psychiatric diagnosis, making the city's jail system the largest mental health provider in the state.[3]

Some people have explained this phenomenon as a transinstitutionalization rather than a deinstitutionalization. They argue that the rise of people with psychiatric disabilities in prisons and jails happened because of changing mental health laws and the downsizing of state psychiatric hospitals. As people were released from mental hospitals back into the community, many did not receive adequate mental health care or social services. As a result, their behaviors were criminalized as police responded to behaviors linked to alcoholism, drug abuse, and trespassing with arrest and jail time.[4] Some scholars have explained these developments with the balloon theory, introduced by the British psychiatrist Lionel Penrose in 1939. Penrose posited that as the number of people in mental hospitals fell, the rates of imprisonment rose.[5] In this model, deinstitutionalization caused the rise of people with psychiatric disabilities in prisons and jails. As a result, prisons became the new asylums. As the psychiatrist E. Fuller Torrey has stated, "Jails and prisons have increas-

ingly become surrogate mental hospitals for many people with serious mental illness."[6]

This historical narrative has had serious implications for contemporary mental health policy. For instance, journalist Pete Earley relied on this failed model of deinstitutionalization to argue that the government needed to interrupt transinstitutionalization by providing socialized medicine and crisis intervention teams. He also proposed the creation of more mental health courts and better reentry programs in jails that assist people when they return home.[7] These last two proposals in particular take for granted that jails and the criminal courts are the most appropriate systems for people with psychiatric disabilities and do not engage with some of the systemic issues that surround them. Torrey maintained that deinstitutionalization went too far and that stricter involuntary treatment laws are necessary, along with better psychiatric care and research on mental illness, in order to reduce the number of people with psychiatric disabilities in prisons and jails.[8] In 2015, three bioethicists at the University of Pennsylvania went even further when they published an article that demonstrated how deinstitutionalization had shifted people from hospitals to carceral institutions such as prisons. In response, they called for the return of rehabilitative institutions like asylums to treat individuals with psychiatric disabilities, a highly controversial concept that received immediate criticism. The premise of the argument rested on the notion that the deinstitutionalization of hospitals had caused the crisis of homelessness and incarceration. A return to asylums could redress those wrongs, according to those bioethicists, and they suggested that the older institutions are due for a revival.[9] All of these proposals continued to rely on coercive confinement as a central way to stop the overincarceration of individuals with psychiatric disabilities.

From Asylum to Prison challenges these arguments for oversimplifying history and ignoring inconvenient facts on the ground. First, deinstitutionalization did not lead to a mass exodus of people from hospitals to the streets to prisons. General hospitals and nursing homes began serving these individuals at much higher rates because of changes in Medicaid and state funding. Relatedly, many individuals did return to their communities successfully and received quality mental health and social services.[10] Second, researchers have found significant demographic differences between people with psychiatric disabilities in mental health institutions and those in prisons and jails. For instance, one study of a Philadelphia psychiatric hospital in 1999 found that only 2 percent of people released from the hospital were arrested.[11] While

these numbers did not apply to all people released from hospitals, they do disrupt the notion that a massive hospital-to-prison pipeline is the primary cause of today's crisis. Additionally, state psychiatric hospital patients have been predominantly white and middle-aged. Incarcerated people with psychiatric disabilities, on the other hand, are disproportionately African American and under the age of forty.[12] Finally, Richard Frank and Sherry Glied, both economists and health policy experts, have argued that the main cause of the rise of people with psychiatric disabilities behind bars has been the growing incarceration rates in the late twentieth century: "Our data suggest that it would be a mistake to attribute the increase in homelessness and incarceration among people with SPMI [serious and persistent mental illness] directly to the experience of deinstitutionalization. . . . Increases in incarceration rates due to the war on drugs and crackdowns of quality-of-life crimes (community policing) would have affected both those deinstitutionalized and the many people with SPMI who would not have been living in institutions even if deinstitutionalization had not taken place."[13]

From Asylum to Prison similarly argues that the overincarceration of people with psychiatric disabilities in prisons has stemmed in large part from the rapid growth of the criminal legal system itself. The crisis of confinement came about as part of a broader shift in governance, as the United States progressively relied on imprisoning its citizens as the main response to social disorder through its war on crime and war on drugs and the increased policing and surveillance of African American communities. As a result, the rates of incarceration in the United States skyrocketed from the 1970s through the 1990s, and by the twenty-first century the country had locked up over 2 million people in prisons and jails, accounting for 1 in 100 citizens. The United States outpaced all other countries in its incarceration rates, a feature that became a hallmark of American government.[14] This rapid rise of imprisonment caught many people with psychiatric disabilities in its net. As the number of people in prisons and jails rose, so too did the number of people with psychiatric disabilities in the criminal legal system.

A robust new field of scholarship has charted the brisk growth of mass incarceration in the late twentieth century. One of its central arguments has been that while prisons sit out of the public eye, changes in crime, punishment, and the carceral state stand at the center of political governance in the United States, casting a long shadow over a host of other political areas such as social welfare, urban planning, and civil rights law.[15] Crime served as a strategic issue for politicians looking to gain political power, and as society

became more punitive and as prisons sprouted up across the country, the discourse and technologies of crime seeped into institutions that seemingly had little to do with the criminal legal system. Public schools criminalized youth behaviors, and family law increasingly came to include criminal charges in the case of child abuse and divorce matters.[16]

The politics of crime and punishment have particularly shaped the social welfare state in the United States. With the rise of a bipartisan law-and-order politics, the focus in social welfare policy making shifted from the rehabilitative ideal to what historian Julilly Kohler-Hausmann has called tough politics. The criminal legal system progressively supervised individuals whom the social welfare state had previously managed, including people with histories of substance abuse, people charged with sex offenses, people with disabilities, and undocumented immigrants. In the late twentieth century, policy makers moved away from the rehabilitative model of addressing social issues such as drug use, crime, and poverty and instead used tough measures such as surveillance, punishment, coercion, and quarantine. By 1996, the United States spent far more on corrections than it did on social welfare programs such as food stamps and welfare grants.[17]

From Asylum to Prison builds upon this literature and takes as its premise that the changes in the criminal legal system had a profound influence on the direction of deinstitutionalization. Historians approaching the history of psychiatric hospitals in the late twentieth century must be aware of the rise of law-and-order politics and how that shaped mental health policy making and the closure of psychiatric hospitals. For example, in 1981, Pennsylvania, along with many other states, faced federal budget cuts. The state's Governor Dick Thornburgh announced a $267 million cut to the state budget, and the state planned to lay off 750 welfare and hospital workers. In response, advocates at organizations such as the Mental Health Association of Southeastern Pennsylvania fought to have the state maintain the current level of treatment and service programs. Robert J. Lerner wrote in the group's yearly publication, *Impact*, "If the decade of the 1960's is lauded for its dramatic public support of broad entitlements (rights) in the interest of social and economic justice, then the 1980's—if current trends continue—should be viewed as an era of benign neglect; an era when those least able to help themselves were trampled under pious rhetoric about self-help; an era in which economic realities, colored by political expediency, led voters to seek simple answers to complex problems."[18] At the very moment, however, that the Pennsylvania state government sought to cut these social welfare, medical, and mental health care

services, it led an effort to expand the state's prison system. The governor's administration unveiled a budget for corrections that hit $7.2 billion for 1981 and 1982 and it proposed the construction of a new state prison—the first of its kind since 1960.[19] These fights over deinstitutionalization and mental health funding in the 1980s did not happen in a vacuum; they were part of a broader financial reallocation of funds from the health and welfare systems to the criminal legal system. Putting mass incarceration at the center of the story of deinstitutionalization disrupts the narrative that deinstitutionalization was primarily a movement to shrink the American state.

This new narrative of the past has implications for how we approach our present. Advocates today argue that in order to cure today's ills in the mental health system, we need to allocate more money to community-based mental health services, health care, outpatient treatments, mobile crisis teams, peer supports, and supportive housing to particularly serve the needs of individuals involved in the criminal legal system.[20] Making these changes, however, would require not only an increase in funding to health and welfare services but also a rethinking of our societal practices of crime and punishment and the billions of dollars spent every year to incarcerate people. Because of the large amount of money needed for these programs, it would require a redefinition of what the state does and when it provides social supports—at the point of need or at the point of law-breaking.

Centering mass incarceration in the history of deinstitutionalization also helps explain the hostile reactions many had against the release of people with psychiatric disabilities from institutions. Beginning in the 1960s and lasting through the 1980s, public fears of urban uprisings, crime in cities, and civil rights and antiwar protests fed a belief that the government's main responsibility was to protect society and to control violence and disorder in African American urban communities. Even though the Johnson administration's war on crime had different intentions than Nixon's and Reagan's war on drugs, these campaigns had a similar effect as they continued to criminalize and police African Americans.[21] This racialized, fear-based politics in turn shaped mental health reforms. In his book *The Protest Psychosis*, medical historian Jonathan Metzl charted how racism and fear of urban crime permeated the psychiatric profession's approach to schizophrenia. In the 1960s and afterward, psychiatrists ascribed paranoid, violent, and dangerous behavior to the diagnosis of schizophrenia, and African American men increasingly began to receive the diagnosis. These diagnostic changes had life-altering consequences as psychiatrists committed larger numbers of African Americans

to custodial institutions like Michigan's Ionia State Hospital for the Criminally Insane.[22]

From Asylum to Prison is the first book to chart the ways that the race-based public discourse of fear and law-and-order politics influenced the policies around state mental health programs and deinstitutionalization. For instance, one Philadelphia newspaper story in 1980, under the headline "Keeping the Maniacs off the Streets," told the story of James Jimbo Willis, a man who had previously killed someone and served prison time. Once he was freed on probation from a state mental hospital, he stabbed a stranger to death with a seven-inch kitchen knife. Willis's story garnered a lot of attention and fueled anxieties around mental illness. At a time when Philadelphians considered crime the city's number one problem, stories of violent individuals with psychiatric disabilities particularly fanned the flames of fear around race, crime, and mental illness.[23] As hospitals closed, local prison officials noted a spike in the number of people with psychiatric disabilities behind bars. These findings prompted policy makers in the 1980s to create psychiatric wards in correctional settings, an action that still placed individuals with psychiatric disabilities in restrictive environments. The choice to expand mental health services behind bars did not happen in a vacuum. Instead, it occurred at a time when imprisonment became a primary solution to a host of social problems. As a result, state and local governments did not create appropriate less-restrictive environments for these individuals, and slowly the corrections systems in Philadelphia and across the country became major mental health providers.

This book argues that the policies regarding mass incarceration and mental hospitals were deeply intertwined with one another. Politicians and policy makers worked on these issues in tandem, as funding decisions in one realm affected funding decisions in the other and as the infrastructure of mental hospitals and prisons often guided decision-making. But the book also argues that deinstitutionalization affected the trajectory of mass incarceration. First, the lack of adequate community mental health services, the recriminalization of mental illness, and law-and-order politics fueled the increasing number of individuals with psychiatric disabilities in prisons and the creation of new mental health services in correctional environments. These developments in turn helped to expand the growth of the criminal legal system in the United States.

Second, the process of deinstitutionalization redefined who could be removed from society and why, changes which greatly influenced how mass in-

carceration developed. *From Asylum to Prison* argues that mental hospitals in the mid-twentieth century were carceral spaces—sites of social control that limited people's freedom.[24] In the United States during this period, many, but not all, states allowed individuals to voluntarily commit themselves to mental hospitals. The majority of people in state mental hospitals, however, were involuntarily committed by a lunacy commission, medical examiners, or a jury. Hospital administrators and state welfare officials often determined when and if individuals were discharged.[25] People lost many personal freedoms inside these institutions, including the freedom to determine the length of their hospitalization, to choose which treatments they received, and to live independently.

Some scholars have argued that a penal-welfare structure operated during the mid-twentieth century, one in which rehabilitation and confinement worked in tandem. They emphasize that the welfare and criminal legal systems were not truly independent entities; they were inextricably linked to one another.[26] *From Asylum to Prison* similarly argues that the social welfare state and the criminal legal system were intertwined. But it adds to this argument by showing how deinstitutionalization marked a fundamental shift in the welfare and criminal systems. The 1960s was a time when the public, policy makers, and politicians rejected the institutional form of asylums and prisons—a development that emanated from reforms in psychiatric hospitals. Ultimately, though, while anti-institutionalism continued in mental health and hospitals closed, institutionalism was reborn in the criminal legal system. As a result, the state's role shifted from policing and confining people because of a diagnosis of disability to doing so because of a person's law-breaking. Deinstitutionalization marked a shift away from state medical and psychiatric authority and toward the criminal courts, police, and corrections officials.

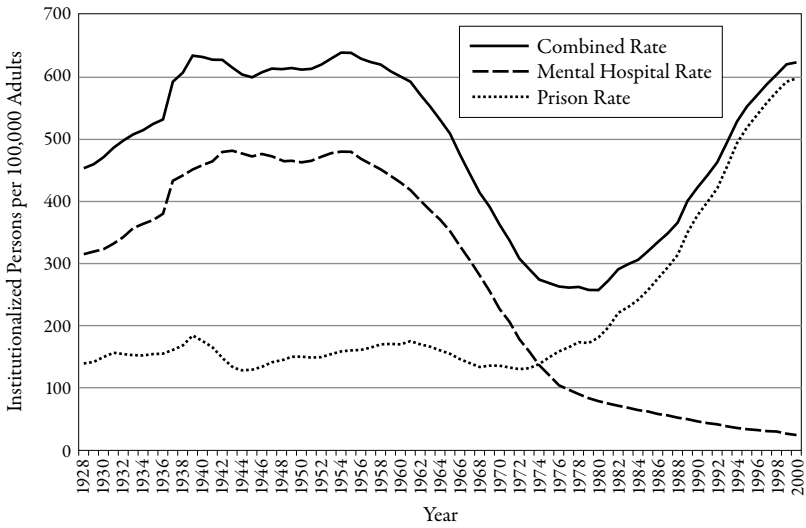
Finally, abandoned state mental hospitals provided the infrastructure that made it easier and more affordable for state governments to build new prisons. *From Asylum to Prison* is the first scholarly work that maps the conversion of mental hospitals into prisons in the late twentieth century. As state officials built new prisons, they often repurposed the empty infrastructures of mental hospitals and developmental centers—the land, buildings, and state employee workforces—into correctional institutions. Recycling old institutions into prisons was far more affordable than building new prisons from scratch. The old asylum infrastructure facilitated the rapid growth of prisons in the United States—particularly in the Northeast and Midwest, where asylums converted into prisons at higher rates.

As a result, today, the United States faces a crisis of imprisonment, sparking widespread activism and national conversations about how to address the high rates of mass incarceration and the inequities in the criminal legal system. In 2013, for example, 30,000 people incarcerated in California went on a two-month-long hunger strike, the third in the state since 2011. The incarcerated activists refused to eat as a way to protest solitary confinement and a host of other injustices.[27] A prison abolition movement to decarcerate prisons and create more equitable and just alternatives to our current system is afoot, led by groups like Critical Resistance and books such as Angela Davis's *Are Prisons Obsolete?* These challenges to the criminal legal system have only become louder with the rise of the Black Lives Matter movement, which grew in the wake of the police killings of Trayvon Martin, Michael Brown, Eric Garner, and Tamir Rice. The 2015 arrest of Sandra Bland and her subsequent death in a jail cell also illustrated police brutality and the violence of the prison system itself.[28]

On the left, prison abolitionists call for community alternatives to prisons; on the right, conservatives question the amount of money the prison system requires to function. Many activists and advocates are seeking to address the crisis of mental health in prisons by reducing the country's rates of incarceration as a broader effort to decarcerate prisons. The American Civil Liberties Union (ACLU) and #cut50 have both worked toward halving the prison population over the next decade by reforming sentencing, bail procedures, parole, and reentry.[29] Conservatives—including the wealthy and influential Koch brothers—have also taken up the cause of decarceration, largely because mass incarceration conflicts with libertarian principles and comes at a huge cost to the state.[30] Because of these changes, the number of people behind bars has started to decrease. In fact, thirty-five states have reduced their imprisonment rates over the past five years. Notably, crime has fallen in the same states that have reduced their incarceration rates.[31]

Calls for cutting prison beds in half by 2030 echo the early years of deinstitutionalization when psychiatrists and advocates envisioned a future without custodial mental health institutions. In 1963, only weeks before his death, President John F. Kennedy signed the Community Mental Health Act. In his special message to Congress, Kennedy announced, "If we launch a broad new mental health program now, it will be possible within a decade or two to reduce the number of patients now under custodial care by 50 percent or more."[32] In the following decades, politicians, policy makers, lawyers, and advocates successfully reduced the government's reliance on custodial men-

U.S. Institutionalization Rates, 1928–2000



Source: Based on figure 1, "Institutionalization in the United States (per 100,000 Adults)," in Bernard E. Harcourt, "From the Asylum to the Prison: Rethinking the Incarceration Revolution," *Texas Law Review* 84 (2006): 1755 (copyright © 2006).

tal hospitals. Kennedy's own campaign to cut mental hospitals by 50 percent in the 1960s bears a striking resemblance to today's #cut50 campaign to reduce the number of prison beds in this country. *From Asylum to Prison* shares the lessons that this history of deinstitutionalization teaches us, especially as people continue to work to downsize our prisons today. What were the processes by which states reduced the numbers of people in mental hospitals? What were the limitations and unanticipated results of deinstitutionalization, and how did they affect the rise of mass incarceration?

This book asks what we can learn from the history of deinstitutionalization, a question other scholars have asked before. Legal scholar Bernard Harcourt has argued that we can better understand the incarceration revolution by looking at the history of deinstitutionalization. One of his major contributions has been his statistical analyses of mental hospitals and prisons. As the graph above shows, even as the rates of people in mental hospitals fell during the twentieth century, the rates of people in prisons rose. Harcourt asserted that we should not pay attention only to the rising rates of imprisonment, but to the aggregate patterns of institutionalization. Harcourt also posited that

a transinstitutionalization occurred in which the state shifted to new types of custodial spaces during deinstitutionalization—a trend that decarceration advocates should try to prevent.[33]

Liat Ben-Moshe works at the forefront of these questions concerning our society's use of institutions and suggests that deinstitutionalization of the mental health system is a type of decarceration that activists can learn from as they promote prison abolition. As Ben-Moshe argues, the core lesson of deinstitutionalization is that the closure of institutions for people with intellectual and psychiatric disabilities did not necessarily bring freedom. While these closures were often a positive step forward, the creation of an honest, just, and equitable society was needed for true freedom. To make this argument, Ben-Moshe has studied the questions of liberty and confinement—not only in mental hospitals but also in the institutions that the states have created for individuals with intellectual and developmental disabilities.[34]

From Asylum to Prison adds to this scholarship by studying the historical processes around deinstitutionalization and the rise of prisons to better understand these changes. First, it lays out how public outrage, changing professional ideology, and political organizing can reduce society's reliance on confinement. Second, the book cautions contemporary scholars, members of the public, and policy makers to think carefully about how to decarcerate prisons and to provide mental health care and services in ways that do not replicate confinement in other forms. Third, it examines the lessons that deinstitutionalization teaches us, such as that reducing our reliance on institutions is not merely a cost-cutting strategy. Finally, the book questions why society has historically responded to social deviance by prioritizing public safety over people's well-being.

This book focuses on changes that took place between 1945 and 1985 in the city of Philadelphia and across Pennsylvania. Other historians have examined the process of deinstitutionalization at the federal level, tracking legal cases, congressional acts, the introduction of Medicaid, changing psychiatric ideologies, and new treatment regimens.[35] This book builds on these studies by focusing on the state politicians, bureaucrats, and advocates who controlled the process of releasing people from mental health facilities. Focusing on a single state is also instructive because it was at the state level that decisions regarding mental hospitals and prisons often intersected. For instance, in the 1940s the Pennsylvania Department of Welfare oversaw both the state's prisons and its mental hospitals.

I chose Pennsylvania as my geographic focus because the state has had

high rates of institutionalization throughout the twentieth century. By the 1950s Pennsylvania was among the largest states in the union, containing one-sixteenth of the U.S. population. Pennsylvania also ran one of the country's largest mental health systems, which held one-fifth of the total U.S. psychiatric hospital population.[36] In 2015 Pennsylvania ranked fifth for the highest number of people incarcerated in the United States and fourth for the total number of people under correctional supervision.[37] Throughout the century, the state has held a large proportion of people in the country's institutions. In this way, Pennsylvania has been representative of the Northeast, which has historically held the largest number of people in mental health institutions.

The book also responds to recent literature on prisons in the South and the southwestern United States. States such as Texas had particularly punitive approaches to crime and punishment, in comparison to the focus on rehabilitation that emanated more from the urban north. Historian Robert Perkinson has argued that these punitive politics left the state and regional level in the late twentieth century and instead became a template for U.S. prison reform. As a result, mass incarceration became the standard practice nationwide, particularly exploding in the South and southwestern United States.[38] A key argument in recent literature is that the punitive practices of the South transferred to the Northeast in the era of mass incarceration. This history of asylums and prisons in Pennsylvania disrupts that narrative. Pennsylvania historically held large numbers of individuals involuntarily in mental health institutions. Between the 1960s and 1980s, while the state rejected this institutional form, it embraced imprisonment, eventually standing as one of the states with the largest number of people in its prisons. When historians identify the asylum as a central site of the carceral state, the rise of incarceration looks different. The growth of mass incarceration in northeastern states such as Pennsylvania did not appear like Venus from the half shell only because of the influence of southern forms of justice. Instead, the growth of imprisonment reflected a transformation away from incarceration in asylums and into prisons. This book represents a case study of a northeastern state, reflecting changes in a region that historically had large numbers of state mental hospitals and expansive welfare systems.

From Asylum to Prison focuses on the history of carceral spaces through politics, policy changes, and legal reforms, and people like governors, psychiatrists, politicians, superintendents, and policy makers all play major roles in the story. Yet, like in many other recent histories of prisons, mental hospitals, and psychiatry, the people who lived in mental hospitals and prisons also are

important to the narrative.[39] I have worked throughout this book to provide alternative perspectives not commonly found in the history of deinstitutionalization. For instance, I have included the viewpoints of authors who had personal experiences with mental health institutions, conscientious objectors (COs) who worked in these facilities during World War II, family and friends of individuals in these institutions, the institutionalized people themselves who wrote letters and participated in lawsuits around conditions of confinement, and finally patients' and prisoners' rights activists. These perspectives have all changed how I have written this history.

Mary Jane Ward's book *The Snake Pit*, based on her own experiences as a patient at a mental hospital, challenged these institutions as carceral spaces, an anti-institutional text that predated Ken Kesey's *One Flew over the Cuckoo's Nest* by almost two decades. A lawsuit filed on behalf of people at the Farview State Hospital for the Criminally Insane in the late 1960s led to the release of hundreds of people at Farview and also thousands of others throughout Pennsylvania's mental health system. Philadelphia-based groups like the Prisoners' Rights Council and the Alliance for the Liberation of Mental Patients organized around issues of state abuse of medical and psychiatric powers and the overuse of confinement in U.S. governance. Patients' and prisoners' rights activists all argued that confinement in institutions was a social justice issue and that racial and socioeconomic inequalities pervaded both the mental health and corrections systems.

Race played a central role in how society separated people and shaped the conditions of people's confinement. Driven by eugenic fears of the biological links between disability and criminality that dated to the Progressive Era—as well as by ideas that held that insanity and feeblemindedness threatened white racial purity—mental health institutions disproportionately held white individuals in the early twentieth century. Psychiatrists believed that the way to promote white racial purity was by limiting the reproduction of individuals with intellectual and psychiatric disabilities. Asylums restricted people's ability to bear children as women and men were separated from each other. Psychiatrists also linked mental illness and feeblemindedness to criminality in the early twentieth century. Many people entered asylums because of social or legal transgressions such as sex offenses (including homosexuality) and petty crimes. In this respect, the mental health institutions of the early to mid-twentieth century shared with prisons a similar logic of removing certain classes of people from society, often based on classifications of disability, race, gender, or sexual deviance.[40]

At the moment that the mental hospital system reached its peak population, social critiques of the system began laying the groundwork for deinstitutionalization. Chapter 1 explores this period of the 1940s, when mental hospitals comprised land, buildings, and workforces used by the states to feed and house hundreds of thousands of people, a population that dwarfed the number of prisoners at the time. COs who did service work at mental hospitals in lieu of military conscription collaborated with journalists to craft news exposés about the concentration camp–like conditions. This group challenged the eugenic connections between heredity and mental illness. Then, in 1946, author and former patient Mary Jane Ward published her book *The Snake Pit*, in which she argued against the loss of freedom that people experienced in mental hospitals, comparing them to prisons. In response to Ward's book and subsequent film, policy makers asked for more money to make mental hospitals larger and more therapeutic while keeping the involuntary commitment system—which Ward had challenged—intact.

In the 1950s the number of people in mental health institutions began a decline that continued through the twentieth century. Chapters 2 and 3 trace the factors that reduced society's reliance on custodial mental hospitals, foregrounding the important—but often overlooked—successes of the deinstitutionalization movement, even as it had complications. Chapter 2 tracks how riots and scandals at mental health institutions put pressure on administrators to make changes. At the same time, the psychiatric profession began to shift its response to individuals with psychiatric disabilities. Stepping away from the institutional model of treatment, the American Psychiatric Association (APA) started to work with states to plan outpatient facilities and psychiatric care in community hospitals. Deinstitutionalization also had limitations and unexpected consequences, which this chapter charts. The 1950s ushered in an era of anti-institutionalism in mental health. Yet at the very same time, the criminal legal system grew as the state continued to manage social deviance through the police and court-ordered rehabilitation programs. For instance, the Pennsylvania state government increasingly policed sex offenses committed by male homosexuals and juvenile delinquents—many of whom were African American—because of racially discriminatory practices by police officers and court officials. Psychiatrists participated in these campaigns as they devised smaller, quasi-rehabilitative juvenile programs, inspired by the broader movement toward community mental health. Thus, chapter 2 shows how on the one hand the 1950s ushered in an era of anti-institutionalism in mental health and the deinstitutionalization of asylums

while, on the other hand, the decade also brought about an expansion of the criminal legal system.

Chapter 3 charts the multiple factors that spurred the deinstitutionalization of the 1960s. In 1963 Congress passed the Community Mental Health Act, which funded the creation of community mental health centers and provided both inpatient and outpatient care, partial hospitalization, emergency services, and public education. At places like the Philadelphia State Hospital at Byberry, administrators started releasing a significant number of patients. Simultaneously, the creation of Medicare and Medicaid became a major catalyst for states to reduce their reliance on custodial mental hospitals because they shifted the funding of institutions from the states to the federal government. Meanwhile, works like Ken Kesey's *One Flew over the Cuckoo's Nest*, a book that portrayed psychiatric authority and state commitment laws as major abuses of state power, spurred patients and legal advocates to file successful lawsuits against involuntary commitment laws. The culmination of all of these trends was that institutionalized people gained a plethora of civil rights and freedoms, further reducing the populations of mental hospitals. The new legal rights granted to institutionalized individuals sought to protect people from abuses of state power. But these legal changes ultimately did not provide the right to adequate medical and social services in their communities.

By the end of the 1960s, the anti-institutional impulse had extended beyond mental health and bled into prison reform. Chapter 4 tracks the rise and fall of the efforts to find alternatives to prisons. During the late 1960s and early 1970s, changes in psychiatry, politics, and the law led to the height of anti-institutionalism in both mental health and corrections policy making. Not only did politicians and advocates look for alternatives to mental hospitals, but they also sought alternatives to prisons. Chapter 4 looks closely at this moment of change when correctional policy makers progressively used probation, parole, and furloughs and created new community-based programs, such as halfway houses and work-release programs. As a result, the number of people in prisons and jails actually began to drop, even during a time of increased policing. These reforms came under attack rather quickly, as politicians fueled public fears about African American communities, urban crime, civil rights protests, and social uprisings. Conservatives depicted people in prison as dangerous criminals in need of punishment and segregation from the community. A racially charged politics of law and order slowed down efforts to deinstitutionalize prisons, and by the mid-1970s, Pennsylvania—

along with many other states—began turning away from its experiments with prison alternatives and started new construction. The anti-institutional movement in corrections lasted only a brief time and was replaced by a call for tougher policies and more prison cells. After more than a decade of decline, the number of people living in the state's prisons started to rise.

This shift in the state's approach to corrections had a devastating effect on individuals with psychiatric disabilities. As people who had been released from state mental hospitals struggled to find housing and employment, more ended up in jail. These increasing arrest and imprisonment rates further criminalized individuals with psychiatric disabilities, even in the face of organized resistance by prisoners' rights and patients' rights activists.

The 1980s hastened both the shrinking of state mental health services and the rise of more punitive practices, developments that come to the fore in chapter 5. President Ronald Reagan supported the continued downsizing of psychiatric hospitals at both the state and federal levels. Homelessness and poverty became more immediate social concerns, since many hospitals closed and states lacked community-based mental health and social services to help all of the people leaving them. Pennsylvania Republican governor Thornburgh closed psychiatric hospitals and cut social welfare while supporting harsh mandatory minimum sentencing laws, which specifically targeted urban black communities. Most critically, the new prison construction siphoned money away from community welfare services that could have served people released from mental institutions. In a vivid example of the link between the two systems, many states turned their abandoned mental hospitals into prisons. These changes did not come without resistance. Advocates at organizations such as the Mental Health Association of Southeastern Pennsylvania fought for the right to the least restrictive environment and promoted adequate medical, mental health, and social services outside of institutions. The group worked in coalition with others to close the Philadelphia State Hospital at Byberry in the 1980s, an effort that offered a model for alleviating the problems of deinstitutionalization.

I have sought to be specific in my language regarding mental health, criminality, and their related institutions. As a historian, I use the language of the period when describing how people discussed mental health, criminality, and institutions of confinement. The terms "mental hospital," "mental illness," "prisons," and "corrections" were the most commonly used terms of the second half of the twentieth century, and I often use them so that they match the meaning of the people at the time. I have learned about the importance

of people-centered language from contemporary disability studies scholars, prison historians, mental health consumers, psychiatric survivors, and prisoners' rights activists. As a result, I have chosen to put people first in my language and describe them, for example, as being convicted of a particular crime rather than as a "criminal." People in the past often used the phrase "the mentally ill." I have chosen instead to use the phrase "diagnosed with mental illness"—unless the person identified himself or herself as experiencing a mental illness—in recognition that some people diagnosed with a mental illness never self-identified that way. I also use the terms "people in mental hospitals" rather than "patients" and "people in prisons" rather than "prisoners" or "inmates." One exception is when activists referred to themselves as prisoners or patients.[41] Finally, at times I use the term "psychiatric disabilities," even though this term was not used during the time period of this book. I use it to place the history of psychiatry and mental hospitals into a broader context of the history of disability. State mental hospitals operated in conjunction with institutions for people with other disabilities, including asylums for people with intellectual and developmental disabilities, schools for people who were deaf and blind, and hospitals for people with epilepsy.

In *Discipline and Punish*, Michel Foucault uses the phrase "complete and austere institution" to refer to prisons and writes that these institutions lead to the "deprivation of liberty and the technical transformation of individuals."[42] I deploy this idea in my analysis of mental health and penal institutionalism. The word "institution" connotes the forcible removal of individuals from their communities and their placement in large custodial facilities. It also captures the notion of these spaces as rehabilitative—the truth of which has ebbed and flowed over time—and marks the state's responses to both mental health differences and criminality. When I use the term "incarceration," I am focused more on the confining aspects of these spaces rather than on their intended power to transform. Finally, I use the term "carceral state," which scholars often use to describe law enforcement agencies such as the police, criminal courts, and correctional institutions. I employ the concept of the carceral state as going beyond law enforcement and permeating other state structures like mental health institutions, which employ various forms of surveillance and state supervision and have the power to limit people's freedom.

Finally, I have a personal connection to this subject. My great-aunt Ruth, a child of Russian Jewish immigrants, had severe physical and developmental disabilities. In the early 1900s, guided by eugenic notions of racial purity,

many states expanded institutions to hold individuals like my great-aunt, who was diagnosed as feebleminded. She was placed at the Stockley Center in Delaware in 1929, living there for four decades until she died in 1969. Although my great-grandparents, my grandmother, and my great-aunts visited Ruth throughout her life, she lived at a time when she could not participate as a full member of our community. While Ruth's experience at Stockley differs from those confined to prisons today, her story has motivated me to stop the cycle of removing people from society and placing them in custodial institutions. History can be a great healer. I write about the deinstitutionalization of mental hospitals and the rise of prisons in order to learn from these cycles of confinement and to work to create a more inclusive and equitable society.

Chapter One

MENTAL HOSPITALS AND THE CARCERAL STATE

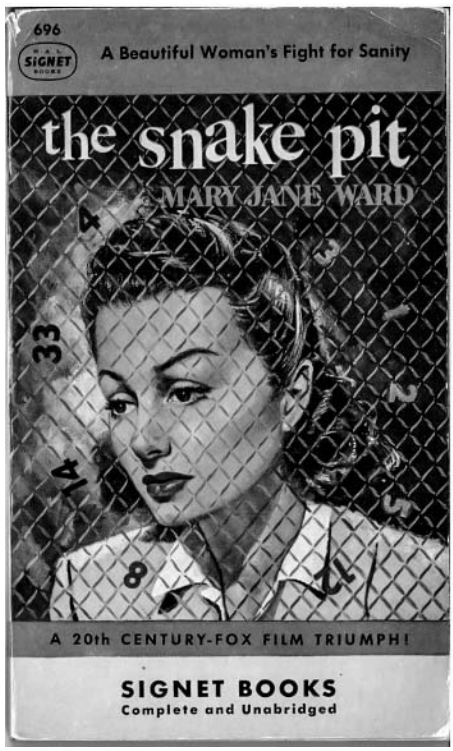
Long ago they lowered insane persons into snake pits; they thought that an experience that might drive a sane person out of his wits might send an insane person back into sanity.

—Mary Jane Ward, *The Snake Pit*, 1946

The Snake Pit (1946), written by Mary Jane Ward, became one of the most famous accounts of mental hospitals of the mid-twentieth century. In her semi-autobiographical book, which became a best seller, Ward drew from her own experience within a system in the midst of great change. Yet even as mental hospitals adopted advances and procedures from psychiatry, Ward portrayed the asylum above all as a site of incarceration.

Born in 1905 to a white upper-class family in Indiana, Ward married statistician and playwright Edward Quayle and lived in Chicago and then Greenwich Village. Soon after moving to New York, Ward suffered a nervous breakdown. Her husband committed her to New York's Rockland State Hospital.[1] After a year in the hospital, she emerged and wrote a novel about her experience with mental illness, a topic that "most people shun," she said.[2]

The Snake Pit depicted one year in the life of Virginia Cunningham, a white middle-class wife who struggles with an unnamed mental illness. The book opens with Virginia's recent confinement to a mental hospital. In a stream of consciousness, Virginia tries to understand her surroundings and the events that brought her to this state of confusion and distress. At first, Virginia focuses on the hospital's "zoo-smell," a permanent odor emanating from women wearing the same dresses day after day. She quickly shifts from thinking about the place as a zoo to thinking about it as a prison. Her prison analogy focuses on the hospital's locked doors, the loss of freedom of the



Book cover of Mary Jane Ward's *The Snake Pit*, 1946. (Penguin Random House LLC)

people there, and the staff person in charge of treating "the women as if they were criminals."[3]

Ward wrote her book in the midst of major changes in psychiatry. Doctors used new procedures such as psychosurgery and shock therapies on people diagnosed with mental illness. Psychiatrists performed many of these procedures in state mental hospitals, which began getting attention for their poor conditions and inadequate funding. Among the first to speak out about the deplorable conditions in mental hospitals were conscientious objectors. While a court had committed George Elder to Byberry, the majority of COs worked as employees at those institutions in lieu of conscription. These COs formed a national network that funneled photographs and stories to journalists who exposed mental hospitals in the national media. Soon after this news blitz, Mary Jane Ward published *The Snake Pit*, which further lambasted mental health institutions around the country and the world. In both *The Snake Pit* and in the COs' accounts, the authors depicted hospitals as prison-

like settings, sometimes even comparing them to concentration camps. The negative publicity caused mental health policy makers and reform organizations to pour money into building more beds and expanding the psychiatric procedures conducted at these institutions.

Even though Ward and the COs criticized these hospitals as inhumane places—calling the entire system into question—a culture of paternal institutionalism dominated the mental health field during this era. Civil rights for the residents of mental hospitals remained on the margins of public debate, even as people like Ward articulated the lack of freedom within the mental hospital system.

Politicians, policy makers, and mental health advocates largely ignored the issue of patients' civil rights during this period. Instead, they focused on improving and expanding coercive procedures. Mental health and social welfare thus came with a loss of liberty in the mid-twentieth century United States as mental hospitals played a central role in shaping the carceral state.

Mental Hospitals and World War II

The years before and during World War II marked a turning point in psychiatry, as procedures like insulin comas, shock therapies, and psychosurgeries emerged. In 1934 Dr. Manfred Sakel induced a coma—through insulin injections—in a person diagnosed with schizophrenia to cure the person's symptoms. In Sakel's procedure, people received daily insulin injections until they fell into a coma. Doctors then revived the person with a sugar solution. He found that in a high percentage of cases, the procedure brought lucidity and eased schizophrenic symptoms, even though insulin comas had major risks and harmful side effects, and some people even died. Despite the danger, Sakel argued that the practice worked, and it spread through Europe and the United States. Psychiatrists were now armed with a physical response to major mental illnesses such as schizophrenia and depression—a harbinger of many new techniques to come.[4]

Shock therapies emerged next. Ladislas Meduna introduced the practice of using Metrazol, a drug comparable to camphor, to induce compulsive fits in people, resembling epileptic seizures. European doctors were the first to use shock therapies, but during World War II, U.S. state hospitals became the main sites of experimentation.[5] By the 1940s, the use of electricity to induce convulsions became widespread, and electroconvulsive therapy (ECT) overtook Metrazol. Dr. Ugo Cerletti had introduced ECT in Rome, performing

the first human trial on a mechanic identified as Enrico X, whom the Roman police had arrested for showing signs of schizophrenia. Multiple rounds of ECT alleviated the more disabling aspects of his schizophrenia, enabling him to return to his wife and his job. Dr. Cerletti conducted an ECT session with Enrico X in front of the Royal Academy of Medicine in Rome to show the other doctors how the procedure eased the man's hallucinations and calmed him. Even though Enrico X suffered another recurrence two years later, news of the procedure spread like wildfire through the psychiatric profession.[6]

Soon after the introduction of ECT, mental hospital psychiatrists in Europe and the United States began using it to treat major depression and manic-depressive disorders. But ECT also brought controversy, and psychoanalysts and some psychiatrists criticized it for its potential to injure people, its indiscriminate use, and its exclusive focus on the physical aspects of mental illness. Even in the face of opposition, though, many doctors found that the practice of ECT altered people's behaviors. They viewed it as a response to the thousands of people whom doctors had previously considered untreatable, and it became widely practiced during and after World War II.[7] Taken as a whole, the advent of shock therapies, insulin comas, and psychosurgeries stoked optimism among psychiatrists that they could cure mental illness by changing the brain.

A new type of procedure—psychosurgery—developed rapidly in the 1930s through the work of Dr. John Fulton, who operated on chimpanzees, and Dr. Egas Moniz, who severed connections in the frontal lobe of humans in 1935. Moniz found that the procedure—which became known as a lobotomy—relieved the symptoms of people with some types of depression and melancholia. Dr. Walter Freeman, an American psychiatrist, learned of this new psychosurgery and took the lead in experimenting with the technique in the United States and around the world. Freeman found that the surgery changed the functional wiring of the brain and extensively documented in his writings and through photographs how it changed the behaviors of people he treated, such as relieving anxiety, insomnia, and nervous tension, among other things. He shared his findings around the country, and the practice spread over the next two decades, in large part because of his advocacy. Psychosurgery also came with controversy, as supporters claimed that it relieved extreme symptoms of mental illness and opponents argued that it weakened people's judgment and social skills. Regardless, the practice spread widely, and by 1951 doctors had carried out 18,608 lobotomies.[8]

The final major psychiatric development of the era came in 1944, when

U.S. researchers discovered that penicillin cured neurosyphilis, an infection of the nervous system that occurs when syphilis goes untreated. The discovery marked a major breakthrough in the psychiatric profession, as a significant number of people in mental hospitals had this disease. The use of penicillin to treat mental illness gave more evidence that medical procedures could cure psychiatric disorders.[9] Even though some people raised concerns about the ethics and effects of this spate of new procedures, psychiatrists took up these new tools, fostering renewed optimism in the profession about the power of medicine to cure mental illness.

Psychiatrists had historically viewed mental illness as a problem of heredity, which had links to understandings of race and ethnicity, and had historically connected insanity with eugenics, the effort to create white racial purity, which started in the late nineteenth century. The practice of eugenics sought to eliminate intellectual disabilities and psychiatric disorders, particularly among whites. Promoters of eugenics supported immigration restrictions on people with mental health diagnoses and laws permitting sterilization to prevent them from reproducing.[10]

These new biological methods in psychiatry weakened that concept. The experience of the world wars also undermined hereditary understandings, as doctors increasingly saw mental illness stemming from environmental causes. During World War I, many soldiers experienced shell shock and psychiatric breakdowns. Consequently, during World War II the Selective Service tried to prevent these disorders by screening draftees to find out who had vulnerabilities to them. The Selective Service also sought to weed out homosexuals, whom military leaders considered mentally unfit and a threat to the strength of the armed forces. Psychiatrists saw mental illness and homosexuality as traits that they could identify with questionnaires and exams.[11] During World War II, psychiatrists created mass screenings of drafted soldiers. Although these short exams often proved ineffective, they reflected the old belief in the biological and innate nature of mental illness and sexual deviance. During World War II, though, many people who had tested as sane developed psychiatric disorders on the battlefield. The war's ability to turn sane people insane led psychiatrists to understand the importance of environment on the mind, a new framework that undermined the hereditary concept of mental illness and eugenic notions of racial inferiority.

Stateside, psychiatrists could commit people diagnosed with mental illness to institutions, but on the battlegrounds of Europe and the Pacific, they had no such option. Instead, psychiatrists responded to combat exhaustion

by prescribing soldiers periods of rest, psychotherapy sessions, and mild sedatives and then sending them back to the battlefields. Wartime psychiatrists found that these noninstitutional approaches significantly reduced symptoms, providing evidence for treatment models that could help people in local settings. Psychology grew rapidly during these years, as military officials applied core concepts from the field to wartime matters such as psychological warfare, the governance of internment camps, and public morale. Finally, psychoanalysis became popular in the United States during and after the war, since it provided treatment outside of the walls of an institution. Psychiatrists and psychoanalysts began responding to mental illnesses in communities and family settings more regularly. They also fostered the rise of the therapeutic state in the second half of the twentieth century as government officials applied psychiatric and psychological methods to social problems such as mental illness, poverty, and crime.[12]

Even in this new age in psychiatry, mental hospitals continued to provide a majority of state mental health services, commanding a large portion of state funds. The centrality of mental hospitals came with a price, though, and state officials scrutinized the high costs of maintaining state mental hospitals during World War II. Pennsylvania reviewed its hospitals to cut costs under Governor Edward Martin, a Republican who took office in 1943. Martin had won on a platform of low state taxes, support for the war, and an anti–New Deal approach to governing, and after the election he focused on cutting domestic spending and government inefficiencies, stating publicly that "at a time when every dollar is needed for war, our social experiments go on and on."[13] Between 1943 and 1944 Martin sought a major tax cut, focusing on the Department of Welfare and its largest and most expensive programs—the state's prisons and mental hospitals. Indeed, the Department of Welfare oversaw both of these types of institutions at the time. Martin viewed prisons and mental hospitals as wasteful social programs, and he ordered surveys of them to cut their enormous costs.[14]

By the 1940s state hospitals had undergone years of neglect.[15] Martin thus appointed committees to study Pennsylvania's public mental hospitals and prisons. The committee to study mental hospitals—called the Petry Committee after its chair—surveyed hospital directors and then visited each institution to see it in person.[16] The Petry Committee found that the overcrowded mental hospitals had resorted to housing people in basements, corridors, and attics. The buildings had become dilapidated, leaving residents vulnerable to fires or sewage hazards.[17] The committee studying prisons—the Ashe Com-

mittee—found similar decay in the state's correctional institutions, a number of which were over a century old.[18] Institutions around the country struggled with overcrowding and long waiting lists; other states filed investigation proceedings. New York, for instance, formed a committee to look into its mental hospitals, finding conditions as abysmal as those in Pennsylvania.[19]

The Petry Committee, which studied mental hospitals, recommended that the Department of Welfare immediately repair the institutions and called for large construction plans to build thousands of new beds and to improve the hospitals' psychiatric programs. The governor also received requests from the Ashe Committee to abandon the antiquated Eastern and Western State Penitentiaries and to build two medium security prisons to replace them.[20] The reforms that these committees proposed came with high price tags, which made the economically conservative Governor Martin reel. Writing privately to the secretary of welfare, he said, "We do not want to make our institutions an inviting place in which to live. I mean by that, they are to be correctional institutions."[21] Martin used the word "correctional" to mean a therapeutic environment where people would receive cures and then return to their homes rather than live in the hospital permanently. His main emphasis remained on reducing the length of people's stay and to provide a base level of treatment. The committees' calls for more money directly challenged this cost-cutting vision of the governor, causing him and the state legislature to reject the proposals made by the Petry and Ashe Committees. Ultimately, the state approved only a small percentage of what the committees had recommended for mental hospital and prison construction projects.[22] The attempt to put money into Pennsylvania's mental hospitals in 1944 failed, reflecting the pervasive idea that hospitals were meant as a last resort and did not deserve significant state support. In the booming postwar economy with millions of dollars in surplus, Governor Martin's administration put money into other projects, with a budget that included $345 million for highway improvements but only $16.5 million for mental hospital construction.[23]

While state officials and politicians debated institutional spending, thousands of conscientious objectors entered mental hospitals across the country as employees. During World War I, many COs served time in prison. In World War II, however, the government took a different approach. While the government incarcerated some COs, such as George Elder, in mental hospitals and prisons, it sent the majority of them to fight forest fires, participate in medical experiments, plant trees, and work in mental hospitals. The Civilian

Public Service assigned approximately 3,000 COs across the nation as workers at mental hospitals and state schools for people with intellectual and developmental disabilities during the war. The male COs, along with a number of women volunteers, worked as untrained attendants who supervised and cared for people in forty-three state mental hospitals around the country. The Philadelphia State Hospital at Byberry was one of three institutions with the highest number of CO employees.[24] The Civilian Public Service purposely put these individuals in places considered out of sight and out of mind, but they did not stay there for long.

Mental Hospitals as Carceral and Curable

Many of the COs who worked at mental health institutions responded to what they witnessed by becoming activists fighting for reform. Initially this activism took the form of resistance to racial segregation. States had racially segregated most mental hospitals in the 1940s, and for the most part they did not employ black attendants. Still, the Civilian Public Service assigned both black and white COs to attendant jobs, making them some of the first people to integrate the staffs at a number of state mental hospitals. The interracial workforce of CO attendants had an activist bent from the beginning, and the pacifist attendants helped spur the racial desegregation of mental hospitals.

More broadly, they fought for more humane treatment. The hospitals assigned a number of COs, who had just one or two coworkers with them, to wards that held 250 to 300 people. Many COs described the stench that hit them the first time they walked into the ward, a visceral experience they remembered for years to come. The treatment they witnessed often conflicted with their values, as many COs opposed all forms of violence, force, and coercion against other people. Consequently, they tried to use nonviolent and humanitarian tactics to help keep order on the chaotic wards.[25] A small number of COs took their stories to the local media—for example, in Cleveland, Ohio, and Mount Pleasant, Iowa—to protest the violent conditions.[26]

While the exposés in Ohio and Iowa did not make national news, they did inspire CO employees at the Philadelphia State Hospital at Byberry, one of the largest psychiatric hospitals in the United States. Four conscientious objectors working at Byberry organized to change the conditions there, incorporating the National Mental Health Foundation (NMHF) in 1946.[27] These COs took their findings to two journalists—Albert Deutsch, who wrote *The*

Mentally Ill in America, and Albert Q. Maisel, who worked for *Life* magazine. Deutsch and Maisel culled through the COs' reports and in May 1946 published separate articles in the leftist journal *PM* and in *Life*, reaching millions of readers.[28] The state of Pennsylvania became the main culprit in these stories, and the reporters identified Byberry as one of the worst hospitals in the country. The horrific conditions the COs exposed and the financial neglect of state hospitals created a nationwide scandal.

To emphasize the hospitals' inhumanity, Deutsch and Maisel compared them to prisons. The first page of one of Deutsch's articles included a photograph of a dark and ominous brick building with impenetrable metal screens over the windows, which called to mind a prison setting. Maisel opened his article—titled "Bedlam 1946"—by describing "a dilapidated overcrowded, undermanned mental 'hospital' known as Byberry. There on the stone wall of a basement ward appropriately known as the 'Dungeon,' one can still read, after nine years, the five word legend, 'George was kill here 1937.'"[29] Maisel reported that beatings and murders, such as the killing of this anonymous man named George, occurred regularly. This was just one of many "indignities we have heaped upon most of the 400,000 guiltless patient-prisoners of over 180 state mental hospitals" across the country. The reporters also criticized the use of restraints, documenting how thousands of people spent long periods in leather handcuffs, canvas camisoles, "muffs," or "mitts." Maisel even published a photograph of a white woman wearing a restraining camisole, the sleeves tied behind her, as she sat in abject neglect.[30] Prison and mental hospital staff nationwide used restraints to control people, and in the 1940s institutionalized people had little recourse to protect themselves.

The journalists also compared the treatment of people in mental hospitals to the atrocities of the Holocaust, further stoking public ire. In the aftermath of World War II, information about the Holocaust horrified Americans as they learned about the Nazis' mass segregation, sterilization, and genocide of Jews and people labeled homosexual, mentally ill, or mentally deficient through countless black-and-white images of corpses, death camps, and emaciated survivors. In 1946 Holocaust references evoked fresh memories of the previous year's liberation. Deutsch wrote in one article that "Byberry, along with too many of our state hospitals, can be compared only to Buchenwald and Belsen."[31] Maisel echoed the liberation images from 1945 with a photographic montage. *Nakedness* showed men wandering around Byberry without clothes, living in filth. *Idleness* depicted thin men sitting naked on the ground,

Despair, by photographer Jerry Cooke, in *Life*, May 6, 1946. (Courtesy of the Jerry Cooke Archive, Inc.)

heads in their hands, their bodies resting on garbage-laden floors. They look as if the staff had left them to die. And in the photograph *Despair*, an unclothed woman sits on a wooden chair, her head bowed and her nakedness revealing her distended stomach, emaciated limbs, and shrunken breasts.[32]

"Through public neglect and legislative penny-pinching," Maisel argued in *Life*, "state after state has allowed its institutions for the care and cure of the mentally sick to degenerate into little more than concentration camps on the Belsen pattern."[33] He closed the essay with a call to action: "Given the facts . . . the people of any state will rally . . . to put an end to concentration camps that masquerade as hospitals and to make cure rather than incarceration the goal of their mental institutions."[34] The reporters charged state governments

with promoting Nazi-like policies, such as incarcerating people diagnosed with mental illness.

Historically, public discourse linked people diagnosed with mental illness to threatening, dangerous, and criminal behaviors. These journalists, however, did not depict them this way. Instead, they described the people as sick, using words like "patient" and "mentally sick."[35] By using the phrase "mentally ill" rather than "insane," the journalists emphasized mental disorders as legitimate medical conditions rather than socially deviant behaviors that connoted threat or danger.

While Maisel and Deutsch never mentioned violence or law-breaking in their articles, in the 1940s many states had hospitals or wards dedicated to the so-called criminally mentally ill or defectively delinquent. Those terms meant that these people had a psychiatric diagnosis and either they had committed a crime or the doctors deemed them dangerous. While these hospitals often had even more troubles than places like Byberry, the media did not cover them. Reporters such as Deutsch and Maisel also did not mention that some people had entered hospitals because of a minor brush with the law, as in George Elder's case. Instead, they focused on representing people in their stories as innocent victims posing no danger to society.

The journalists also eschewed any connection between mental illness and racial inferiority. In the aftermath of the Nazis' "Final Solution," psychiatry distanced itself from the language of racial, class, and biological hierarchies. Maisel and Deutsch similarly never mentioned race or eugenics in their articles, nor did they bring the experience of African Americans into their stories and national advocacy. African Americans resided in mental hospitals, but from the photographs in *Life* and *PM*, readers would never know about them or about people like George Elder. African Americans were also often institutionalized in segregated asylums or in places for people with mental health and criminal histories.[36] But these places did not get much news coverage and remained marginal in exposés. The COs and journalists focused on the white people in mental hospitals as victims of neglect and in need of care in order to portray them as deserving of better treatment.

The journalists' calls to action thrived in an era that rejected biological racism, eugenics, and the atrocities of the Holocaust. American concepts of freedom after World War II facilitated the development of a more pluralist vision of society, promoting tolerance and assimilation as American virtues, and the language of freedom inspired early civil rights activism against seg-

regation, job discrimination, and the denial of government benefits.[37] Mental health reform thrived in this framework of social justice. The NMHF and journalists shunned the language of eugenics and ignored racial injustices in the mental health system, and their claims gained traction in the years after World War II.

The journalists argued that state mental hospitals institutionalized people without treating them, a state sanction equivalent to incarceration. "In some hospitals the shortage of personnel and the patient overload have progressed to a point where physicians make little pretense of treating any large proportion of the patients," Maisel wrote.[38] He reported that for every 100 people in mental hospitals in the United States, only 12 percent improved enough to leave the institutions each year. He also wrote that many hospitals, particularly in the South and West, did not implement the eight "special therapies" psychiatrists used—including electroconvulsive therapy, hydrotherapy, and psychotherapy.[39]

In "Bedlam 1946," Maisel argued that more psychiatric treatments could help people improve and establish meaningful lives outside of the institution. With this investment, "the state receives a high proportion of useful, economically productive citizens, while the custodial institutions, harboring identical cases, spend as much or more per patient at their deceptively cheap daily rate and, in the end, fail to restore the majority of these citizens to society."[40] By pouring more money into hospitals, the state could make these places more humane. According to Maisel, the new psychiatric treatments also made the hospitals less expensive, as they could rehabilitate people and return them to society.

Maisel's and Deutsch's articles struck a chord with the American public. In Pennsylvania, citizens flooded the governor's office with letters.[41] One man wrote, "When groups of mentally incompetent, bewildered human beings are herded into unfurnished concrete chambers and left to rot in the stench and slime of their own ordure, how dare we condemn the wardens of the German prison camps? There at least there was hope of release by death, and who can say that the mercy-deaths of the Germans were not more merciful indeed than life in Byberry? We blame German citizens for the horrors of Dachau because they did not make it their business to know and protest; we *do* know, and we must protest."[42] This man urged the governor and the legislature to erect new buildings, buy modern equipment, and attract trained staff to make mental hospitals more curative. "Until they are provided we should not

even consider any other public works," he wrote.[43] Another woman wrote, "I always thought the place for the mentally ill was in an institution but certainly they shouldn't be put in places like these."[44]

The journalists' and COs' exposés rallied citizens and politicians to reform mental hospitals. During the war, politicians could ignore the conditions in these places, but public outrage after the war made them impossible to ignore any longer.

Incurable Snake Pits

COs and journalists were not the only people writing about mental hospitals in the 1940s. Former residents of mental hospitals also critiqued mental health institutions by writing autobiographical and semiautobiographical accounts. In 1940 Margaret Wilson published *Borderland Minds*, the story of her incarceration—as she deemed it—at a large southern institution between 1931 and 1937. In 1947 Lenore McCall MacLeish's less scathing account, *Between Us and the Dark*, explained how the insulin-based procedures she underwent while hospitalized brought her back from the brink of suicide. That same year, Walker Winslow published *If a Man Be Mad*, under the pseudonym Harold Maine. Winslow described his struggles with alcoholism, which first led him to jail and then to Bellevue Hospital in New York. Ultimately, he decided to treat himself by taking a job as an attendant in a mental hospital. While he did not find treatment there, he did find a good story. His book documented the Kafkaesque world of people in mental hospitals, including the residents at a Veterans Administration facility.[45] These books offered a different perspective from that of the COs and journalists, as these authors had themselves experienced hospitalization.

Mary Jane Ward's book *The Snake Pit* came out amid these books in 1946. In writing *The Snake Pit*, she took a leap of faith. As a woman in upper-class society, she had a lot to lose by publicly disclosing her mental illness. Still, she published under her own name (albeit her maiden name) and acknowledged the book's semiautobiographical nature.[46] Her bravery paid off as *The Snake Pit* stands as a leading text of anti-institutionalism in its time. While Ward's challenge to mental hospitals echoed that of the COs and the journalists, she took aim at the coercive psychiatric treatments and procedures and contested state psychiatric power itself—a significant departure from the articles in *Life* and *PM*.

Ward centered the question of freedom and civil liberties in her account

of mental hospitals. During this time, many people in mental hospitals were involuntarily committed. While the commitment laws varied from state to state, often friends, family, or public officers such as welfare officials applied for the commitment of a person they deemed insane. Then, physicians examined the person and signed a certificate of insanity. The court or a state board such as a lunacy commission held a hearing and could sign an order to commit the person to a hospital. The hospital superintendents or boards of trustees then decided when to release the person or put him or her on parole for a trial period at home. People in institutions often did not have legal representation during this process and had few chances to seek their freedom through the courts.[47] For instance, in 1947 a white preacher helped George Elder seek his release from Byberry. Nothing came of it, though, and Elder had no one else review his case for release until 1962. Elder did not go to court and did not have access to a lawyer—the hospital administration controlled who could leave and when.[48]

In its depiction of state-sanctioned psychiatry, *The Snake Pit* took aim at this involuntary confinement, which blurred the lines between American democracy and totalitarianism. Ward's references to imprisonment without rights resonated during a period when fascism and communism had taken center stage in international affairs. Ward compared the hospital to a prison, and by the end of the book, when a psychiatrist literally holds a document approving the release of Virginia Cunningham, the main character, Virginia watches her every word so that she will sound sane enough to leave. Her sanity becomes both the literal and figurative key to her freedom.[49]

Ward also lashed out at the celebrated psychiatric procedures of the time, including the new electroconvulsive therapies and insulin shock comas that the psychiatric profession celebrated.[50] Psychiatrists often initiated therapies without people's consent, and people often had no right to refuse the doctors' orders. Ward and other authors questioned these involuntary commitments, the hospitals' psychiatric procedures, and even the practice of psychiatry itself. In *The Snake Pit*, Virginia receives therapy from the well-meaning—but ultimately insensitive—Dr. Kik, a character based on the psychoanalyst Dr. Gerard Chrzanowski, who worked at Rockland State Hospital. In the book, Dr. Kik's diagnoses often seem unfounded, even to his supervisor. In real life, one psychiatrist misdiagnosed Mary Jane Ward as schizophrenic, and another doctor later diagnosed her as bipolar. She captured these inconsistencies in the opening of the book when an unnamed doctor at the hospital asks Virginia, "'Do you hear voices?' . . . 'You think I am deaf?' 'Of course,'

she said, 'I hear yours.' It was hard to keep on being civil. She was tired and he had been asking questions such a long time, days and days of incredibly naïve questions."[51]

The procedures Virginia underwent make for the book's most disturbing passages. For example, as part of hydrotherapy, the attendants wrap her tightly in blankets, restrain her, and force her to remain in a tub. Deeply distressed, Virginia finds solace only in her wild imaginings.[52] Ward also describes the experience of the most cutting-edge therapy of the time—shock therapy—through Virginia's perspective: "Even now the woman was applying a sort of foul-smelling cold paste to your temples. What had you done? You wouldn't have killed anyone and what other crime is there which exacts so severe a penalty? Could they electrocute you for having voted for Norman Thomas? Many people had said the country was going to come to that sort of dictatorship but you hadn't believed it would ever reach this extreme. Dare they kill me without a trial? I demand to see a lawyer. And he—he always talking about hearing voices and never hearing mine."[53] During Virginia's distraught stream of consciousness, she wonders what crime deserved this kind of punishment and whether she was locked in the hospital for her leftist views, such as voting for Norman Thomas, the socialist and pacifist presidential candidate. In the aftermath of the Nazi rise to power, the fear of imprisonment because of political views loomed large; in Virginia's mind the hospital could do that. Virginia's fears were well-grounded as many marginalized people, including a number in prisons and mental health institutions, underwent procedures without consent during this period and had few legal protections to protect themselves.[54] To Ward, the era's celebrated psychiatric treatments did not liberate people diagnosed with mental illnesses but rather caused fear and confusion due to overreaching state power.

Ward's account provided a more damning critique of the mental hospital system than the pieces written by Maisel and Deutsch, as her title showed. Ward chose it from a historic story, which she included in the book. "Long ago they lowered insane persons into snake pits; they thought that an experience that might drive a sane person out of his wits might send an insane person back into sanity. By design or by accident, she couldn't know, a more modern 'they' had given V. Cunningham a far more drastic shock treatment now than Dr. Kik had been able to manage with his clamps and wedges and assistants. They had thrown her into a snake pit and she had been shocked into knowing that she would get well."[55] Virginia's traumatic experiences in the hospital do help her to get well—not by curing her with new therapies

but rather by scaring her straight. The harsh conditions of the general ward prompt Virginia to improve and ultimately leave the hospital—but her cure did not come at the hands of doctors.

Ward also represented her own ambivalence about treatment and reform with a fictitious hospital nurse, a compassionate character who argues for changes in mental health care. In *The Snake Pit*, the nurse does not save the day; instead, she becomes hospitalized herself. In this way, Ward's writings stand as an early anti-institutional text, one that predates the major challenges to psychiatric authority in the United States in the 1960s with the publication of books like Ken Kesey's *One Flew over the Cuckoo's Nest* and Thomas Szasz's *The Myth of Mental Illness*.

But while the book diagnosed mental hospitals in the 1940s as incurable, the film had a far different message. Mary Jane Ward's *The Snake Pit* received attention as a "Book of the Month" and a national best seller, which caught the eye of a Hollywood director. The Russian émigré Anatole Litvak had purchased the film rights to the book and shopped the film around to various studios. Most Hollywood producers found the subject too grim and thought audiences would not want to see it. Litvak disagreed, arguing that the public hungered for films about contemporary social issues.[56] Eventually 20th Century Fox accepted the risk and took over the production of the film. Litvak hired Olivia de Havilland to play Virginia Cunningham, and the movie team made multiple visits to mental hospitals to understand more about the subject matter.

The film became well known both nationally and internationally and won multiple awards.[57] Ward herself expressed surprise with the story's popularity, particularly since she thought *The Snake Pit* had "no plot, no love story, and it concerns a subject most people find disagreeable."[58] But the book had significant differences from the movie, which reached far broader audiences. In the book, Ward portrayed Dr. Kik as ineffective and the administrators of the hospital largely as agents of control, much as Ken Kesey later did with his character of Nurse Ratched in *One Flew over the Cuckoo's Nest*. But Dr. Kik's character changes profoundly in the film. In it, Virginia falls in love with the doctor, a development that casts him in a more favorable light. In the movie, Virginia views Dr. Kik as a savior—someone who can help her heal and bring about her release.[59]

The trope of the helpless female patient and the male savior figure played out in Dr. Kik's treatment of Virginia in the film. In "The Final Analysis" section of the film, Dr. Kik uses psychoanalysis to treat her schizophrenia. In the

late 1940s, psychiatrists around the country increasingly deployed psychoanalysis, which emphasized the power of the unconscious and saw early childhood experiences as core causes of mental illnesses. These ideas also entered into the wider American culture, and audiences had some understanding of them at midcentury. Dr. Kik has Virginia unearth the death of her fiancé, identifying it as a root cause of her struggle to identify as a wife and mother and to find stability in marriage. Kik then goes deeper and links her schizophrenia to the fact that she did not receive love from her mother. In the film this breakthrough helps her, and later she declares to Dr. Kik, "I'm not in love with you anymore."[60] Virginia also gets better with his diagnosis and treatments and eventually goes home—not because of finagling the system but because he cures her.

In turning the book into a film, Litvak relied on contemporary notions of female sexuality and gender roles to make the narrative more appealing to a broader audience. His new version also celebrated the promise of psychoanalysis to heal individuals with mental illness in state mental hospitals. These changes were not minor tweaks but fundamentally changed the meaning of the book—the hospital became a place of cure rather than one of confinement. Hospitals could become more curative places if states provided more money and treatments to bring about the type of healing that Dr. Kik offered.

While Litvak, Maisel, Deutsch, and the COs considered the hospitals worth saving, Ward and other authors had far less optimism. In the histories of mental health, scholars have often merged the COs' and journalists' calls for reform with Ward's radical critique in *The Snake Pit*.[61] But while they all deeply criticized state hospitals, they had different ideas about how the state should respond. Ward did not describe hospitals as places in need of more state money. Instead, she portrayed them as part of an institutional system that re-traumatized people. Ward's writings and the writings of other people who had experienced hospitalization often focused on the imbalance of power between institutionalized people and psychiatrists, and in that way they differed strikingly from Litvak, the COs, and the journalists.

Their charges pointed to the ways that mental hospitals served as carceral spaces. At this time, mental hospitals were not just places for people diagnosed with psychiatric disorders but also places where state psychiatrists, family members, and the courts sent homosexuals, people who broke social norms, and individuals who broke the law. George Elder's commitment represented the blurry lines between the concepts of mental illness and social nonconformity. His pacifist beliefs flew in the face of U.S. patriotism during

World War II, and his request that the government reimburse Native Americans lay outside the mainstream. Elder's radical views certainly played a part in his diagnosis of paranoid schizophrenic.

The story of another famous nonconformist elucidates the connections between law-breaking and mental hospitals in the 1940s. In 1949 police arrested a young Allen Ginsberg for participating in a car ride that turned into a police chase and wreck. In lieu of jail time, Ginsberg agreed to mental hospitalization. Ginsberg's and Elder's commitments show how a brush with the police in the 1940s could lead to hospitalization rather than prison time.[62] Not all people who entered mental hospitals had broken the law or experienced psychiatric disabilities. But it is important to remember that mental hospitals had a much broader net in the mid-twentieth century than they do today and that many people who displayed socially deviant behavior faced confinement in a hospital rather than in a jail cell.

These institutions also operated on a mass scale. By the end of World War II, 190 state mental hospitals around the country held 538,629 people. Without a national health care system in the United States, most state welfare departments funded and ran the majority of these mental hospitals. It cost the states approximately $200 million per year to run the 190 state mental hospitals across the country. Only a small minority operated privately, at a huge financial cost to the people held there and their families.[63]

Many people in mental hospitals worked on hospital farms and in kitchens, laundries, and industrial shops, sustaining the institution with their labor. The institutions in turn served an economic purpose to local communities. Many state hospitals had large workforces who often had organized into unions. People in rural areas depended on the work that these institutions offered. The infrastructure of these institutions formed a system similar to the prison industrial complex, the term Angela Davis coined to describe the political and economic infrastructure of mass imprisonment. This infrastructure relied on caging people, exploiting their labor, and making a profit for businesses and local communities.[64] While state mental hospitals did not explicitly have ties to business, they echoed the prison industrial complex in their reliance on involuntary confinement, their economic benefits to local communities, their use of the labor of people in mental hospitals, and the sheer size of the state's landholdings, buildings, architecture, and labor force.

In the mid-twentieth century the infrastructure of state mental hospitals dwarfed that of state prisons. In 1944 Pennsylvania ran eighteen public mental hospitals and four institutions for people with epilepsy and people diag-

nosed as "feebleminded," a historic term roughly used to describe what we would consider intellectual and developmental disabilities today. In comparison, the state ran only five prisons and one juvenile reformatory.[65] The size of the hospitals also overshadowed that of prisons. For instance, Byberry housed 6,100 people in 1946. That number approximated the prison population in the entire state.[66]

Byberry was not alone in its size. Many other hospitals across the country held thousands of people. New York's Central Islip and Pilgrim State Hospitals, for instance, held 7,000 and 10,000 people respectively.[67] Some of the country's largest state hospitals and mental health systems operated in New England, the Mid-Atlantic, and the Midwest in the 1940s, and the percentages of people confined in mental hospitals were greater in these regions than in other areas of the country.[68]

The Last Hurrah of Mental Health Institutionalism

Confronted with cries of concentration camp–like conditions and snake pits, policy makers began to address the problems of state hospitals in the postwar era. The Pennsylvania Department of Welfare responded to the accusations of poor conditions in mental hospitals by issuing its own pictorial report in 1946. While the department admitted that some institutions were overcrowded and understaffed—particularly Byberry—it maintained that the worst wards did not represent the state's mental hospitals as a whole. Still, the Department of Welfare used this negative publicity to call for more community involvement; the emergency also empowered the department to reiterate its request for the funding that Governor Martin and the legislature had denied a few years earlier.[69]

The NMHF actively supported government spending to improve public mental hospitals. It published the public-education pamphlet *For These We Speak*, blaming the concentration camp–like conditions of public mental institutions on "lack of funds and personnel" and calling for "higher standards of care and treatment in mental institutions."[70] Other organizations joined this effort, including the Pennsylvania Citizens Association and the League of Women Voters. These organizations, along with the NMHF, called upon the Pennsylvania legislature to increase by 50 percent its appropriations for the Department of Welfare's programs for people diagnosed as mentally ill, mentally defective, or epileptic during 1947–49.[71] This money would fund a large institutional expansion to accommodate more beds and alleviate over-

crowding. The organizations' advocacy efforts echoed New Deal ideologies, which promoted more government spending to help people in need. To these advocates, the terrible conditions in mental hospitals resulted from the fiscally conservative policies of politicians such as Governor Martin, whose failure to spend money on mental hospitals had led to the suffering that the conscientious objectors witnessed.

The NMHF sought changes throughout the country, not just in Pennsylvania. It connected with celebrities to help meet its goal, an unusual but strategic move for an organization less than two years old, taken in hopes the celebrities would give legitimacy to a marginalized subject and to the COs, whom many people considered unpatriotic. It found an important ally in Supreme Court justice Owen Roberts, a Pennsylvanian who had retired to his home state in 1945. While Roberts had some conservative economic stances, he was more liberal on civil rights and civil liberties. For instance, he had vehemently opposed the internment of Japanese Americans during World War II and advocated for the rights of indigent people to counsel, the freedom of speech, and the freedom of religion.[72]

When the Byberry reports hit the newspapers, Justice Roberts championed mental health and eventually became chairman of the NMHF sponsors.[73] With Roberts's backing, former first lady Eleanor Roosevelt—soon the chairwoman of the United Nations Commission on Human Rights—agreed to sit on the board of directors. Mrs. Roosevelt—who had also opposed the internment of Japanese Americans—had become a great supporter of welfare causes.[74] Civil libertarian Roger Baldwin also joined the board, both because of his past as a conscientious objector and his commitment to civil rights. The involvement of these key figures reflected how, in the era of the Declaration of Human Rights after World War II, human rights became a central rationale in the fight to reform U.S. mental hospitals.[75]

The revelations about American mental hospitals sparked a bipartisan drive for reform in the spirit of American democracy and caring for the weak. The postwar United States experienced economic prosperity and liberal governance, in which state and federal governments expanded their domestic social programs. Many organizations worked to create a political consensus around racial and religious tolerance, anti-totalitarianism, and pluralism during this period, and this attitude of consensus and pluralism in the postwar era permeated mental health reform.[76] Democratic leaders—such as United Auto Workers president Walter Reuther and First Lady Bess Truman—put their names on the list of national sponsors of the NMHF, providing a stamp

of approval from the liberal establishment. Republicans such as Henry Luce, the distinguished owner of *Life* magazine and a renowned anti-communist, joined as well.[77] From their perspective, the United States had to eliminate the prisonlike conditions of its "snake pits." The presence of high-level sponsors helped the NMHF change public conceptions of people in mental hospitals as deserving of care rather than just custody. To them, people diagnosed with mental illness were worthy of tolerance and increased acceptance among the polity.

The impetus to reform—rather than to dismantle—mental hospitals arose both from these liberal ideologies and from the optimism in science, medicine, and psychiatry after World War II. In the decade following the war, the medical profession and the public celebrated procedures to rehabilitate the human body. Disabled veterans touted their new prosthetic devices and plastic surgeries, while hormone treatments and sex reassignment became national news.[78] By the 1940s, the federal government had greatly expanded employment opportunities and vocational rehabilitation programs for people with physical and intellectual disabilities. Psychiatrists and policy makers also moved away from associating people with intellectual disabilities with eugenic notions of mental defects and criminality.[79] Optimism pervaded social medicine, and the focus shifted to curing—rather than just providing custody for—people with disabilities. This spirit infused the political reforms and overshadowed Mary Jane Ward's critiques of coercive medical treatments and state psychiatric authority.

In Pennsylvania, the new Republican governor James H. Duff supported social services more vocally than his predecessor Governor Martin. While Duff opposed economic regulations and organized labor, he differed from Martin in his support for social services. The Pennsylvania Economy League, a Republican-leaning business interest organization based in Pittsburgh, supported mental health policy changes as well, with the call to "improve government efficiency [and] eliminate wasteful spending."[80] The organization created a language of productivity to support the reforms: "When a patient is discharged he ceases to be a ward of the state. He gets a job, becomes a producing member of the economy and he pays his share of taxes."[81]

Economic conservatives became interested in mental health legislation because of the potential implications for taxes and the state budget.[82] The Pennsylvania Economy League supported the governor's hospital construction program while emphasizing the importance of "a planned curative program."[83] A bipartisan effort to reform mental hospitals through increased

government spending was afoot, as alliances between politically liberal organizations, such as the NMHF and the Pennsylvania Citizens Association, and more conservative groups, like the Republican Party and the Pennsylvania Economy League, emerged.

These political reforms focused on fixing institutional buildings, workforces, and treatment protocols. In 1947 the Pennsylvania legislature passed a bill allowing the state to use $82 million to build new mental hospitals—one of the largest appropriations the Department of Welfare ever received, "greater than the total of all previous appropriations combined in [its] history."[84] At Byberry, the funds enabled the department to modernize kitchens and bathrooms, to build new garage and storage facilities, and to renovate nine buildings.[85]

The changes to these hospitals had mixed results. On the one hand, family and friends of people in mental hospitals showed great appreciation for the improvements. For instance, one woman wrote that her friend in a state hospital appeared cleaner and better dressed after the reforms.[86] Others wrote that they appreciated the government's efforts to take better care of their loved ones. On the other hand, the construction projects increased the number of beds that the mental health institutions had and thus the number of people whom the hospitals held.[87] The country's total number of people in mental hospitals also rose, and the rates of commitment reached their highest point in U.S. history. While World War II had taught psychiatrists the value of community care, politicians and policy makers still focused on custodial institutions as the place for reform.

The state also increased funding for more psychiatric staff and procedures such as lobotomies and ECT. The doctors believed these methods cured people, and policy makers saw them as fiscally efficient. In 1947, Pennsylvania secretary of welfare Charlie Barber optimistically estimated that, with better treatment programs, the best state mental hospitals could return 70 percent of people—excluding the elderly—to their communities within a year. The main difference with elderly people was that there was no new set of treatments to rehabilitate them, as with mental illness.[88] The very treatments that Ward had criticized grew during this period.

In 1951, after the dust settled, Albert Maisel again picked up his pen and wrote about the changes in mental health since "Bedlam 1946." In preparation for this retrospective, Maisel visited thirty hospitals across the country. Pennsylvania and other states such as California, Kansas, and Minnesota had increased appropriations for mental hospitals and initiated reforms. Many

states had raised wages for their staffs and hired more attendants, psychiatric aides, doctors, and psychologists. They also passed multimillion-dollar bonds to renovate and build hospital buildings in places as far-flung as Milledgeville, Georgia, and Northville, Michigan.[89]

Maisel celebrated new centers like the Youngstown State Hospital in Ohio, a significantly smaller institution that cost more per person than the average mental hospital but had higher rates of discharge. These smaller, more therapeutic institutions were the wave of the future, according to Maisel. He concluded his essay with a 1949 photograph of the Ohio governor on Halloween setting fire to a pile of straitjackets, cuffs, and mittens at the Minnesota Anoka State Hospital, symbolically breaking with the mental hospital's prisonlike past.[90]

Psychiatric procedures in state hospitals during the late 1940s and 1950s continued to take place largely without people's consent or input and without any discussion of the involuntary nature of treatment. Letters from institutionalized people and their supporters gave a more complicated view of the progressive reforms of the late 1940s. One person who had experienced hospitalization wrote to Governor Duff about her concerns over the rush to build. She had lived at Danville State Hospital from 1944 to 1945, and her husband had committed her without her consent. Danville's conditions were not adequate, she wrote, but rather than supporting the building program, she questioned it. Aiding people in mental hospitals "will not come through building more and greater buildings to house more and more frustrated and afflicted people."[91] One man used even stronger language. Challenging the appropriations as oppressive government intrusions, he wrote, "Do you know that we have a million slaves in mental institutions, just be cause [*sic*] we have no legislation to rehabilitate them again for life in a free Democracy. We are now forming a human rights Commission for the freedom of such individuals. These people are only ignorant of their rights and of what is now happening to them."[92]

These voices of opposition along with the writings of Mary Jane Ward and other authors remained marginal to policy debates. Mainstream political reform omitted the lack of freedom and the overreach of medical authority that the authors had articulated in their writings. Few politicians, policy makers, or mental health advocates worked to change involuntary commitment laws or to provide people with more legal protections. The system of paternalist institutionalism did not change. These critiques and demands would not be heard or heeded until a larger movement for patients' rights developed in the

1960s, with the writings of Ken Kesey, Erving Goffman, Thomas Szasz, and Michel Foucault. For all the public discourse and policy reforms around mental hospitals in the 1940s, these institutions continued to be places of confinement. Access to mental health care came with the loss of liberty, and hospitals served as a primary institution embedded within the carceral state.

The question of how mass incarceration rose so quickly in the Northeast and Midwest is a complicated one. These regions had small correctional systems before the 1960s and strong traditions of social welfare, which stood in stark comparison to the more punitive justice systems in the South.[93] The history of mental hospitals in the mid-twentieth century sheds new light on that question by showing how confinement and coercion were embedded within the welfare state itself. Mental hospitals served as sites of confinement and made up a significant portion of the carceral state in the mid-twentieth century. Calls to lock people up in the law-and-order movement of the 1960s and afterward were not new; the practice of confinement had been long-standing in U.S. governance and particularly in the Northeast and Midwest. That tradition of custody fueled the rise of mass incarceration in the late twentieth century—as one form of confinement morphed into another.

Chapter Two

UNLOCKING THE DOORS

Cast from shackles which bound them, this bell shall ring out hope for the mentally ill and victory over mental illness.

—Inscription on the Mental Health America Bell, cast in 1953

In 1953 the National Mental Health Association (now Mental Health America) reached out to hospitals nationwide, asking their administrators to send any shackles or chains that the institutions had historically used on the people hospitalized inside.[1] Many hospitals complied, and in April of that year the organization held a ceremony at the McShane Bell Foundry in Baltimore. Politicians, socialites, and religious figures attended the event. Association supporters melted down the chains to represent the end of an inhumane era of bondage and confinement. By shaping the metal into the 300-pound Mental Health Bell, they turned the relics of a fraught past into a symbol of hope.[2] Yet this bell not only represented the end of restraints—it signaled broader changes in the 1950s, reflecting a widespread rejection of mental hospitals as carceral spaces.

In 1955 the rates of people in mental hospitals reached almost 500 per 100,000 adults, one of the highest points of mental hospital institutionalization in the twentieth century. Within twenty-five years, the number of people in mental hospitals had fallen by more than half, and the decline continued into the twenty-first century.[3] These changes reflect a tectonic shift in how society responded to mental illness. Politicians, policy makers, and advocates moved away from the institutional model and toward community alternatives. The Mental Health Bell came into existence just as mental hospitals began to downsize.

And yet, this decarceration movement in mental health did not end con-

Maryland governor Theodore A. McKeldin and
Mrs. A. Felix DuPont casting the Mental Health Bell,
1953. (Courtesy Mental Health America)

finement in the United States—quite the opposite. Instead, policing, prisons, and the criminal legal system expanded from the 1950s through the early twenty-first century. While mental health officials sought alternatives to mental hospitals, the state built new correctional institutions: prisons, diagnostic centers, and therapeutic programs like forestry camps. At the very moment that mental hospitals shrunk their role in the carceral state, the criminal legal system grew.

In the 1950s turmoil rocked prisons and hybrid correctional–mental health centers, particularly those that had deteriorated due to state neglect and lack of funds. Prisons erupted in riots in 1952 and 1953, and whistleblowers exposed abusive conditions in institutions serving both mental health and correctional purposes. These events—along with the growing concerns about crime, delinquency, and social disorder in the Cold War era—led states to reform these systems.

Mental hospitals also struggled in the wake of the reforms of the 1940s, and psychiatric policy makers began sketching out plans for community mental health centers as an alternative to hospitals. New psychiatric approaches

fueled this shift away from the asylum. Psychoanalysis had reached its peak of popularity, and a culture of therapy and self-help spread rapidly throughout American culture. Pharmaceutical companies introduced new commercialized tranquilizers and sedatives, and mental hospital staffs around the country particularly prescribed the antipsychotic medication Thorazine to their patients, which they argued led to remission and early discharge.[4] The new drug therapy transformed psychiatric care in mental hospitals, which policy makers started to view as obsolete. If the 1940s brought the peak of confinement in mental health, the 1950s heralded a new anti-institutionalism. Pennsylvania stood at the forefront of these changes, and during this decade it reduced its mental hospital population.[5]

As Pennsylvania and other states began abandoning the custodial mental hospital model, the criminal legal system expanded, and prisons underwent changes of their own. After World War II, liberal penology, with an emphasis in rehabilitation, gained traction as early forms of drug regulation emerged.[6] The period was marked by a renewed emphasis on rehabilitation, psychiatric responses to crime, and community-based correctional approaches. These changes were linked to a revival of what sociologist David Garland called a "'penal-welfare' structure," which focused less on punitive, incapacitating approaches to crime and more on treatment.[7] In the 1950s states across the country maintained punitive prison systems, but they increasingly used probation, parole, and furloughs. They also created forestry camps for youth and work release programs, in which people worked in the community during the day and returned to prison at night.[8] In Pennsylvania, state officials called for these reforms, which they termed "out-prisoner" programs, similar to outpatient mental health programs. This is not to say that the prisons themselves became therapeutic spaces—their focus on security and social control remained constant. Still, politicians and policy makers used rehabilitation as a main justification for arrest and imprisonment, often of African American men. These changes and reforms laid the groundwork for the rise of imprisonment, which took off in the last quarter of the century.

Developments in the criminal legal system did not operate in a vacuum, however. They occurred in tandem with changes in psychology and mental health. A new emphasis on rehabilitation and treatment infused reforms in both mental health and corrections but had a different effect. In mental health, it caused policy makers to search for alternatives to institutions, and in corrections, it caused policy makers to expand prisons with new rehabilitative imperatives. These twin developments showed how society shifted its

approach to institutionalization—rejecting it for people with diagnoses of mental illness and increasingly approving it as a response to law-breaking.

When the National Association for Mental Health (NAMH) melted the shackles from asylums, it represented the weakening of mental hospitals as part of the carceral state. At the same time that it destroyed the shackles, however, the state was building up a different wing of the carceral state—corrections. Race, gender, and sexuality were central to these changes, since mental hospitals had historically housed mostly white residents, and women made up a large percentage of the patient population. As mental hospitals closed and corrections grew, more African Americans were entwined in the carceral state, a poignant shift in an era of civil rights and desegregation.

Institutions on Trial

In the 1940s journalists and authors like Mary Jane Ward brought traditional mental hospitals—such as the Philadelphia State Hospital at Byberry—into the spotlight. These activists had not, however, focused on prisons, institutions for the feebleminded, juvenile reformatories, or hospitals for the criminally insane. Most of their attention—and most of the reforms—in Pennsylvania focused on civil mental hospitals. Plans to improve correctional institutions were "shelved in competition with other social welfare and health claims"—namely mental hospital reform.[9] Beginning in 1952, however, these correctional institutions came into the spotlight and experienced scandals that directly called into question whether these places were rehabilitative, as the state claimed. The exposure of corruption and abuse at correctional institutions caused policy makers to look for new techniques to run these places.

Because correctional institutions had not received the public attention that mental hospitals had in the previous decade, they deteriorated, soon facing crises of their own making. Yet in the 1950s, correctional institutions received more attention because of the intensified interest in the policing of deviant and delinquent behaviors. During the years of anticommunist witch hunts and surveillance, Pennsylvania passed laws prohibiting adult pornographic literature and regulating the illustrations of drugs, violence, and vulgarity in comic books. With more crimes to watch for, more police were needed. The state also increased the commonwealth's police forces and built a new police academy in the town of Hershey.[10] In this environment of heightened attention to crime and perceived social deviance, prisons and mental health institutions attracted even more public attention.

Forty riots broke out in prisons across the country between 1952 and 1953. The wave reflected rampant unrest in the country's correctional system, including in Pennsylvania, when in 1953 a riot broke out at Western State Penitentiary. The people imprisoned there made a list of demands, including a board of parole, proper medical care, access to legal books, the freedom to file petitions to the courts, and the right of a grand jury to come to the prison once a month to talk to the people institutionalized there. Days later, hundreds of people incarcerated at a different prison — Rockview — took hostages in protest of the prison. After a two-day standoff, the state brought armed troops to the scene, along with two fighter planes, and ended the uprising. These events, however, led to the scrutiny of prison conditions in the state. The investigation resulted in a legislative report that suggested reforms of Pennsylvania's prisons, including the reduction of capacity at Western State Penitentiary, the elimination of solitary confinement, salary raises for personnel, the growth of prison industries, and other reforms.

Perhaps the largest reform in Pennsylvania was the removal of the correctional institutions from the Department of Welfare's purview and its placement in the Department of Justice. The committee appointed by Governor John Fine to investigate the correctional system wrote in its report in 1953, "The term 'Welfare' implies concern over the health, happiness and happy association of individuals in a civilized congregation and . . . in ordinary good practice, the rehabilitative factors of peno-correctional activity should be administered by a department devoted to social progress. We were swayed, however, in our deliberation by the practical aspects of the situation as it exists in the Commonwealth at present." The state could no longer run its prisons in the Department of Welfare — the Department of Justice had to take over, the committee decided.[11]

Scandals also erupted at a number of institutions run by the Department of Welfare that served both correctional and mental health functions: the Farview State Hospital for the Criminally Insane; Laurelton State Village, an institution for women diagnosed as feebleminded; and the Pennsylvania Training School at Morganza, an institution for juveniles run by the Department of Welfare.

News coverage about egregious cases at the Farview State Hospital for the Criminally Insane raised deep questions about psychiatric authority at the institution. Farview had opened in 1912 as the state's first and only mental hospital for people labeled criminally insane.[12] By the mid-1950s, most of Farview's residents did not come there directly from the courts. Instead, they

came to the institution from prisons that deemed them criminally insane, from physicians' commitments, or from other hospitals, where they "had proved too violent or troublesome for the staff to handle."[13] Often prisons sent people to mental hospitals like Farview not only because of their psychiatric diagnosis but also because they had proved problematic at the prison, an "inconvenience."[14] In Pennsylvania, people at Farview could be held there after their criminal sentences had expired without any judicial action or review. The courts did not get involved in the commitment decisions, and the hospital staff controlled when people could leave the facility.[15]

In many ways, Farview resembled a mental hospital—the individuals had rather indefinite terms and could leave only when the staff determined them cured. But it also operated like a prison. For instance, a man named Ralph Hoge murdered his young son. He later appealed the court's ruling that he was insane so that he could transfer back to Western State Penitentiary, where he had a better chance of parole. At Farview, he most likely never would have left, because few people could leave under the commitment rules. Hoge's desire to return to an actual prison reflected how Farview already resembled a prison.[16]

Farview's problematic system of commitments came into the spotlight with the case of Louis Henry Ross, also known as the "Laughing Eel." Ross had acquired this nickname because of his practice of hysterically laughing at his victims after robbing them, though he also possessed an uncanny ability to elude the police. After a string of robberies in the 1920s, he received a six- to ten-year prison term. The judge, however, declared Ross insane, consigning him to Farview rather than to prison. Institutionalized in this way, Ross's six- to ten-year sentence was now meaningless, and he lived at Farview for the next thirty years until he tried—unsuccessfully—to escape. The police caught him and took him to court, where the judge determined that he had served nearly two decades of extra time and "must have been sane since 1943."[17] Ross finally left Farview as a free man. The story of the Laughing Eel spread through the national media, from Long Beach, California, to Hagerstown, Maryland. As the media paid greater and greater attention, Farview became known as "the road of no return."[18] The Laughing Eel's story revealed that a commitment to Farview amounted to lifelong imprisonment, and it exposed the grave injustices that occurred when the mental health system failed.[19]

Soon after the Farview scandal, the death of a teenager at the Pennsylvania Training School outside Pittsburgh drew public criticisms that these institutions were unsafe. The state had established Morganza as a training school for

boys convicted of delinquency, and by the 1950s it held both boys and girls diagnosed with mental health disorders in cottage-style dormitories, with no bars on the windows or external walls.[20] The place faced systemic issues, however, as the story of James O'Dell revealed. O'Dell had come to Morganza because he had participated in a holdup of a service station with some other youths. After eight months there, he suffered a head injury and died. The superintendent maintained that the boy had died of pneumonia. The coroner, however, found that his death had resulted from someone striking him with a pipe.[21] A few days later, Judy Ward, a fifteen-year-old girl, ran away from Morganza because an attendant had hit her with a belt. State officials found bruises and scratches all over her body, lending credence to the charges that staff there had beaten her and other youths regularly.[22]

Because of these stories, the Pennsylvania legislature held hearings and investigated the conditions. During the testimony, employees spoke about the use of physical reprimands and isolation cells. Four African American young women also testified and reported guard beatings.[23] In the middle of this investigation, a number of youths took matters into their own hands. Fifteen teenage girls—dressed in jeans and blue jackets with white stripes—ran away from the facility by climbing through the cottage windows at night. It was the largest escape at the facility in some years, and it reflected the teenagers' resistance to their confinement.[24] The investigations raised questions about the basic safety of youths at these Department of Welfare facilities and the purpose of these places.

A third major crisis occurred at Laurelton State Village. The state had created Laurelton in 1913 as the Pennsylvania Village for Feebleminded Women in order to provide "the segregation and care for feebleminded women of childbearing age in order that they might not pass on their defect to any children they might produce if left in the community."[25] Laurelton Village, like many other mental health institutions, separated women of childbearing age from men in order to prevent them from having children. Because of this rule, the women at Laurelton stayed an average of twenty-nine years, often gaining release only after they had reached menopause. The Department of Welfare considered Laurelton a "closed institution," with locked cottages, and the state even built a maximum security facility there in 1953 because, by that time, the place confined many women with histories of delinquency.[26] Department of Welfare secretary Harry Shapiro took interest in Laurelton and inspected the conditions there. He found that the women had access to water only once per day and that staff had restrained women, beat them, and

dragged some by their hair. These abusive behaviors—along with the maximum security cottages—were "reminiscent of the Dark Ages," as he said to the press.[27] With these reports in hand, Shapiro got the backing of Governor George Leader, and together they successfully pressed the legislature to investigate conditions at Laurelton, eventually leading to major changes there.[28]

The crises at these institutions—Western State Penitentiary, Rockview, Farview, Morganza, and Laurelton—in the span of only a few years caused psychiatrists and state officials to seek reform. Ironically, even though the scandals challenged the quality of therapy and rehabilitation that these institutions purportedly provided, state officials turned to rehabilitation to solve the problem.

Outpatient Initiatives

In 2009 historian Kenneth Wolensky interviewed George Leader, who had served as governor of Pennsylvania in the 1950s. Wolensky asked Leader about the state's mental health program in the mid-twentieth century, and Leader recalled that "Pennsylvania's state mental hospitals were horrible places then. They were medieval. . . . We had 39 plus thousand people in our mental hospitals, and the number was going up every year. We could hardly build them fast enough—like the prison system now."[29] The former governor's comparison of 1950s mental hospitals to prisons in the early twenty-first century highlights how the system was overcrowded, custodial, untherapeutic, and in crisis when he held the executive office. Just as correctional institutions were rocked by scandals, the state-run mental hospitals also struggled, even though the government had poured money into them in the post–World War II era.

In the 1950s Pennsylvania stood in the middle—and sometimes in the back—of the pack among states in terms of its mental health services. The Keystone State ranked forty-fifth for the number of people released from mental hospitals at that time, a statistic that made it one of the worst in the country for "warehousing" people in institutions. It also allocated smaller amounts of money per person in its mental hospitals compared with other states. Those problems affected a large number of individuals as Pennsylvania held one-fifteenth of all people residing in U.S. mental hospitals in 1955.[30] The state's difficulties stemmed from several factors. First, Pennsylvania had repeatedly cut allocations for its mental health system. Second, it had not put significant money into community services, such as outpatient clinics, vocational and rehabilitative facilities, and halfway houses for people discharged

from hospitals. Finally, the state still allowed political appointees to decide the staff at many state institutions, which made them less desirable places for people to work long-term.[31]

In the midst of this crisis in mental health, a number of states were seeking alternatives to custodial institutions, marking the beginning of a new era in psychiatric policy making. The federal government had made inroads into community mental health with the creation of the National Institute of Mental Health, but change largely took place at the state level. The federal government's ability to shape the mental health field in the 1950s still had significant limits. By contrast, state governors and welfare officials wielded great power.[32] For example, in 1954 the Governors' Conference on Mental Health convened for the first time in Detroit. In the years leading up to the conference, states had poured money into their mental health systems and had built up their state hospitals. States continued to face long wait lists, however, and attendees at the conference felt that the hospitals still resembled "snake pits." Because problems still plagued the mental health system, governors and state representatives at the conference spent most of the time discussing the sheer expense of mental health care and debating who should pay.[33]

If people were committed to a general hospital for psychiatric treatment or if they sought treatment at private clinics, they had to pay out of pocket. A few private insurance companies existed, but they typically did not cover mental health treatment. People diagnosed with mental illness and in need of long-term care were usually committed to mental hospitals, largely funded by counties and states. The federal government and individuals and their families covered some of the costs, but the state and local governments paid the majority. Presenters at the governors' conference estimated that these hospital admissions cost taxpayers $3 million per day, with $635 million in tax funds specifically spent on mental hospitals.[34]

Because of the high cost and continued problems with hospitals, the attendees at the conference focused on how to prevent mental illness, ways to increase the rate of discharges from hospitals, and how to move away from the mental hospital model. As the former governor of Minnesota Judge Luther Youngdahl said at the conference, "All groups, private and public, must join together in the mental hospital crusade until such hospitals become houses of hope and not mere custodial places to house our so-called expendables."[35]

A few states led the quest to create alternatives to mental hospitals. Michigan created four outpatient clinics, at which people in the early stages of acute mental distress lived at home and received intensive treatment at the

clinic during the day. The Boston Psychopathic Hospital established one of these clinics, which, by 1954, had kept 175 people out of mental hospitals. States also created small psychiatric wards within general hospitals. The Hill-Burton Act partially funded these facilities, giving hospitals loans for construction and modernization. For instance, St. Joseph's Hospital in Savannah, Georgia, created a thirteen-bed psychiatric ward, which lowered its county's mental hospitalization rate by 58 percent. Many states created these alternative programs, and by 1954, 1,234 community clinics operated nationwide.[36] Attendees at the Governors' Conference argued that the community clinics were more affordable than state hospitals and suggested them as a way to cut costs.[37] New York enacted the Community Mental Health Services Act, which funded outpatient clinics, and California passed the Short-Doyle Act, which provided state funds for localities to create outpatient clinics, psychiatric wards in general hospitals, and community rehabilitation programs in clinics, hospitals, or centers.[38] Many states that took the lead in reform had large mental health systems, a plethora of psychiatrists, and a commitment to social welfare.[39]

In the face of the calamities in Pennsylvania's mental hospitals and correctional institutions, the state sought change in community-based mental health reforms. Governor Leader spearheaded this effort, bringing new energy to the state government as a young Democrat who took office in 1954. Leader had grown up on a poultry farm in rural York County, served in World War II, and attended graduate school at the University of Pennsylvania's Fels Institute of State and Local Government. After service and school, Leader successfully ran for his father's former seat in the state legislature and then set his sights on the governor's office. Leader's support from farmers and organized labor helped him to win the seat, which had been held by only one other Democrat in the twentieth century, George Earle.

Leader became one of the most progressive governors the state had ever elected. He boldly worked to improve social services, to modernize the civil service system, and to establish the Pennsylvania Industrial Development Authority, which created jobs and supported manufacturing. Leader also implemented the Fair Employment Practices Commission, and he helped to pass a law to expand women's rights with respect to property ownership.[40] He believed that state government had the ability to create better housing, to cure mental illness, and to prevent youth law-breaking—it just needed the programs to do so. Leader's political platform celebrated the liberal ideal of strengthening the country with social programs and civil rights policies that

promoted the economic and social well-being of its citizens.[41] His administration placed a high value on social welfare and rehabilitation, and mental health fell squarely into this mix.

A central plank of Leader's program was to rehabilitate individuals with disabilities. For instance, he oversaw the creation of a vocational training facility for people with physical disabilities in Johnstown, Pennsylvania. This facility was the largest and best-funded program of its kind nationwide. The governor also appropriated funding for children with disabilities to study in public schools and exempted individuals with visual disabilities from various fees and regulations. These initiatives sought to rehabilitate people with disabilities in order to make them more productive citizens.[42] In this model, the state had a primary responsibility to provide rehabilitative and social service supports for its citizens, often in community settings.

The governor's liberal zeal, coinciding with the revelation of deep-seated problems in Pennsylvania's mental health system, sparked a second wave of reforms that came a decade after the activism of the conscientious objectors and *The Snake Pit*. Democratic state senator Harry Shapiro became Leader's main partner as the head of the Department of Welfare, and he collaborated with Governor Leader to improve conditions at institutions. Leader later commissioned and coauthored a book about Shapiro—titled *Unlocking the Doors*—about the efforts during this era to make the mental health system more therapeutic, less custodial, and more community-oriented.[43]

Changes in the psychiatric profession spurred state officials like Shapiro to look beyond the institution for mental health care. By the 1950s the majority of psychiatrists worked outside of mental health institutions, a far cry from the beginning of the century, when the majority worked inside them. Psychiatry in the mid-twentieth century was no longer psychiatrists in far-off asylums but was closer to home.[44] By the mid-1950s, for instance, psychoanalytic practices were increasingly deployed in doctors' offices and at community mental health clinics, and they permeated American culture.

At midcentury, Freudian psychoanalysis promised new approaches to mental health disorders. Even though many psychiatrists did not explicitly identify as psychoanalysts, they still identified with psychoanalytic approaches, emphasized the power of the unconscious, and saw early childhood experiences as core causes of mental illnesses. Reflecting the ascension of this field, *Life* magazine published a 1957 series titled "The Age of Psychology," in which writer Ernest Havemann commented, "In many parts of the world, all knowledge of [psychology and psychoanalysis] is still restricted to the col-

lege classroom or the doctor's office. But in the [United States], for better or worse, this is the age of psychology and psychoanalysis as much as it is the age of chemistry or the atom bomb."[45] Psychoanalysis pervaded psychiatric and popular understandings of social disorders and human nature, including sex, family structures, conflicts, and neuroses. Consequently, the United States became an international center of psychoanalysis.[46] The rise of psychoanalysis further weakened the custodial mental hospital. First, it fostered the idea that mental health disorders could occur throughout the populace rather than only among people diagnosed with mental illnesses. Second, psychoanalysis as a cure could be provided anywhere—it was not limited to an institution.

In addition to rehabilitative approaches and psychoanalysis, the rapid growth of prescription drugs fostered the new vision of a society without large custodial mental hospitals. Just as psychoanalysis rose in prominence in the 1950s, so too did psychopharmacology. With the medical advances of World War II—including penicillin and the polio vaccine—researchers rapidly identified new medicines that dramatically altered people's behaviors and mental states. Between 1955 and 1965, tens of millions of Americans began using antianxiety, antipsychotic, and antidepressant medications.[47] Even general practitioners prescribed new drugs such as Miltown and Equanil. Psychiatrists used the major tranquilizers reserpine and chlorpromazine (brand name Thorazine), mostly in mental hospital settings. These powerful medications could alleviate delirium by sedating patients, but they also often caused serious side effects, such as jaundice, trembling, and suicidal depression. Another serious side effect was tardive dyskinesia, which included involuntary and repetitive movements that occurred all over the body, with grimacing, jerking, or writhing. Still, in 1955 alone, Thorazine's manufacturer sold $75 million worth of this medication in America. Psychiatrists in mental hospitals prescribed these potent drugs far more than psychiatrists in private practices. At Rockland State Hospital, which Mary Jane Ward wrote about in *The Snake Pit*, nearly 80 percent of patients took these drugs. The widespread use of heavy tranquilizers in mental hospitals sowed the seeds of protest against what many people saw as the "chemical straitjackets" that psychiatrists used on patients who were unruly.

Thorazine and other tranquilizers transformed the practice of psychiatry within mental hospitals. The drugs' power to sedate large numbers of people made psychiatrists far more optimistic about curing mental illness. The emergence of drugs also generated new visions of mental hospitals releasing people, sending them back to society with the appropriate prescriptions. The

introduction of tranquilizers dramatically shaped the policy-making imagination, creating a vision of the future in which mental health institutions would be obsolete.[48]

A therapeutic ethos pervaded reforms in mental health. In *The Triumph of the Therapeutic*, sociologist Philip Rieff wrote that American society in the 1950s had eschewed religious faith to focus on personal fulfillment and change. The public was increasingly concerned with its mental well-being.[49] This therapeutic ideal in psychiatry permeated American culture and guided policy making. Over the next two decades, welfare programs increasingly provided recipients with income assistance and social programs devised to rehabilitate them and make them financially independent. State governments expanded new vocational programs for individuals with physical disabilities to make them more productive in the capitalist market. In the case of intellectual disability, a movement of families of people then labeled mentally retarded advocated for better services in institutional settings, community vocational programs, and increased access to public schools.[50] The rehabilitative ideal of fixing individuals to solve social problems played a central role in the liberal state programs of the 1950s.

New optimism regarding the power of psychoanalysis, psychiatric drugs, and state-sponsored rehabilitation programs fostered an idea that people could receive treatment at home or in the hospital for shorter periods of time. Department of Welfare secretary Harry Shapiro wanted to apply these new ideas to serve the 50,000 people in Pennsylvania who were "forgotten and neglected, subjected to cruelties and punishment; mechanically restrained; locked in cells and solitarily confined for horribly long periods of time."[51] To Shapiro, these individuals represented "the pawns of unscrupulous politicians and the victims of a myth that nothing could be done for this."[52] The department's report *The Quiet Revolution in Mental Health and Welfare* argued that people diagnosed with mental illnesses needed to be "seen as whole people, living lives as complex as any others. They were not simplifications to be immediately identified by such neat labels as psychotic, retarded, emotionally disturbed, dependent and neglected, delinquent."[53]

Shapiro then took a "brains not bricks" approach to reforming mental health—meaning that the department would improve staffing and administration rather than continue to keep expanding the buildings themselves. Under Shapiro, the Department of Welfare not only invested in renovation and construction but focused even more on rehabilitation and release. Embodying Leader's brain-trust mentality, the Department of Welfare con-

tracted with the American Psychiatric Association, the nation's most prestigious mental health organization, to assess the situation and to make recommendations. The APA had already conducted surveys in Louisiana, Arkansas, Kentucky, Indiana, and Costa Rica before Pennsylvania approached the organization. The state's Department of Welfare pushed for the survey, as did Pennsylvania Mental Health, Inc. (PMH), a citizen-led group that had branched away from the Public Charities Association. Pennsylvania Mental Health had become quite active by 1955, and its determination to change the mental health system brought the APA to Pennsylvania.[54]

The APA evaluated the state's system and made a series of recommendations for change in 1956. In particular, the APA suggested that the state create psychiatric wards in general hospitals. The state did this, as Governor Leader's administration used Hill-Burton funds to build new psychiatric beds in thirty-one of Philadelphia's general hospitals.[55] The APA also recommended that the state create community mental health centers, such as the Commonwealth Mental Health Center in Philadelphia. That center included a twenty-four-hour reception center for diagnoses and referrals to other agencies, general hospitals, or clinics, "in many cases eliminat[ing] the need for hospitalization."[56]

Reflecting the confident and optimistic spirit in psychiatry at the time, the APA urged the state to establish day hospitals where patients could go for eight to ten hours during the working day. It also encouraged the creation of night hospitals, where patients could receive insulin or electric shock procedures, drug regimens, or psychotherapy, and proposed new diagnostic and classification centers to identify specific problems that individuals were having. Finally, the APA recommended that the state build small-scale institutions for people with physical disabilities: foster homes; halfway houses; sheltered workshops, which employed people with disabilities; and rehabilitation centers. The report acknowledged that these places were designed for people with disabilities and not for people diagnosed with mental illnesses, but it posited them as exciting new alternatives.[57]

The APA echoed the national attitude shift in mental health. The National Institute of Mental Health funded a spate of projects, surveys, and conferences on treatment, rehabilitation, and reintegration. Concurrently, Congress passed the 1955 Mental Health Study Act, which created the Joint Commission on Mental Illness. The commission became a driving force in community mental health, engaging in the scholarly studies and advocacy that led to the 1963 Community Mental Health Act.[58]

In Pennsylvania, the Department of Welfare implemented many of the APA's suggestions, especially to make mental hospitals more therapeutic and to create mental health services in local communities. The state particularly invested in community clinics and increased appropriations for them. By 1955 the state had eighty-three clinics, predominantly in urban areas. Philadelphia alone had twenty-seven clinics at general hospitals, medical schools, the Veterans Administration, and other state and private clinics. These facilities were different from mental hospitals in a few ways. Clinics were all outpatient and did not offer overnight stays. Also, the community centers provided diagnosis, treatment, referrals, and public education—a far cry from hospitals' focus on intensive inpatient stays, which were geared toward people with more severe diagnoses.

Only two clinics—at Philadelphia State Hospital and at Philadelphia General Hospital—offered outpatient services to people released from mental hospitals. The other major development during this period was the growth in the number of people admitted to Pennsylvania's general hospitals for mental illnesses. Forty-four hospitals in the state accepted psychiatric patients, but their care varied greatly. Only about one-half of hospitals had separate units or wards dedicated to psychiatric services.[59]

These new programs reflected how the community approach had its complications. The psychiatric profession expressed ambivalence about whether these community clinics should augment hospitals or replace them entirely. The clinics did not serve the same population that stayed in the mental hospitals, and not everyone agreed that these programs could effectively serve individuals diagnosed with severe mental illnesses. Finally, while some claimed that clinics prevented hospitalization, not much evaluation to prove this claim was in place. For instance, one study found that community clinics did not meaningfully serve people with more severe disorders.[60]

At the same time that the state increased community psychiatric services, it also sought to reform mental hospitals. In doing so, it followed the "brains not bricks" mentality. Pennsylvania followed the lead of states such as New York and California when it passed legislation that created a commissioner of mental health position and an advisory council. It also stripped administrative power from the politically appointed boards of trustees at state hospitals, centralizing power in the Department of Welfare. Legislators also approved an increased budget for the Department of Welfare, which gave more money for mental hospitals per person—bringing Pennsylvania's rate of funding to the national average.[61]

Pennsylvania also improved its staffing practices, which had posed a significant challenge to reform. At that time, politicians often determined who got jobs, based upon their connections to the party in power instead of merit. Pennsylvania Mental Health, Inc., pinpointed this corruption by summarizing that "the size of the payroll and the number of jobs have always made mental hospitals a good target for the spoils system."[62] As a result, "incompetent psychiatric workers who drifted from one place to another" caused a high turnover rate among hospital staff.[63] To make mental hospitals more therapeutic, Pennsylvania Mental Health and the Department of Welfare worked with Governor Leader—known as "Mr. Clean"—to pass legislation that placed psychiatric workers on a merit system. The Department of Welfare banned partisan politics and dismissed people "who were making political use of state facilities."[64] It also created 2,000 civil service jobs and launched Operation Opportunity, a recruiting campaign to bring better-qualified staff into the mental health system, concomitant with salary raises that made Pennsylvania competitive with other states.[65] By 1956 the department boasted that politicians no longer controlled the appointments of psychiatric workers. The mental hospital staff now worked for the people in the hospital, not for the politicians. The state had created a new civil service branch disconnected from the patronage system.

The Department of Welfare also worked to integrate the institutions themselves into the community. The state hospital at Embreeville became a model institution for these changes, as the department hired better staff and increased occupational, recreational, and industrial therapies.[66] The department reported that "dilapidated buildings were repaired. Patient lounges were brightly redecorated, given comfort—and television sets. Uniforms for patients were abolished and a variety of clothing styles was introduced to restore a sense of personal identity and dignity. A single menu was established for patients and employees."[67] The new pharmaceutical drugs received only a brief mention—less than a sentence in the Department of Welfare's report on the changes at the mental hospitals—perhaps reflecting the department's discomfort with exposing the drastic effect that these drugs had on the people taking them. The department instead touted its open-door policy. Hospital administrators removed locks from the doors and allowed a number of people at the hospital to return to their homes. By 1956 Laurelton State Village, which had undergone investigations, no longer had locks on its cottage doors. The department converted the maximum security facility into an "open institution" with individual rooms. Laurelton also returned many

women to their communities, so the average length of stay fell from twenty-nine years in 1955 to a mere four a decade later.[68]

The state heralded these reforms as a triumphal start to making mental health institutions obsolete. The Department of Welfare called this change a "quiet revolution." It publicized that "in 1956, Pennsylvania was one of the few states where patient population of mental hospitals declined. Twelve of its 17 hospitals reported reductions in the percentage of over-crowding. In 1955, there were 40,920 men and women in state mental hospitals. Today there are 38,700. A decrease of 2,220 may not appear impressive as a number—but it is when it is thought of as representing 2,220 individuals who have been restored to sanity, and so to themselves and their families."[69] Not only did the number of institutionalized people decline, but the concept of the mental hospital itself changed. Pennsylvania Mental Health wrote that "the idea that a hospital is the only site of psychiatric treatment, or even the most important site, is a thing of the past. Other forces at work in the community are coming to the fore. These forces are directed at preventing mental illness and thus eliminating the necessity of sending a patient to a hospital."[70]

In 1958 Harry Boyer, the president of the Pennsylvania Congress for Industrial Organizations, reflected on these advances. He remarked, "It is clear now that this neglect has taken its toll in life and in liberty—in the confinement of countless numbers in far off institutions to whom the pursuit of happiness is just so many words. . . . For the first time in the history of the Commonwealth, human dignity has been restored to the patients in our institutions; many of them have been returned to their homes so that they, too, may enjoy the pursuit of happiness. Restraints of all kinds have been discontinued. In many of our institutions wards have been opened, locks have been removed, and many patients enjoy the freedom of the hospital and its grounds."[71] Boyer's optimism reflected the cultural shift away from institutionalizing people for long periods of time.

These changes represented the broader effort to make mental health institutions less carceral. The end to uniforms at Embreeville and the changes in the food menu reflected the institution's treatment of people less like inmates and more like individuals. Removing the locks on the doors made the mental hospitals less prisonlike. The height of institutionalism in mental health had passed, and the number of people living in mental hospitals began to decrease, a trend that lasted through the rest of the century.

In this discursive move away from the asylum and toward community care, the Pennsylvania Department of Welfare did not explicitly mention race,

class, or gender in its main report, *The Quiet Revolution in Mental Health and Welfare*. Still, white middle-class women, children, and the elderly appeared in the report's photographs as the individuals most in need of services. The report opened with two images: one of a white girl's ankles and shoes and the other of a white boy, looking downward, while a white hand with a wedding ring pats his shoulder. In the section on children and youth was a photograph of a white teenage girl and boy, well dressed and walking happily down a path, embodying proper teenage behaviors. As far as older adults were concerned, the report contained a picture of an elderly white woman's hands on a table with an embroidered tablecloth and china plates, presumably in a middle-class home.

The report closed with a photograph of a white middle-class family in a convertible. The father sat in the driver's seat, the mother next to him, their two children waving to the camera as the car drove away.[72] Other than this image with the car, men did not appear in the report, and they were not often shown in the wider literature. In the publications of the Public Charities Association, for example, men did not appear in the mental health sections but rather in the crime and delinquency sections. African Americans were absent from these publications, even though African Americans did receive mental health services from the Department of Welfare.[73] So, despite the fact that race and gender were rarely mentioned in the text, the images of innocent people were highly racialized and gendered. The report reflected an implicit bias in favor of whites, a lens that blinded state officials in mental health and corrections to the needs of African Americans. These photographs reflected the reality that the people in mental hospitals were largely white in the 1950s. In Pennsylvania, the census listed 92.6 percent of people in hospitals as white in 1950.[74]

The Growing Criminal Legal System

Beginning in 1950, Albert Deutsch, the journalist who had written about mental health, shifted his attention to the criminal legal system. That year, he published the book *Our Rejected Children*, which critiqued the juvenile reformatory, and in 1955 he published *The Trouble with Cops*. Though these would be among his last works before he passed away in 1961, Deutsch clearly detected the next frontier for social welfare reform.[75] His personal shift from mental health to the criminal legal system marked a broader shift in national attention.

Juvenile delinquency became a lightning rod for public discussions of crime and social deviance in the 1950s. It was the term used when youths under the age of eighteen broke the law or committed acts that were considered illegal when performed by minors—such as truancy. Because the young people were underage, the courts did not consider their law-breaking a crime, and welfare agencies often handled their cases. In the years before, during, and after World War II, rates of juvenile delinquency in the United States rose, due to the social upheaval produced by the two wars and the Great Depression. Between 1917 and 1960, many adults thought young people were out of control, and juvenile delinquency took center stage in the political arena and in American culture.[76]

While juvenile delinquency existed in urban areas, it also posed a serious threat in rural regions—and the phenomenon affected both young men and women. This perceived problem became so critical that the U.S. Senate created a subcommittee on juvenile delinquency in 1953 that held hearings in numerous cities, including Philadelphia. The movie industry also made juvenile delinquency a concern in American life. In 1955's *Rebel without a Cause*, James Dean played the rebellious outsider who got into knife fights and enjoyed drag racing. That same year, *Blackboard Jungle* showed the struggle of a war veteran working as a teacher in a school racked with violence. These film depictions and congressional actions reflected the social anxieties around youth and social disorder during the Cold War era.[77]

Juvenile delinquency also sat at the crossroads of social welfare, corrections, and psychology. The new therapeutic ethos also shaped changes in the criminal legal system as notions of rehabilitation and treatment flourished in juvenile justice policy making and corrections more broadly.

Before one dives into the rehabilitative impulses behind juvenile justice reform, it is important to understand the centrality that race played in the system in the 1950s. While African Americans made up only a small percentage of people in Pennsylvania's mental hospitals, they represented a disproportionate number of people in the state's prisons and jails. In 1950 the census reported that almost 40 percent of incarcerated people in the state were not white—a significantly higher number than those in mental health institutions.[78] Race permeated discussions of youth crime as the Department of Welfare and social scientists turned their attention to juvenile delinquency in urban areas and defined the behavior of youth crime through the lines of race and social class. For instance, criminologists conducted a study of the delinquent behaviors of 10,000 boys living in Philadelphia who were born in

1945 (and turning eight in 1953). The researchers found that socioeconomic status shaped delinquency in part, as working-class youths were more likely to be labeled "delinquent" than were boys of higher socioeconomic statuses. When studying racial demographics, the authors reported that "these differences are not, however, as pronounced as the differences between whites and nonwhites," and they found that half of the African American youths in the study were picked up by the police.[79]

By comparison, the police detained less than a third of the white youths whom the criminologists studied. Young African Americans made up far more of the recidivists—or chronically arrested—individuals. The researchers also mapped intellectual disability onto criminality. They found that chronic offenders had lower IQs, higher rates of mental retardation, and lower rates of achievement and argued that these trends were more pronounced among African American youths. The criminologists linked mental ability and race to the likelihood of committing crimes, a practice that dated back to the Progressive Era.[80] Categories of race and intellectual ability had serious implications, as institutions for youths with intellectual disabilities and criminal backgrounds disproportionately held African Americans.

The criminologists also found that the courts treated African Americans charged with juvenile delinquency much more harshly than their white counterparts. White youths in the birth cohort were half as likely to be arrested for their offenses as black youths. Black youths also received harsher disciplinary actions with longer terms of probation and institutionalization.[81] African Americans' higher rates of arrest reflected how, when it came to juvenile delinquency, the police and the courts viewed young men of color as requiring the most state interventions. These decisions mirrored the sociological studies of the 1920s and 1930s, when civil rights organizations tracked how policy makers and the public responded more harshly to black individuals than to whites who had committed the same crimes.[82] The criminal legal system had a long history of racial biases, which influenced the proposed reforms to the juvenile justice system in the 1950s.

The main state response to juvenile delinquency was to attempt to transform individual youth's behaviors. During the 1930s and 1940s, Pennsylvania often committed to institutions youths deemed juvenile offenders and adults deemed pedophiles, homosexuals, and rapists—both to rehabilitate them and to prevent further criminal activity.[83] During the years of the Great Depression and World War II, custody dominated as the response to these forms of social deviance. In the 1950s, however, during the age of psychology,

treatment and rehabilitation became more prominent as the justifications for imprisonment.[84] Experts flooded the system, and rehabilitation became the watchword at places like California's San Quentin State Prison. During the mid-1950s, the term "corrections" came into popular use among prison officials. The American Prison Association changed its name to the American Correctional Association and urged state officials to use the terms "correctional institutions" and "correctional officers." The decade stands apart as the time when the psychological treatment model dominated, and the world of psychology was rife with ideas about alternatives to prisons.[85] Mental health officials sought to make mental hospitals more rehabilitative, and prison officials sought to do the same.

In response to rising rates of youth crime, policy makers touted the creation of new rehabilitative and community-based programs. For example, the Pennsylvania Bureau of Correction built a prison for the first time in over two decades: in 1956 the state legislature appropriated money for a correctional institution for defective delinquents in Dallas, Pennsylvania. Dallas became a hybrid mental health/penal facility and held people labeled as having mental defects and criminal propensities.[86] A disproportionate number of people deemed "defective delinquents" were African American, and the Dallas institution held far more African Americans than their numbers in the population of Pennsylvania would suggest.[87] By investing in the Dallas institution and focusing on defective delinquents, the state tried to curb youth crime by treating intellectual disabilities. The construction of this facility demonstrated the state's increased attention to law-breaking, especially among African American young people, and the inclusion of mental health in its crime-fighting.

Some 2,500 children in the state went to institutions because of the juvenile courts each year with the support of Governor Leader, who proclaimed that "these children can be saved for productive citizenship."[88] When the reform school at Morganza came under scrutiny, the governor called for the state to give leadership to local communities to address the problem of juvenile delinquency, "which cripples children, destroys family life and represents a cradle for future inmates of our mental hospitals and adult prisons."[89] Psychiatric reforms at juvenile correctional institutions went on display at the Morganza Training School even after the scandals there called into question the rehabilitative nature of the facility. The Department of Welfare initiated new therapeutic programs at Morganza, with the intention to develop standard techniques in other juvenile institutions, the majority of them county-owned or privately owned.[90]

The state experimented with new community services to address juvenile delinquency, as it had done for mental health. The Department of Welfare stated in its report *The Quiet Revolution in Mental Health and Welfare* in 1957, "The institutions for delinquents were primarily custodial. . . . To be sent to them was far too often to be headed on the road to failure with a mental hospital or a prison the next stop."[91] The Department of Welfare created a Division of Youth Rehabilitation to implement new programs and to consult with local agencies about adoption, foster care, protective services, and childcare.[92] Governor Leader summarized the changes, saying, "We do not need to send so many of our children to institutions and separate them from their families. Many could be rehabilitated in their home communities if enough and proper personnel facilities were available."[93] He believed that if the state used its "case-finding and treatment methods early enough," it could cure juvenile delinquency.[94]

In the early 1960s the state spent millions of dollars to create new, smaller facilities for youths convicted of juvenile offenses. Its most popular idea was forestry camps for fifteen- to eighteen-year-olds, where teenagers worked in small settings in the outdoors rather than in large institutions. The state increased its funding to county juvenile institutions, established a state delinquency control institute, and created subsidies and grants for probation officers and police specialists willing to work with youths and address gang issues. By investing in these projects, the department projected growth in—rather than a contraction of—the juvenile system, stating, "By 1970 the system must provide for 1,700 additional children."[95] Between 1955 and 1965 the number of rehabilitation-focused programs and facilities in juvenile justice grew. This growth often came with the building of new facilities, however, expanding the juvenile corrections system.

These community-based reforms in the juvenile justice system foreshadowed changes in adult corrections. The Department of Welfare had overseen the juvenile institutions and programs, while the Bureau of Correction in the Department of Justice had recently taken over supervision of the prisons from the Department of Welfare. The bureau learned from the Department of Welfare's efforts in juvenile justice and similarly worked to expand rehabilitative programs in corrections in the 1950s.

In doing so, however, the bureau's efforts differed greatly from the Department of Welfare's reforms of mental hospitals. While state officials had shifted away from the institutional model in mental health, the Bureau of Correction built up rehabilitative programs in its prisons and jails. The bu-

reau created two new classification centers in which staff interviewed people upon entering the prison system and evaluated each person's custody level. The bureau also made Graterford and Bellefonte stand-alone prisons (previously, they had operated as satellite facilities). Prison officials also sought to grow prison industries—especially when the people in custody worked trades such as bookbinding, typewriter repair, and concrete production. The prisons often profited, and prison officials argued that the industries brought in at least $4 million and could bring in even more money. They also held that the industrial work benefited the people in prison through vocational training.[96]

The creation of classification centers and a focus on trades were done under the rubric of rehabilitation. The bureau touted these rehabilitative efforts as liberal reforms. The celebration of rehabilitation also legitimized the continued reliance on incarceration. For instance, Eastern State Penitentiary publicized its art club in the Philadelphia newspaper the *Evening Bulletin*. A photograph of the art club shows people in prison garb painting at easels against the bleak nineteenth-century prison walls. Notably, even though there are both African American and white people in the photo, all of the painters appear to be white. The picture captures the contradictions of rehabilitation in total institutions informed by racism, as people sought individuality and creative expression within the confines of prison.[97]

In the face of these contradictions, the Bureau of Correction continued to make rehabilitative changes and to expand corrections. In 1960 Pennsylvania's attorney general Anne X. Alpern headed the Department of Justice, the first time that a woman held that office. In response to uprisings in the state's prisons around that time, Alpern proposed closing Eastern State Penitentiary and creating "out-prisoner programs" at the state's other prisons. Newspaper accounts reported, "Miss Alpern likened her proposal to the State's present out-patient program of mental health, which has been credited nationally with reduction of the State's hospital inmate total."[98] Prisoners would receive counseling and out-prisoner training, "just as an out-patient hospital program" would do.[99] Ultimately, the Bureau of Correction did not ultimately implement Alpern's out-prisoner programs. The growth of juvenile justice and the new rehabilitative programs in prisons did lay the groundwork, however, for new community-based corrections programs that became more popular in the 1960s.

Even with these reforms, the prison system was still rife with violence and abuse, as illustrated by the story of one man's time in a Pennsylvania prison.

Art club, Eastern State Penitentiary, by photographer Dominic Ligato in the *Philadelphia Evening Bulletin*, May 9, 1960. (Special Collections Research Center, Temple University Libraries, Philadelphia, Pa.)

Lonnie Patrick Jr., an African American man, was diagnosed with a nervous and mental disorder. He had served in Korea and was institutionalized for these same disorders at the Veterans Administration hospital at Leech Farms in Pittsburgh. The court charged him with burglary, assault and battery, and attempt to commit rape. Upon the advice of his counsel he pled guilty, thinking that he would get parole. Yet his attorney suppressed evidence of his diagnosis of mental illness. Patrick went to prison, where he experienced severe beatings and solitary confinement. In 1959 civil liberties lawyer Hymen Schlesinger wrote to state officials on Patrick's behalf to investigate the charges. The state began a special investigation and found no basis for the charges.[100] In the midst of these liberal changes to prisons, the basic issues of violence, solitary confinement, and lack of due process remained.

While the state made the mental health system less carceral and began shifting away from the custodial institution, it used rehabilitation to grow

the correctional system with new juvenile delinquency programs, classification centers, and a more centralized prison system. In the 1950s, psychological responses to mental illness and criminal behaviors spread throughout society. The Mental Health Bell symbolized a new era, with ideologies that rejected large custodial institutions in mental health. State officials increased the psychiatric services available in general hospitals and community clinics and provided more services for individuals diagnosed with mental illnesses—focusing on recipients who were white—in their home communities. Meanwhile, the state also created new correctional treatment programs and prisons to house people who broke the law, relying on state-sponsored rehabilitative interventions—infused with psychiatric ideas—to change people's behaviors. As a result, from 1955 to 1965 the criminal legal system grew rapidly, despite the move away from large institutions.

Lonnie Patrick Jr.'s story lays bare the problems with this model. He successfully escaped from the relatively open VA hospital at Leech Farm, but upon facing new charges from the courts, his psychiatric diagnosis no longer factored into his sentence. Instead, he went to prison, where he faced abuse and solitary confinement. Even in the face of scandals that questioned whether correctional institutions could have a positive impact on society, the state relentlessly continued to build up the criminal legal system. In an age of welfare-state liberalism, these changes constituted a reimagining of American governance. The focus on rehabilitation in corrections ultimately made it easier for the criminal legal system to expand and to begin absorbing some functions of the mental health system. As the mental hospital arm of the carceral state shrunk, the prison arm grew.

Chapter Three

FLYING THE CUCKOO'S NEST

Unscrew the locks from the doors!

Unscrew the doors themselves from their jambs!

—Allen Ginsberg, *Howl*

Ken Kesey's *One Flew over the Cuckoo's Nest* is among the most poignant books about mental hospitals of the twentieth century. The course of the narrative recounts story after story of repression and struggle on a psychiatric ward, and the book culminates in Chief Bromden's decision to suffocate his lobotomized friend Randle McMurphy. He then hurls an object through a glass window, breaking out of the hospital to run to the highway. "I felt like I was flying. Free."[1]

The hospital in Kesey's book resembled a prisonlike combine, an inhumane machine. Its therapeutic regime disempowered patients and controlled their actions through forced medications, seclusion, electroconvulsive therapy, lobotomy, and an unsympathetic staff, headed by the cold Nurse Ratched. The court had deemed Randle P. McMurphy—a prisoner and the leader of the hospital rebellion—a psychopath. Consequently, it transferred him from a prison work farm to a mental hospital. McMurphy thought the hospital would be an easier place to do time. He was wrong. He mutinied against the therapeutic prison, and ultimately his resistance cost him his life.[2]

Ken Kesey wrote *One Flew over the Cuckoo's Nest* based on his experience as a hospital worker. The novel came out at the moment when state mental health programs were undergoing revolutionary changes. Just as Chief Bromden escaped from the hospital, patients won new rights and an array of freedoms in the 1960s. *One Flew over the Cuckoo's Nest* became a blockbuster, critiquing mental hospitals, institutionalism, and social conformity

Film still from *One Flew over the Cuckoo's Nest* of Chief escaping. (Courtesy The Saul Zaentz Company; copyright © 1975, 2008)

in America. It reflected the broader cultural trend of questioning psychiatry, and the movie's popularity sparked a tidal change in mental health, raising deep-seated questions about state power.

Yet not long after the publication of Kesey's novel, Chief Bromden's fictional break through the walls of the hospital became a reality. In the late 1950s state governments had begun to reject mental hospitals as carceral spaces and to create community-based alternatives while still maintaining governmental control over rehabilitation. During the 1960s, widespread anti-institutionalism and the passage of Medicare and Medicaid informed changes in psychiatry and hastened the shift to a community mental health model and away from state-run mental hospitals. Legal challenges to involuntary commitment laws also had a large impact during this period, undermining the century-old parens patriae approach of the state, by which it acted as a caretaker of individuals diagnosed with mental health disorders. This transformation occurred so dramatically, in fact, that by the time *One Flew over the Cuckoo's Nest* became a movie—a decade after the book's publication—many courts had already overturned state commitment laws, and mental hospitals faced large-scale deinstitutionalization. Tens of thousands of people returned to their communities, and the involuntary confinement of people diagnosed with mental illnesses dropped precipitously.[3]

Pennsylvania stood as one of the first states to implement these changes. At the Philadelphia State Hospital at Byberry, Dr. Daniel Blain initiated one

of the first major deinstitutionalization programs in Pennsylvania and across the country. Prior to working at Byberry, Blain had served as the president of the American Psychiatric Association, and his work mirrored liberal developments in the psychiatric profession nationwide. Under Blain's leadership, Byberry's population decreased dramatically, and in Pennsylvania alone the number of people living in mental hospitals fell by almost half in less than seven years—from 34,000 in 1966 to around 18,000 in 1973.[4] The state touted its reforms in national and international publications, and Pennsylvania stood as a leader in early deinstitutionalization efforts. Unfortunately, Pennsylvania and many states across the country did not provide adequate community social services for many people released from hospitals at this time, particularly for those diagnosed with more chronic and severe mental illnesses.[5]

The rejection of confinement as a state response to mental health disorders bled into prison reform as well. During the 1960s correctional policy makers created community-based alternatives to institutions, such as furloughs, halfway houses, and work-release programs. They looked to localities to alleviate crime, finding inspiration in new community-based ideologies within psychiatry and anti-institutionalism. By the early 1970s, the numbers of people in prisons and jails across many states reached their lowest point in decades, despite rising crime rates, urban riots, and expanding police forces. Pennsylvania—home to a long tradition of prison reform and the Pennsylvania Prison Society—adopted many of these community corrections strategies, and its prison numbers fell as well. Prisons, mental health institutions, and juvenile facilities suddenly seemed relics of a soon-to-be bygone era.[6]

Anti-institutionalism emerged as a powerful force in the establishment of patient- and prisoner-based civil rights. A nascent mental patients' rights movement was emerging, one that coalesced in the 1970s.[7] People in hospitals connected with legal advocates—such as lawyers working for the American Civil Liberties Union—who then filed suits on their behalf to win civil rights protections for institutionalized people. These activists denounced the use of involuntary servitude in mental hospitals and advocated for the better treatment of children in the mental health and the juvenile justice systems.[8] Some of the most important legislation around involuntary commitments to mental hospitals came from mental health institutions that held people convicted of crimes or people that the state deemed a threat to the public but who had not broken the law. By the 1970s the state government's ability to commit people to mental health institutions against their will had greatly diminished.

It was an era in which the courts showed increased concern about protecting individuals from the abuses of state power.

This growing public concern with freedom and human rights provided fertile ground for *One Flew over the Cuckoo's Nest*, especially its themes of nonconformity and anti-institutionalism. In this milieu, deinstitutionalization in the 1960s moved forward in mental health—albeit unevenly—because of the efforts of psychiatric policy makers and civil rights lawyers. The number of people committed to mental hospitals decreased dramatically. Enthusiasm for community-based alternatives also spread into prison reform, leading to the decline in the number of people in prisons. It was a moment when people envisioned a world without large custodial institutions.

At the same time, the courts established a host of new protections to shield individuals from coercive state policies. But while new civil liberties for people in prisons and hospitals were articulated during this period, they were often negative rights—such as the right to freedom from coercion or the loss of liberty. Positive rights—such as to adequate mental health services, housing, and a sustainable wage—did not gain the same traction.

Unscrewing the Locks from the Doors

DEINSTITUTIONALIZATION IN MENTAL HEALTH

By the early 1960s the state had created halfway houses, outpatient programs, and community mental health centers, partly because of new psychotropic drugs and community-based theories of treatment. Still, these changes occurred at a seemingly glacial pace. While the number of people living in mental hospitals began to fall in the 1950s, state mental health systems still operated on a mass scale.

Antipsychiatric and anti-institutional themes pervaded popular culture and formed the backdrop for the politics and policies of deinstitutionalization. During the 1960s everyday people questioned the purpose of mental hospitals as they read the works of Kesey, Erving Goffman, Thomas Szasz, and others. A spate of books came out that challenged custodial institutions for being ineffective, for acting inhumanely, and for permanently altering the stakes of psychiatric reform. Allen Ginsberg galvanized this new wave of writing in 1956 with his epic poem *Howl*. Ginsberg had experience with mental hospitals, as his mother had stayed in a mental health institution for years, and Ginsberg himself was committed for a short time to the Rockland State Hospital in New York. A stint in a mental hospital seemed like a rite of pas-

sage to writers at the time, since so many of them had spent time in institutions, including Jack Kerouac, William Burroughs, Ezra Pound, and Anne Sexton. Literary scholar Jonah Raskin observed, "The madhouse seemed a required station of the cross for the American poet."[9]

In *Howl*, Allen Ginsberg recasts people experiencing mental illness both as disabled by it and also as the recipients of some of the highest levels of genius in America: "I saw the best minds of my generation destroyed by madness, starving hysterical naked."[10] In a socially conformist era—during which mental health programs sought to cure all social disorder—Ginsberg's *Howl* celebrated transients, people with psychiatric disorders, homosexuals, pacifists, and everyone living against the grain of American society. The mental hospital did not help them; instead, it held them captive. "I'm with you in Rockland / where you bang on the catatonic piano the soul is innocent and immortal it should never die ungodly in an armed madhouse," he wrote.[11] Ginsberg criticized the mental hospital for being restrictive and coercive, much as Mary Jane Ward had done in *The Snake Pit* a decade earlier. But Ginsberg also celebrated madness as a source of inspiration; the "madmen and artists" of Kerouac's circle made up the heartbeat of his new generation.[12] Censors quickly banned the poem, but a court eventually overturned the obscenity charge. The censorship of the work helped to make *Howl* a national sensation, and the concepts of mad genius and restrictive mental hospitals became increasingly popular. Ginsberg's *Howl* paved the way for a spate of anti-institutional texts in the years to come.[13]

A cluster of books challenging psychiatric treatment and mental hospitals went to press in the early 1960s.[14] In 1961, Thomas Szasz tracked the history of psychiatric diagnoses in his seminal work, *The Myth of Mental Illness*. Szasz used historic understandings of insanity to challenge contemporary notions of mental illness, which he argued was a socially constructed disease. Across the Atlantic that same year, French historian Michel Foucault published *Folie et Déraison: Histoire de la folie à l'âge classique* (translated as *Madness and Civilization: A History of Insanity in the Age of Reason*), in which he claimed psychiatry and its institutional underpinnings were instruments of social control rather than of benevolence, a concept that reverberated through future studies of asylums and prisons. Soon after, American sociologist Erving Goffman's *Asylums* came out, arguing that residential institutions—like prisons, mental hospitals, and army barracks—dehumanized their inhabitants through strict regimentation.[15] The works of Foucault, Goffman, and Szasz, along with others by R.D. Laing and David Cooper, often were at odds with

each other and were a far cry from the poetry of *Howl* or the narrative of *One Flew over the Cuckoo's Nest*. But collectively, these works challenged these institutions' places in modern society.[16]

New autobiographies also changed public conversations about mental health. The New Zealand novelist Janet Frame wrote of a woman's abuse in a mental hospital in her best-selling book *Faces in the Water*, based on Frame's own experiences. London's Heinemann Press published *The Bell Jar*, Sylvia Plath's semiautobiographical novel, which tracked a woman's struggle with mental illness. The novel described the protagonist's psychotherapy, insulin, and shock treatments in detail. Partly because Plath committed suicide one month after the book's publication, *The Bell Jar* became one of the most famous works on mental illness. Even though Plath's work was less damning of psychiatry than some similar publications, her death underscored the widespread public discontent with its effectiveness.[17] These academic and literary works unsettled the practice of psychiatry and mental hospitalization in the early 1960s, more so than in any previous period.

In this cultural context where fiction and nonfiction books brought anti-institutional ideas to the public, psychiatric treatment shifted away from custodial settings and toward community mental health. The APA and other organizations pressed for federal legislation, and in 1963 Congress passed the Community Mental Health Act, a bill supported by President John F. Kennedy. Kennedy had a sister with an intellectual disability who had undergone an unsuccessful lobotomy. While still a presidential candidate, Kennedy had visited his sister in a Wisconsin institution and thereafter became more involved in issues related to mental health.[18] The Community Mental Health Act appropriated $150 million dollars to underwrite the creation of community mental health centers across the country. This landmark act marked a turning point for the federal government, which began to take a more proactive leadership role in mental health and worked more directly with local communities.[19] The community mental health model also responded to anti-psychiatry critiques at the time.

The 1963 Community Mental Health Act was a significant achievement, prompting reforms in mental hospitals across the country. In Pennsylvania, federal legislation provided $400,000 to the state, enabling it to embark on the first comprehensive survey of its mental health system. Pennsylvania created forty task forces and held countless public hearings. In this multiyear project, the Department of Public Welfare used its survey results to draft plans for new community mental health centers. These facilities contained

inpatient and outpatient services, twenty-four-hour emergency care, partial hospitalization, and education programs—all created with large grants from the federal government. The legislation approved the construction of these new mental health centers, many of which treated a different clientele than the state mental hospitals had, and the act did not order the direct release of people from mental hospitals. As a result, the release of individuals to their communities in the 1960s most often happened at the level of individual institutions, guided by administrators and Department of Public Welfare officials. The Community Mental Health Act set the stage for major reforms, as it expanded outpatient services. It also reflected the shift away from the institution as a way to deal with social issues.[20]

The passage of Medicare and Medicaid had just as much, if not more, influence on mental health policy making than did the Community Mental Health Act. In the mid-1960s mental health reforms interacted with Great Society programs, which emphasized creating social welfare services across the country. The enactment of Medicare led to the federal regulation and accreditation of general and psychiatric hospitals. The accreditation requirements often forced states to make changes to their mental health institutions, and sometimes, when the changes proved too costly, the state decided to downsize and even close these institutions. Medicaid transformed governmental services for elderly people with psychiatric disorders who lived in poverty. Medicaid money could go directly to nursing homes. States, in turn, chose between paying for care for elderly people with conditions like dementia in state mental hospitals or paying 17 to 50 percent of the cost to house those individuals in nursing homes. The federal government paid the rest of the bill under Medicaid. This legislation caused the number of elderly people in mental hospitals to drop precipitously. The number of people over sixty-five in mental hospitals in 1963 was 41 percent; that number fell to less than 23 percent by 1969.[21] The expansion of Supplemental Security Income and Social Security Disability Insurance in the 1970s later provided some financial resources for people leaving mental hospitals. These programs offered "a new set of bureaucracies that were lifelines for people with mental illness."[22] Because they were largely the "byproduct of policy aimed at health and disability insurance generally," however, they often did not focus on particular problems caused by mental illnesses.[23]

These first attempts to release people from mental hospitals came largely from institutional administrators and Department of Public Welfare officials who collaborated with politicians and APA representatives. Dr. Daniel Blain,

a leader in the APA, spearheaded deinstitutionalization in Philadelphia and Pennsylvania in the sixties. Blain grew up in China, the son of missionaries. As a young adult he trained as a psychiatrist in the United States and led the Merchant Marines' psychiatry program during World War II. After the war he worked at the Veterans Administration and in 1948 took the post of medical director of the APA. While at the APA he encouraged the creation of community mental health programs, and after leaving the post in 1958 he implemented deinstitutionalization programs in Colorado and California. He also lived for years with chronic illness and underwent multiple surgeries for a hiatal hernia and on his gall bladder. His sickness caused him to move to Philadelphia—his wife's family's home—where he began working at the historic Institute of Pennsylvania Hospital. His illness did not prevent his continued involvement in national affairs, and in 1964 he became the president of the APA for a one-year term.[24]

At the APA, Blain proposed revitalizing the psychiatric profession with a "new look," which would provide medical services in a vastly different form. In 1965 he began his presidential speech to the APA by recounting the accomplishments of Dr. Benjamin Rush, the Revolutionary War–era "father of psychiatry." By harkening back to the field's origins, Blain legitimized psychiatry as part of a long tradition of medical care for people diagnosed with mental illness. This did not mean, however, that he did not seek change. Addressing the APA, Blain called for a "novalescence . . . the opposite of obsolescence but connoting also youthful devotion to excellence, the development and maintenance of creativity and the idea of renewal."[25] To him, psychiatry represented a historically specific response to protect individuals diagnosed with mental illness from personal suffering and social stigma. To him, the 1960s had ushered in a new era of change to further that mission.

Blain created this vision at a time when the anti-institutional writings of Goffman, Kesey, and Szasz had entered the public consciousness. His speeches as the president-elect and then president of the APA in 1963 and 1964 made no mention of these works, even though they had a large public audience.[26] His silence, however, did not reveal ignorance. Among the hundreds of pages of speech writing in his archives, one speech sits quietly at the back, undated and apparently never delivered in public. This speech, "The Crisis in Psychiatric Legitimacy: Reflections on Psychiatry, Medicine and Public Policy," addressed the issue of antipsychiatry. Blain wrote, "In the past fifteen years we have seen the concept of mental illness itself assailed as an ideological construct, useful more in enforcing the values of society and expressing its in-

ability to tolerate deviance than in expressing the data of empirical observation."[27] In this piece—most likely composed in the early 1960s—Blain argued that, even though the psychiatric profession faced these critiques, it "must still deal with the clinical burdens of a society which 'produces' vast numbers of individuals whose behavior is stigmatized by that society as constituting mental illness. It must deal as well with even greater numbers suffering emotional pain and varying degrees of incapacity."[28] Blain responded to Goffman, Kesey, and Szasz not by directly engaging with them but rather by foregrounding the profession's historical legitimacy and calling for a new era of psychiatric treatment.

In 1965, after completing his term as president of the APA, Blain tried again to implement the novalescence he called for in his speeches. At age seventy, he became a psychiatric hospital superintendent, a position he had never held before. For this new venture, Blain chose the Philadelphia State Hospital at Byberry, the infamous institution that the conscientious objectors had exposed and where George Elder, the World War II pacifist, still lived. The institution sat in a city rife with racial divisions and poverty. In "Building Public Support for the Bedlam of Philadelphia," Blain and a staff member wrote that the hospital had a "style of architecture midway between Neo-Prison and Bureaucratic Bold." Byberry had thirty-four buildings and housed 6,200 people, 2,000 people over capacity. Overcrowding plagued the hospital, just as it had in the 1940s, when the COs had exposed the conditions there. Even as inpatient populations had slowly declined in mental hospitals across the state and country, Byberry's had instead grown.[29] To Blain, Byberry represented the ultimate custodial institution, marked by a troubled past and in need of a major overhaul.

The Byberry reforms became part a of statewide process to look into the mental health system led by K. Leroy Irvis, one of the most prominent African American politicians in the state. Irvis came from a black working-class family and earned his law degree at the University of Pittsburgh. In 1958 he ran for office as a Democrat, winning a House of Representatives seat and rising quickly through the ranks.[30] Irvis had a passion for justice, sponsoring hundreds of bills through which he fought for civil rights, fair housing, better education, and improved public health services.[31] He approached the issue from a different vantage point than Blain's. While he had no professional connections to psychiatry, he did have a commitment to social justice and issues affecting marginalized people. Irvis turned his attention to mental health and galvanized the legislature to create a bipartisan investigative committee to

survey conditions at state institutions. The legislature agreed to this suggestion after the publication of a series of shocking articles about the plight of patients at the Pennhurst State School. Irvis then headed up the investigation of the state's twenty-nine mental health institutions, visiting a number of them and diligently assembling his results.[32] The report recommended a series of administrative reforms and increased funding with a goal to create programs that "successfully [return] as many patients to society as possible."[33] This legislative investigation bolstered Blain's work to reform Byberry.

Blain's efforts at Byberry rejected the entire idea behind custodial mental hospitals. He stated to the press, "If, in the past, they had been curing people here rather than just locking them up, it wouldn't have become this large. . . . This place has got to go. . . . The tragedy of mental hospitals that have remained in this State is that most of these patients can be relieved of their symptoms—if not completely cured of their illness—and returned to society. . . . The old theory was 'dump them here.' With some help, I'm going to get them out and tear this place down."[34] With these words, Blain articulated psychiatry's rejection of large institutions in the 1960s. He emphasized to reporters that "professionals around the country have held for a long time that Byberry is terrible—it needs help."[35] Blain posited that the mental health system was ultimately compassionate but it needed to change, and he insisted the asylum had become outdated and that psychiatric professionals and administrators wanted to improve—rather than dismantle—the mental health system. This ideology flew in the face of Goffman's, Kesey's, and Szasz's depictions of psychiatric hospitals as places of social control. Using Byberry—the ultimate custodial institution—as a model, Blain attempted to put a complete stop to housing individuals diagnosed with mental illnesses in large institutions.

Blain worked with Pennsylvania politicians to continue deinstitutionalization statewide, as he had also started in California. On October 4, 1967, he led Pennsylvania's Governor Raymond Shafer on a tour of Byberry. Photographs of the meeting show the governor touring the cramped dormitories and talking with both administrators and people who were staying at the hospital. After visiting, the governor ordered Blain to close two fifty-year-old buildings at the hospital, which would greatly reduce the hospital's population and the resultant overcrowding.[36] Shafer's order reflected Blain's own anti-institutional viewpoint. After their visit to Byberry, Blain embarked on a "superhuman effort" to prepare people to return to their communities.[37]

As he overhauled Byberry, Blain advanced the ideal of community-based

programs. In 1967 he formed a task force of about two dozen people. This task force reviewed case files and released everyone who could be better served in other settings, transferring hundreds of people to the care of their families. Those who could not go to family members' homes went to outpatient care at community mental health centers, geriatric centers, and private nursing homes.[38] To help with this adjustment from Byberry to the outside world, Blain set up a federally funded Socialization Unit, in which twenty social workers worked with people who had lived at Byberry. The Socialization Unit helped people find housing and live independently, with the help of the services at the seven community mental health centers built in Philadelphia.

Finally, in a process the staff members called the "Great Migration," Blain reorganized Byberry. People no longer stayed in wards according to their classifications—such as depressive or psychotic—but instead according to where they resided at home in the different parts of Philadelphia. Blain rearranged the hospital so that it no longer had an insular quality; rather, it emphasized connections among the people living at Byberry and their home neighborhoods.[39] The reorganization of the hospital along geographic lines had racial implications. Because the city was significantly segregated by race, the new wards that were tied to parts of the city most likely became more arranged by race as well.

These reforms fostered a community focus at the hospital and led to the rapid release of hundreds of people. In October 1968—only one year after Governor Shafer's visit to Byberry—Blain had closed buildings S-1 and S-2. The inpatient population had dropped by 2,000 people since 1966.[40] A 1968 *Philadelphia Evening Bulletin* article reported that one-half of people who had stayed at Byberry now lived in foster homes, with a comparable number living in their own homes, the homes of their relatives, or nursing homes. Medicare covered the cost of care for individuals with senility at the Philadelphia Psychiatric Center, the Friends Hospital, and the Northeast Mental Health Center. According to Flora M. Gross, a worker in the social service department, "This was possible because of the new drugs for mental illness. . . . We only move out the people who are able to go. We don't just push them out."[41] While Gross insisted that the hospital did not force people to leave, she became defensive about the speed with which people exited the institution. These changes occurred quickly and were conducted at the level of the institution, with the support of federal funds and the leadership of the APA.

Blain did more than just move people out of Byberry; he also welcomed community members into the affairs of the institution. He set up a publicity

Benjamin Rush House groundbreaking ceremony (Daniel Blain on far right), ca. 1960s (Philadelphia State Hospital Graphic Material [Series #23.644], Record Group 23, Records of the Department of Human Services, Pennsylvania State Archives; courtesy of Pennsylvania Historical and Museum Commission)

office that touted current reforms and brought numerous community groups to the facility. In one progress report, the hospital emphasized its efforts in "bringing the community in," illustrating its point with a photograph of a Boy Scout troop volunteering on the grounds.[42] In 1968 Blain led a fund-raising effort to preserve the historic birthplace of Benjamin Rush, located just four miles from Byberry. Blain wanted to move the farmhouse to the hospital's land; there, he could restore it as a museum so that the public could learn about the father of psychiatry. While at this historic site, the public could also find out more about the history of treatment and new developments at the mental hospital. In this way he hoped to attract more people to the hospital's grounds, and the effort represented a mentality of bringing people to Byberry rather than keeping it as a walled-off institution.[43]

Unfortunately, the efforts to save the Rush house failed. In 1969 a city worker mistook it for a condemned dwelling and bulldozed it to the ground.

Sam Nicholson, a Byberry employee, recalled that the hospital abandoned the project, and that some parts of the former Rush house sat in the institution's basement after the accident.[44] In spite of this failure, Blain's effort to restore the Rush house represented a moment of optimism as he worked not only to overhaul one of the most troubled mental hospitals in the country but also to foster a public appreciation for psychiatry.

During this period of deinstitutionalization, in 1971 the hospital administration released George Elder, aged sixty-four at the time.[45] The *Evening Bulletin* covered the man's release and celebrated this deinstitutionalization. The *Bulletin* reported that 1,700 people who were "virtually imprisoned at Philadelphia State Hospital at Byberry because no one bothered to get them or they had no place to go . . . have been released during the last two years."[46] A few months later, the paper ran a story titled "Foster Homes *Shelter* 1,000 from Byberry" (emphasis added), reflecting media accounts that depicted keeping people out of the hospital as a major step forward.[47] The repeated failure of institutional reform campaigns—coupled with the anti-institutionalism zeitgeist of the time—coalesced to remove people en masse from custodial facilities, a development that the public praised.

But Elder's case complicated the story. Once Elder left Byberry, he felt cut off from the life he had known. He soon became depressed and suicidal and also became ill with cancer. After five months, he moved back to Byberry. In 1971, when reporters learned of his story and interviewed him, he told them that he wanted to die in Byberry—that the time for his release had come and gone.[48] While many people returned to their communities and families with no further problems, many people like Elder left the institution to find only poor housing and limited access to services.

During this rapid deinstitutionalization, the state government had few resources available for people leaving the hospitals. The Socialization Unit had only a small group of social workers to serve the hundreds of people who had left Byberry by then. Sam Nicholson remembered that many had difficulty accessing their social security checks after release. Residents often left the hospital to find poor housing options and few sources of employment.[49] *The Evening Bulletin* reported the story of a woman who, after her brother had been released from Byberry in 1971, never saw him again. For ten years she drove the streets looking for him, to no avail. Furious at the mental health system, she claimed that it had taken action to "protect their rights, but not the patients. They're just opening the doors and sweeping them out."[50]

Her story and that of George Elder were not anomalies. Advocates argued

that the Philadelphia State Hospital was "dumping patients" with no concern for their welfare. Dr. Franklyn Clarke, Blain's successor and the first African American superintendent of Byberry, disputed the claims. Years later, though, he said, "We were wardens instead of therapists. Patients got worse, but you [the community] slept nights."[51] Within only a few years, the people who had left Byberry without any support would be nicknamed "Byberry people." According to a 1974 *Evening Bulletin*, these individuals were "not wanted by their communities" and were "forced to live as pariahs in what are sometimes called 'mini-Byberries'—the boarding homes."[52] Unfortunately, Byberry's wave of releases had sent many people out of the hospital without enough resources to sustain themselves.

This issue remained on the margins of public consciousness, however. While advocates and family members criticized the dearth of state social services, for the most part this weakness went unheeded by the larger public in the 1960s. Instead, the focus in the media often lay on the newly found freedoms many people won upon reentering society. Anti-institutionalism dominated the public discourse and mental health policy making. The deinstitutionalization at Byberry modeled how other hospitals—both in Pennsylvania and beyond—could reduce their reliance on custodialism. In this way, the era brought a spate of negative rights—new freedoms from confinement and medical coercion, the growing right to the least restrictive environment, and a right to self-determination.[53] The right to adequate medical care, social services, and an income, however, did not emerge in the same way to meet the needs of many people who left the hospitals.

COMMUNITY CORRECTIONS

The movement away from custodial institutions affected not only mental hospitals but also prisons. In 1972 historian David Rothman made what seemed an unusual prediction about the future of prisons in America: "The basic statistics are, themselves, most striking. Since 1955 the annual number of inmates in the nation's mental hospitals has been falling. . . . A similar decline has occurred in correctional institutions. In 1940, 131.7 prisoners per 100,000 of the population served time in federal or state penitentiaries; in 1965, the number fell to 109.6 per 100,000, and this without a concomitant drop in the number of crimes committed or criminals convicted."[54] Rothman did not think that state institutions would entirely disappear, yet he argued, "Nevertheless, when our current practices are viewed within historical perspective, the degree to which we have moved away from the incarcerative

mode of coping with these social problems is clear enough. We are witnessing nothing less than the end of one era in social reform and the beginning of another."[55] The search for alternatives to the asylum led to a pivotal moment, a time filled with optimism that society would reject large custodial institutions of all types—including prisons.

Throughout the 1960s and into the 1970s, prison policy makers boldly experimented with rehabilitative programs in prisons, with "out-prisoner" programs that echoed the outpatient models in mental health. These liberal ideas sought to reduce what the public saw as increasing criminality and social disorder during the tumultuous 1960s. In this era, law and order became central political issues for both Democrats and Republicans. From the post–World War II era into the 1960s, opponents of civil rights and southern Democrats conflated civil rights organizing and urban uprisings with crime. During the Montgomery bus boycotts, police arrested blacks for carpooling or walking together, and southern Democrats later criminalized the actions of freedom riders and sit-in participants. Conservatives also argued that policies like the Civil Rights Acts of 1957 and 1964 would cause black crime and that the urban riots in the 1960s were due to crime rather than racial inequality and social unrest.[56] As the political scientist Naomi Murakawa wrote, "The U.S. did not confront a crime problem that was then racialized; it confronted a race problem that was then criminalized."[57] Urban uprisings rocked many American cities in the mid-1960s, including Philadelphia, and they peaked in 1967, during which 163 cities erupted in violence, often due to police brutality and economic inequality.[58]

Actual rates of crime indeed rose during the 1960s. Violent crime increased, and nationally, the homicide rate nearly doubled, from 5 murders per 100,000 people in 1960 to 9.8 per 100,000 in 1974.[59] Criminologists have typically attributed the rising rates of reported crimes to urbanization and to the fact that the Baby Boomers were reaching young adulthood, an age associated with higher rates of crime. Additionally, police departments used new reporting methods to count crimes more thoroughly during the 1960s, which in turn bolstered the statistics.[60]

The rising crime rates, urban riots, and political protests led to an increase in fears for personal safety, particularly among whites, even though rioting rarely affected white areas. Very few rioters attacked whites, and most of the casualties were at the hands of police rather than of the rioters, the majority of whom did not carry firearms. A 1964 Harris poll demonstrated that 73 percent of Americans sensed that crime had grown in their communities,

and in 1967 the National Opinion Research Center reported that one-third of Americans feared walking alone in their neighborhoods.[61] Rising crime rates collided with civil rights advances, urban uprisings, and conservative discourses that associated racial equality with criminality, making public safety a key political issue of the 1960s.

The 1960s law-and-order movement used racialized language to call for a stop to what people saw as violence and disorder in the streets. Conservative Republican Barry Goldwater ushered in this movement during his 1964 presidential campaign. This year marked a high point of civil rights activism, especially with the passage of the Civil Rights Act and the activism during Freedom Summer. Consequently, Goldwater made safety a centerpiece of his platform against President Lyndon B. Johnson. Goldwater argued that civil rights and integration would lead to "dangerous streets." He believed that the Democrats had allowed violence to flourish there, under "the license of the mob and of the jungle."[62] Crime became the central issue in a presidential campaign, which had happened only rarely in elections past.[63] The discourse around crime reached a fever pitch, rising faster than the rate of crime itself.

Republicans were not the only ones to emphasize law and order; Democrats did as well. The conservative outcry around violence on the streets—coupled with rising crime rates and more urban riots—led many Democrats, particularly President Johnson, to take a vocal stance against crime. Johnson waged his own "war on crime." He spearheaded legislation, starting with the 1965 Law Enforcement Administration Act, one of the first times the federal government tried to influence policing. In 1967 President Johnson's administration published The *Challenge of Crime in a Free Society*, which identified crime as a major issue. The following year Congress passed Johnson's Omnibus Crime Control and Safe Streets Act, which awarded grants to expand and improve police departments across the country. Johnson's administration is often remembered for the advent of the Great Society, with the Voting Rights Act, the Civil Rights Act, and the passage of Medicare, Medicaid, and Supplemental Social Security Insurance legislation. But a key component of Johnson's administration was also the war on crime in which law enforcement expanded throughout the country, as did the number of arrests, particularly in black communities.[64]

While liberals put more police officers on the streets, they also took a more anti-institutional approach, similar to the one taken in mental health. To liberals, crime was not the result of the dangers of civil rights; rather, it signaled that civil rights had not gone far enough. Liberals believed that solving

the problems of poor housing, education, and unemployment would alleviate crime. In 1965 Democrats passed the Prisoner Rehabilitation Act, which created halfway houses; in 1966 they passed the Narcotic Rehabilitation Act, which allowed for civil commitments for people with drug addictions; and then they passed the Juvenile Delinquency Prevention and Control Act, which created after-school programs.[65] The Johnson administration's report *The Challenge of Crime in a Free Society* captured the spirit of these changes. In the section titled "Community-Based Corrections" it read, "Clearly, there is a need to incarcerate those criminals who are dangerous until they no longer are a threat to the community. However, for the large bulk of offenders, particularly the youthful, the first or the minor offender, institutional commitments can cause more problems than they solve."[66] Liberals broadly rejected institutions that incapacitated people rather than helped them. Instead, they sought alternatives to the prison, relying on their optimism that government programs could cure crime.

Pennsylvania led these liberal criminal justice reforms. In the late 1960s, an opponent described the members of the Pennsylvania Bureau of Correction as "long-haired Utopians."[67] And utopian it was. In 1967 the state's attorney general, William Sennett, opposed the new prison construction, stating, "There has been a national change in concept from the large type institution to community based correctional programs and community based correctional facilities."[68] Under this attorney general, the Bureau of Correction encouraged using probation rather than imprisonment, and many criminal judges agreed.

Consequently, the bureau increasingly used probation, and during the 1960s the state supervised two-thirds of people convicted of crimes in their communities. The liberalizing of prisons gained momentum throughout the 1960s, particularly because of the Pennsylvania Crime Commission, which sought to rethink the prison itself. One crime commission task force recommended that the state replace the State Correctional Institution (SCI) at Philadelphia with "small-capacity prisons offering specialized services to offenders."[69] In lieu of prisons, the commission suggested that the state create diagnostic, classification, and smaller "community-based institutions."[70]

The *Pennsylvania Psychiatric Quarterly* highlighted these changes in an article, "Treatment of Offenders in the Community Setting." Author James T. Barbash wrote, "Greater psychological sophistication on the part of law enforcement personnel, attorneys, and judges is becoming a reality. Research funds are currently available. Correctional institutions, probation

departments and parole boards are placing greater emphasis on a need for psychotherapy. The cumulative effect of these modifications has already resulted in unmet requests for diagnostic and treatment facilities."[71] The article exposed the deep connections between the psychiatric profession and the criminal legal system. Mental health professionals fostered this broad shift away from institutions and toward community-based programs. These recommendations came while the governor's office and the Department of Public Welfare actively sought to create community-based mental health services and to deinstitutionalize large psychiatric institutions, such as the Philadelphia State Hospital at Byberry. Pennsylvania's eight state prisons also only operated at less than 70 percent capacity by 1968, as the number of people in prison dropped from 8,300 in 1963 to 5,300 in 1968.[72]

The reforms reached their zenith in 1971 with the appointment of Allyn Sielaff, the new commissioner of corrections in Pennsylvania. He began with a mandate to liberalize the prisons, to "turn the system around, [and] to humanize the prison."[73] Sielaff stood six feet five inches tall and was only thirty-nine years old when he started. He had worked for the Bureau of Correction for only two years as deputy commissioner so had not come up through the ranks. Instead, he had a law degree from Cleveland State University and a master's in social work from Case Western Reserve.[74] Prior to coming to Pennsylvania, he had worked at the National Center for Crime and Delinquency, a progressive think tank that promoted correctional reforms. When Sielaff took office, he refused to address inmates by number; he let them grow their hair long; and he worked to make prison conditions less institutional. He also wanted "to better prepare inmates for life after prison," and he saw the "bureau's objective as being 'to correct deficiencies, to rehabilitate, and to finally integrate into society those whose futures have been delivered into our hands.'"[75]

The Bureau of Correction issued *The Changing Concept: Corrections*, a report illustrating its ideology. The front cover featured a white man standing alone by a tree. On the back cover, he no longer stood alone. Instead, the pictured showed him walking toward a white woman and child, a rehabilitated man returning to his heterosexual family and society. In the foreword to the report, Commissioner Sielaff wrote that "the old, walled prisons cost more—not only in money, but in the price they exact from all of us."[76] The report continues by explaining that the "'out of sight, out of mind' philosophy has passed. . . . Having learned that this approach was a miserable failure, society now demands a totally different approach."[77] Community leaders and orga-

nizations could support residents "in various and controlled situations in a gradual preparation for final release."[78]

This reformist language represented an integrationist model of corrections. While liberal politicians and policy makers funded the expansion of police forces, in corrections they worked to change people's behavior to prevent future crimes. They embraced an ideology of community corrections. Just as in the mental health system, criminal justice reformers wanted to reintegrate people convicted of crimes back into society, using more community-focused programs. *The Changing Concept: Corrections* also echoed the literature that the Department of Public Welfare issued about mental hospitals. Those reports rejected isolating people in far-off hospitals and instead emphasized returning people to their homes. Considering Sielaff's training as a social worker, he most likely knew this mental health language of return and community integration.

To make the report's vision a reality, the Bureau of Correction instituted work and education release programs. These initiatives allowed residents to leave prison during the day to go to work or school, and the bureau also created home furloughs, which lasted from one to seven days. Even before inmates reached their minimum sentences, corrections officials allowed them to return home for short stints to visit family, find housing, and attend job interviews.[79] Over the course of 1970, people incarcerated in Pennsylvania's prisons left on furlough almost 10,000 times, with 98 percent of them coming back at the end of their furloughs.[80] If they returned to prison smoothly, they became eligible to transfer to small regional facilities or community treatment centers, which the legislature had authorized in 1965. These places were "designed for the express purpose of . . . keeping [the offender] close to his community, his family, and educational, cultural, employment, religious and other community resources."[81]

Regional prisons held between 150 and 250 people, and the bureau described them as "non-prisons in design."[82] Community treatment centers held no more than 20 people. Staff supervised the residents twenty-four hours a day, and after they had successfully progressed through the programs, they gained release to their homes, YMCAs, foster homes, or drug treatment centers.[83] In both regional correction facilities and community treatment centers, the Bureau of Correction let inmates leave to go to work or school.[84] The bureau argued that these programs helped to make people convicted of crimes into upstanding citizens. It publicly stated that home furloughs lessened the damage of incarceration on families, helping to "preserve a husband-wife re-

lationship."[85] Community treatment centers and regional correctional facilities kept people close to their families and to employment opportunities. The community—rather than the prison—became the ideal place to rehabilitate convicted men into strong heads of heterosexual households.

The search for community-based alternatives also permeated women's prisons. Female penologists in the late nineteenth century had established a tradition of a separate system for women in prison, which included more treatment-oriented services to prepare the women for lives of domesticity. Although this model changed during the twentieth century, separate and more rehabilitative services for incarcerated women remained.[86] In Pennsylvania, they served a graduated sentence—with no minimum but rather a maximum sentence—and lived at SCI-Muncy, a facility that looked like a college campus with beautiful brick buildings and that resembled a prison only because of the bars on the windows.[87]

In 1968 the Pennsylvania Program for Women and Girl Offenders formed in Philadelphia. This organization came together because of the neglect of women in prison and because it "assumed that the public would be more sympathetic to the needs of women and would tolerate them in the community because they were not seen to be as dangerous as men."[88] With the help of caseworkers and volunteers, the organization provided services to women on probation and created a Release on Your Own Recognizance program, in which women convicts did not get prison time. Instead, the court released them to the supervision of the organization.[89] Such alternatives permeated correctional reforms for both men and women, echoing the changes in mental health.

Smaller facilities and community programs brought financial benefits to the state. The Bureau of Correction touted these reforms for saving taxpayers nine dollars per day per person in prison, which translated into millions of dollars each year.[90] While the state had to pay to set up the programs, in the long run it saved money. A monitoring firm found that these community programs reduced recidivism. They also provided a solution to the expense of imprisonment, since the number of prisoners would fall over time. The Bureau of Correction further claimed that these programs reduced the number of people on welfare, since vocational and educational training would help people leaving prison to secure much-needed jobs. Taxpayers, in turn, benefited from the taxes that formerly incarcerated people paid when they found employment.[91] This language of cost cutting and taxpayer savings resembled the discourse in mental health at the time. Often, politicians and

policy makers celebrated the changes in state mental hospitals as benefiting people diagnosed with mental illness as well as the state's pocketbook.

As mental hospitals emptied, prison reform encouraging rehabilitation and community services became increasingly popular. While law-and-order conservatives wanted criminals off the streets, liberal legislators and prison officials wanted to put them back while helping them with counseling, education, and job training. Liberals did not, however, ignore rising crime and urban uprisings. In fact, liberals took an interventionist position, seeking to make communities safer by expanding law enforcement. They wanted to place people in corrections programs and rehabilitate them with community-based services. Correctional reforms often involved people who had had experience with mental health reforms. These people became the bridge between the two systems. Consequently, just as mental health reformers made hospitals more rehabilitative and community-based, prison reformers made corrections facilities the same way.

Unscrewing the Doors from Their Jambs: Legal Reform

The peak of anti-institutional thought not only occurred in popular culture and in policy making; it took hold in the courts as well. Civil liberties lawyers successfully argued in the 1960s that institutions trampled people's civil rights and that those individuals needed protection. While Daniel Blain and other psychiatric professionals tried to limit the system's reliance on custodialism, civil libertarians began a legal battle to transform the terms of mental health commitments. As noted earlier, individuals had resisted the psychiatric profession before. Conscientious objectors exposed conditions in the press; Mary Jane Ward published *The Snake Pit*; people wrote letters to their elected officials; and right-wing conservatives challenged what they saw as the left-leaning mental health establishment. During the second half of the 1960s, however, the activism by and for people within mental health institutions took a more central role in mental health reform, particularly in the legal system. Consequently, the courts considered the rights of people living in mental hospitals, an issue that had been left almost untouched since Reconstruction.[92]

In the 1960s protecting the civil liberties of people in mental hospitals came to the forefront of legal concern. During these years the focus was on mental health institutions that also served the correctional system. At these institutions, which held people deemed dangerous or criminal, very little had

changed since early deinstitutionalization efforts. For instance, the institutionalization of people whom the courts deemed sex offenders, defective delinquents, or the criminally mentally ill did not change through the actions of policy makers. Instead, the courts became the arbiters of how to supervise these individuals. At Pennsylvania facilities like the Farview State Hospital for the Criminally Insane and the newly built Institution for Defective Delinquents at Dallas, superintendents did not simply release these people back to their communities. While the psychiatric profession considered community settings the best place to provide mental health services, this model did not extend to people considered criminal or dangerous. The state continued to use the custodial model for such people, reasoning that it was needed to protect public safety.

The tensions between deinstitutionalization and custodial care led people at these facilities to call for their release. The first major legal action concerned Pennsylvania's Institution for Defective Delinquents at Dallas. In 1937, Pennsylvania had implemented its defective delinquent statute, a law that the Department of Welfare applied to "males over the age of fifteen who have been convicted of a crime or held as juvenile delinquents, and who, in the opinion of the examining authorities, are mentally defective and have criminal tendencies, 'whether or not coupled with mental instability.'"[93] The state gave these youths indeterminate sentences, meaning they had completed their juvenile sentence and yet continued to live indefinitely in an institution because of their classification as defective delinquents. The number of people held in this manner had risen so much that, in 1960, Pennsylvania's Department of Public Welfare built a multimillion dollar institution in Dallas, only the second of its kind in the country.[94] While the Dallas institution greatly resembled a prison, its commitment structure echoed that of mental health facilities.

During this period the federal court system was considering the rights of institutionalized people, particularly people in prisons. In 1964 the U.S. Supreme Court ruled that black Muslims had the right to worship in prison. In the wake of this decision, the federal courts increasingly ruled in favor of incarcerated people. This change in the courts inspired incarcerated people nationwide to file their own lawsuits and to seek assistance from lawyers through Fourteenth Amendment claims. Prisoners' rights activism had close ties to racial justice work in the 1960s because of the terrible racial disparities in the legal system. Black men in particular fell victim to this structural racism. The prisoners' rights movement grew quickly, gaining a national following and recognition across the globe.[95]

The individuals at Dallas were no different, and they wrote to public interest attorneys in Philadelphia for help leaving the facility. Consequently, the ACLU of Pennsylvania took up the cases of hundreds of inmates at Dallas between 1966 and 1968. In particular, the ACLU challenged the constitutionality of the defective delinquent statute, calling it a violation of due process.[96] The legal atmosphere was ripe for such a test. In 1964, just a few years earlier, a civil liberties attorney in Pittsburgh had successfully challenged the constitutionality of the state's Barr-Walker Act, which gave indeterminate sentences to individuals labeled sexual psychopaths.[97] Additionally, in 1967 the Supreme Court decided in *In re Gault* that juvenile delinquents had rights to attorneys, trials, and other legal protections. In the past, juveniles had not had these protections, since the courts deemed them wards of the state. But the *Gault* ruling challenged the parens patriae relationship of the state and juveniles. It rejected the claim that youths should lose basic civil liberties because the state acted in loco parentis.[98] Legal precedents such as this one and the establishment of prisoners' rights in other cases helped the ACLU's case for the rights of people deemed defective delinquents.

Freeing people from Dallas, however, did not come without a fight. The Department of Public Welfare called the ACLU "irresponsible" for securing the release of these young men. To the Department of Public Welfare, Dallas provided people with much-needed social services in an institutional environment, and the department defended the parens patriae structure for determining the best treatment for them. Still, the ACLU continued to challenge the law, citing due process violations and arguing that the state imprisoned people who had never committed a criminal act. Because of the organization's efforts, the state legislature repealed the law. At least eight hundred men left Dallas. ACLU executive director Spencer Coxe termed the effort a "legal 'jail break' campaign," and he later described it as one of the most important victories of his long career.[99] The parens patriae approach to people with mental health diagnoses weakened after the state legislature repealed the defective delinquent act.

As the commitment practices of people diagnosed as defective delinquents, sex offenders, and juvenile delinquents changed, the courts heard cases related to the treatment of people in mental hospitals. In 1966 the federal appeals court in Washington, D.C., ruled in *Rouse v. Cameron* that people in mental hospitals had the right to treatment while confined in those places. Judge Bazelon wrote the opinion, and in it, he began building the legal foundation for right-to-treatment claims, which posited that if the government

could violate the liberty of someone with a mental health disorder, then it had an obligation to provide adequate treatment for the individual at the institution.[100] In the mid-1960s, liberal concerns for the welfare of citizens meant either providing effective treatment in institutions or moving people out of them.

Civil liberties advocates also challenged the commitments of people deemed criminally insane. In New York the court system sentenced Johnnie K. Baxstrom to two and a half to three years for second-degree assault. While in prison, a physician certified Baxstrom as insane and moved him to the Dannemora State Hospital for the Criminally Mentally Ill. When Baxstrom's sentence expired, the hospital head tried to have him civilly committed, arguing that his mental illness required care. And Baxstrom did remain at the hospital after the end of his sentence. He did not stay quietly, however, fighting his commitment in state and federal courts. He filed a habeas corpus petition that alleged his commitment was unconstitutional. The case made its way to the U.S. Supreme Court, and in the opinion from February 1966, Chief Justice Warren found that the statute by which Baxstrom (and other inmates) had been committed was unconstitutional because it "denied him equal protection of the laws guaranteed by the Fourteenth Amendment."[101] As a result of this ruling, the state sent Baxstrom and 966 other inmates from Dannemora and Mattawean State Hospital—the other New York State maximum security mental hospital—to civil hospitals for reassessment, eventually freeing the majority of them.[102]

Initially, the U.S. Supreme Court's ruling led to the direct release only of people at New York state institutions, since the case centered on an issue with the New York Constitution. But the success of the *Baxstrom* case also had a national impact, since it made similar cases in other states easier to litigate. In 1969, for instance, a case emerged in Pennsylvania concerning the Farview State Hospital for the Criminally Insane.

Two criminologists—Terence P. Thornberry of the Center for Studies in Criminology and Criminal Law at the University of Pennsylvania and Joseph E. Jacoby, assistant professor of Criminal Justice at the University of South Carolina—conducted research on Farview in the 1970s, providing invaluable information about the institution. In reviewing the case files, Thornberry and Jacoby found that about two-fifths of their research subjects died at Farview, making death the most common mode of discharge in the 1960s. People at Farview stayed in institutions much longer than the average person imprisoned in Pennsylvania did. This was not necessarily because

of the severity of their crimes. Instead, the reason for their unusually long stays stemmed from the Farview employees' hesitance to release people when the public would hold the institutional staff responsible for any crimes committed after release.

As a result, it was relatively easy for people to enter Farview, but it was extremely hard for them to leave. Bob Bechtel, a man whom the state committed to Farview for committing a violent crime, recalled that a psychiatrist told him that he would most likely be at the institution for the rest of his life even though he had not received a formal life sentence.[103] In the criminal legal system, judges could give set sentences for various crimes. But in the mental hospital system, the staff had no set structure and often decided to hold a person longer than originally planned. The parens patriae imperative intersected with the state's responsibility for public safety, resulting in the overconfinement of individuals with dual diagnoses of criminality and mental illness. These individuals became the most vilified in and most quarantined from society.

As a result of these disproportionately long detentions, people at Farview, Pennsylvania's mental health facility that also served as a prison, wrote letters seeking their freedom. In the 1960s most did not have access to attorneys, and because the staff did not often release people, letter writing to potential allies became a lifeline to freedom, as it had been at the Dallas institution.[104] One Farview resident wrote a letter that landed at a nascent prisoners' rights project at the University of Pennsylvania, led by Professor Curtis Reitz. At the time, Richard Bazelon, the son of Judge David Bazelon—who had established the right to treatment for people in mental health institutions—worked with the prisoners' rights project at the university. Bazelon and Reitz understood the civil rights issue for this Farview resident who had served his criminal sentence yet remained confined.[105] Mental health law was wide open at this time, and Judge Bazelon's recent decision about the right to treatment, the ruling at Dannemora in New York, and other challenges to mental health laws provided a promising atmosphere for new litigation. On July 25, 1969, Reitz and Bazelon took on the resident's case and filed *Dixon v. Attorney General* in the district court in the Middle District of Pennsylvania.

One of their first steps was to create a class of individuals to represent. This class included all of the people committed—not by a family member but by a member of the Farview staff.[106] None of the class members were still serving time for their criminal sentences, if they had ever had them. That said, a small group had had their sentences deferred pending a psychiatric exam. Accord-

ing to a demographic study, the *Dixon* class's average age was forty-seven, and 12 percent were over age sixty-five. "[M]embers of minority groups and the poorly educated [were] over-represented in the Dixon class," according to Thornberry and Jacoby, and 40 percent of the class were African American—far higher than the number of African Americans statewide, which stood at 9 percent.[107] Almost half of the *Dixon* plaintiffs had no education beyond sixth grade; 59 percent were listed as unskilled laborers; and only 14 percent worked as professionals, managers, or farmers. Many had spent time in other mental hospitals.[108] Because of the disproportionate representation of African Americans and the working class, the Farview case was not just about the injustice of mental health laws; it was also a civil rights issue.

In the case of the Institution for Defective Delinquents in Dallas, the Department of Public Welfare had protested the ACLU's efforts because of concern for public safety. Similarly, in the past the Farview staff had not wanted to take responsibility for discharging individuals, fearing public ire if someone released from Farview committed more crimes. If the federal court decided to discharge the individuals, however, the public could not blame the institution's staff for any future problems. So, behind closed doors, the Department of Welfare supported releasing people, since it recognized the deep problems at Farview. In fact, the state encouraged civil rights lawyers to challenge the practice of long-term confinement there and made it significantly easier for them to access clients and documents at Farview to help them create the class.

During the hearings, public safety became the central feature of the U.S. District Court judges' deliberations. At the *Dixon* hearing on July 22–23, 1970, the plaintiffs called witnesses involved in "Operation Baxstrom," the nickname for the movement of inmates from maximum security mental hospitals in New York. These witnesses testified that only 7 of the 1,000 people released from Dannemora and Mattawean returned to maximum security institutions. The plaintiffs argued that the people at Farview did not have any major criminal propensities or severe disabilities that would prevent them from living outside of Farview and outside of institutional settings more generally.[109]

The lawyers relied on the erasure of any disabilities, criminal histories, or other social differences in this class of people to gain their civil rights. Claims for civil rights along race and gender lines often came with the denial of any disability or difference, in order to justify people's capacity for citizenship

rights.[110] The *Dixon* attorneys argued that the people at Farview should have the right to due process protections and that they did not have any major disabilities or propensity to commit further crimes. In doing this, the lawyers upheld a hierarchy that excluded people deemed dangerous or disabled from full citizenship.

Ultimately, the constitutional argument for civil rights protections prevailed. The court found the recommitment procedures no more than a "'paper notation,' without any formal hearing or process whatsoever," and it redefined the commitment laws. In the court's opinion, "the plaintiffs contend that Section 404 [of the Pennsylvania Mental Health and Mental Retardation Act] is unconstitutional on its face and also as applied to plaintiffs . . . We agree. Indeed, the defendant does not contend otherwise."[111] The court based its majority opinion on recent U.S. Supreme Court decisions concerning the due process protections of people convicted of sex offenses and on the unconstitutionality of the Barr-Walker Act in Pennsylvania. The court also cited the *Gault* case that granted due process rights to juvenile delinquents. "We are unimpressed by the *parens patria* argument," the Pennsylvania District Court wrote, "and strong courts have not been persuaded by it."[112] This decision caused the state to transfer patients out of the institution. When the 586 people at Farview heard of the court's ruling, the vast majority wanted to return to their communities immediately; few wanted to remain institutionalized. Most of them got their wish, as the state first transferred them to civil institutions near their homes and later totally released them from the mental health system.[113]

In their study of people who had left Farview, Thornberry and Jacoby found that most *Dixon* plaintiffs did not commit violent crimes or reenter hospitals after their release. These findings countered the prevailing political fear that these individuals would start a crime wave upon their return to their communities. Overall, the released people adjusted to community life, with many living with their families and a few staying in boardinghouses. In light of these findings, the researchers posited that a new commitment system for people deemed criminally mentally ill might be more based on "just deserts," or a sentence more proportional to the crime that they had committed. The researchers called for more procedural protections to lessen the possibility that they would spend an inordinate amount of time in mental hospitals.[114] While Thornberry and Jacoby argued against mental hospitalization for these individuals, they did not oppose criminal sentences as appropriate responses

to individuals diagnosed with mental illnesses, continuing the process of the criminalization of these people.

The *Dixon* case led to more than the release of people from Farview. Its determination of the state's commitment law as unconstitutional affected the lives of thousands of people in the mental health system. By eliminating the legal foundation of Section 404 of Pennsylvania's mental health law, the district court overturned thousands of involuntary commitments and ordered the release of people committed without due process. System-wide, the Department of Public Welfare contacted about 14,000 individuals and their families, notifying them of the court's decision.[115] The legal redefinition of the rights of mental hospital patients in Pennsylvania occurred at the intersection of the mental health and correctional systems. The ruling clarified whom the state could remove from society and why.

In the wake of the *Dixon* decision, the Philadelphia State Hospital at Byberry underwent a second wave of discharges, three years after the first effort to release people under Daniel Blain, because Section 404 had become unconstitutional. By 1971, the number of individuals had dropped to 2,400, and because of the *Dixon* order, the Byberry administration notified its staff that 1,800 of the 2,400 individuals at Byberry now had the option to leave the facility or stay, whatever they decided. The Philadelphia State Hospital *Staff Bulletin* announced the same information.[116] Many people did choose to go, but this time they left at their own discretion. Blain's efforts to deinstitutionalize Byberry had reduced the number of people there, and after the *Dixon* decision the numbers again decreased significantly. This occurred because commitment laws no longer permitted the involuntary confinement of people based solely on their diagnosis of mental illness. Many people in mental health institutions gained new freedom from involuntary commitment and a stronger right to self-determination.

In the 1960s institutions were under attack from multiple directions. Anti-psychiatry and anti-institutional attitudes spread through the works of scholars and authors with personal experiences with mental hospitals. Those cultural currents legitimized the reforms of mental health and correctional officials who sought to move away from large institutions and toward community-based programs. These impulses also permeated the courts, which increasingly granted civil rights to people in prisons and mental hospitals.

Yet a core tension lay at the heart of the changes. On the one hand, many people diagnosed with mental illness gained a host of negative rights, such as

the freedom from confinement. On the other hand, the more positive rights, such as the right to mental health care, housing, and a sustainable income, did not materialize. These tensions would only heighten in the 1970s with the growth of law-and-order politics, the criminalization of mental illness, and the expansion of imprisonment once again.

Chapter Four

CUSTODIALISM REBORN

Emphasis today has switched from rehabilitation to custody. The faith in rehabilitation has been replaced by a feeling that those who commit crimes should get their "just deserts."

—John P. Conrad, *Philadelphia Evening Bulletin*, August 26, 1979

Robert "Stonewall" Jackson was an impoverished African American man from Philadelphia. The courts had convicted Jackson of burglary and, because of his psychiatric diagnosis, committed him upstate to the Farview State Hospital for the Criminally Insane. It was at Farview in 1976 that he was found dead, his neck broken.

Jackson's suspicious death caught the attention of an editor at the *Philadelphia Inquirer*. The editor put a young African American reporter named Acel Moore on the case. Already known for his writing on juvenile delinquency and gang crime, Moore contacted the coroner, who refused to speak to him. Searching for leads, Moore called Jackson's nearest relative. As soon as she picked up the phone, she screamed, "Oh my God—my prayers have been answered!" This relative had called numerous people about Jackson's death, but few took interest in the fate of an African American man, labeled by the criminal justice system as dangerous and diagnosed with mental health issues.[1]

Soon after Moore's first story about Jackson came out, a former resident of Farview contacted Moore. Not only had he known Jackson personally, but also he told Moore that he had heard him beaten to death in the cell next to him. The man described a level of violence in Farview that Moore had never heard before. Moore teamed up with another journalist, Wendell Rawls Jr., and spent three months investigating the hospital in a series that eventually won them a Pulitzer Prize. They wrote about staff forcing the people at Far-

Interior of Farview State Hospital in *Farview Findings*, 1976. (Used with permission of *Philadelphia Inquirer*; copyright © 2017. All rights reserved)

view to participate in fights and gambling on the winners. Moore and Rawls also reported that the institution covered up the violence—such as when the staff wrote off a murder as a heart attack. To Moore, the fact that the staff was predominantly white while so many people held at Farview were black made the situation particularly dangerous. Moore's investigation of Farview, then, became not only about mental health but also about race, class, and caring about people whom society had discarded.[2]

Journalists like Moore were not alone in reexamining the mental health system. Spurred on by the anti-institutional sentiment of the 1960s, activists in the 1970s challenged medical and psychiatric authority in myriad ways: organizing against forced sterilization, for the right to abortion, against experimentation on people in mental hospitals and prisons, and against the diagnosis of homosexuality as a psychiatric disorder in the second edition of the *Diagnostic and Statistical Manual of Mental Disorders*.[3] At the same time, during the 1970s, American governance experienced a "crisis of competence," as many people on both the left and the right found social welfare policies to be too interventionist, ineffectual, or wasteful.[4] As faith in the powers of medical and state authority weakened, the search for rehabilitative methods of corrections specifically came under assault. In the early 1970s the public lost significant faith in the American prison system's ability to rehabili-

tate people.[5] In the case of Robert "Stonewall" Jackson, the implication that the state of Pennsylvania had run a downright violent mental hospital—one that may have even killed someone—furthered public outrage around government abuses.

In the 1960s people had embraced the idea that institutions harmed people and society, as policy makers responded with deinstitutionalization and the advent of community programs. In the 1970s, however, distrust of the state's medical authority reenergized the idea that the government's primary role should be protecting society from dangerous individuals. Policy makers in Pennsylvania rewrote the mental health commitment laws during these years, creating stringent restrictions against committing people to mental hospitals against their will. Family members, psychiatrists, or the police could no longer place people in mental health institutions because of psychiatric disorders or socially disruptive behaviors. Instead, commitments could happen only if the person posed a clear and present danger to himself or herself or others.

Months after the passage of the new mental health law, Philadelphia police commissioner Joseph O'Neill published a directive that encouraged police to take people exhibiting antisocial behavior to jail, since they could no longer take them to hospitals involuntarily. As a result of these policy changes, the number of people diagnosed with mental illnesses entering the prison system sharply increased, a trend that occurred in countless cities across the United States.[6]

As mental illness became progressively criminalized in the 1970s, prisons became more punitive and grew in size. The liberal trend toward deinstitutionalizing prisons and creating community corrections programs came to a halt in this decade. At the center of this shift was an assault on rehabilitation—the notion that prisons could or should work to promote positive behavioral change among the people held behind bars. Debates in Pennsylvania around the Good Time Bill, which became a flashpoint piece of legislation in the wake of the Attica prison uprising in New York, laid bare the deep divisions among legislators about how to treat people convicted of crimes. Fear-based politics caused policy makers to return to the punitive prison model, ultimately passing legislation that criminalized a host of social behaviors, including drug use and mental illness. Pennsylvania was among the many states in which the rehabilitative ideal was rejected in the 1970s, and it was replaced with incapacitation and imprisonment. In turn, correctional institutions emerged as the primary carceral spaces in the United States. While prisoners' rights and self-described mental patients' rights activists had challenged the

rehabilitative model and institutionalization, only the former went on the chopping block.

Deinstitutionalization during this decade did not entail a rejection of custodial institutions as reformers had hoped in the 1960s. Instead, the meaning of institutions changed as their role became focused on removing people from society in order to protect the public.

Criminalizing Mental Illness

After the 1971 *Dixon* ruling overturned the mental health commitment laws in Pennsylvania, lawyers and policy makers spent the next five years drafting new commitment guidelines.[7] These professionals entered a national struggle over the civil liberties of people in mental hospitals in the early 1970s as grassroots activists began to organize around this issue and the courts heard more and more cases.

One of the key activists to emerge during this moment was Judi Chamberlin, a woman diagnosed with chronic schizophrenia. After a voluntary commitment, she was confined to a state hospital for months. She described that period as the worst of her life, and her experiences inspired her to join expatient groups. Here, Chamberlin connected with early mental patients' liberation activists, a 1970s civil rights movement that was small and unfunded.[8] Other early groups included the Insane Liberation Front in Portland and the Mental Patients Liberation Front in Boston. The groups quickly connected at the North American Conference on Human Rights and through the Madness Network News from San Francisco, which Chamberlin called "the voice of the American ex-patients' movement."[9]

The psychiatric survivors' movement was composed of people who had experienced hospitalizations, and many of them challenged both the medicalization of mental illness and also medical power, in line with Thomas Szasz's theories. They provided mutual supports for each other and advocated for facilities run by people who had experience with mental illness, shifting power away from psychiatric professionals. The movement rejected the discrimination of people with mental illness, and its members fought against the marginalization of those individuals. In particular, they advocated for a host of rights for ex-patients and psychiatric survivors, taking a stand against involuntary commitments and treatments and for the right to counsel in the face of confinement.[10]

Public interest lawyers took these issues to court and profoundly influ-

enced the establishment of the civil rights of people in mental hospitals. The Mental Health Law Project, for instance, worked to strengthen the constitutional rights of individuals facing mental hospitalization, and its staff published the handbook *Legal Rights of the Mentally Handicapped*.[11] The group built its case on the right to treatment, which Judge David Bazelon had articulated in *Rouse v. Cameron*: if a state institutionalized a person, then it had to provide treatment to that person. The case *Wyatt v. Stickney* in 1972, heard by a federal court in Alabama, made the right to treatment a constitutional right, a decision that fostered major reforms in the mental health system in Alabama and nationwide. *Jackson v. Indiana* held that individuals with mental disabilities had the right to due process if they were to be involuntarily committed, a legal right also established in *Lessard v. Schmidt*, a Wisconsin case. *Lessard* required that people in mental hospitals receive a host of procedural protections, such as an attorney and a full hearing before institutionalization. The case also held that a person had to demonstrate a threat of immediate harm to himself or herself or others before being committed. These new rights resembled those granted to criminal defendants.[12] These cases all established the right to treatment and due process for people in mental hospitals and encouraged the state to use the least restrictive environments possible.

In the wake of the *Dixon* ruling, policy makers in Pennsylvania worked to keep up with the changes. Two Philadelphia lawyers—Richard Bazelon, who had represented the prisoners in the *Dixon* case, and Alan Davis—drafted the new reforms. They, along with the Mental Health Association of Southeastern Pennsylvania, wrote a new act that set the parameters for the legal issues of any people who "were seeking treatment; were having treatment sought for them, against their will; were in treatment, voluntarily or involuntarily; or were released from treatment." Between 1972 and 1976, the drafting group worked with the Department of Public Welfare and the Pennsylvania Psychiatric Society to hold numerous public hearings.[13] Revising the rules proved to be long and arduous, but it resulted in the Mental Health Procedures Act, signed into law on July 9, 1976, just a few days after the country's bicentennial Independence Day.

The committee that drafted the new legislation argued that historic commitment laws had arisen for benevolent purposes, but they had gone deeply awry over time. To make this point, the authors of a report on this legislation quoted Judge David Bazelon: "It sometimes happens that a system de-

signed to protect the disadvantaged ends by oppressing them."[14] The report continued:

> The network of mental-health services is potentially such a system. That same benevolence of which it was born can, in the absence of explicitly statutory guidelines, lead to the presumptions of authority which seriously threaten the rights and freedoms of those it means to serve. The benevolent purpose of mental health treatment seems to give mental health laws a certain constitutional respectability, despite their obvious flaws—which include lack of due process, denial of equal protection, and invasion of privacy—and despite the fact that enforcement of such laws often leads to an abridgment of constitutional rights and may intrude on such basic freedoms as the rights to marry, divorce, enter contracts, and manage one's own business affairs.[15]

The drafters wanted to provide a spate of new civil rights protections to people diagnosed with mental illness—rights that the state had previously denied them in the name of benevolence.

This movement for more civil rights around mental health issues coincided with struggles over funding in federal and state mental health budgets. In February 1973, President Richard Nixon's administration recommended scaling back federal grants to the states to build new community mental health centers, a program initiated under President Kennedy ten years earlier. In the new model, the states would take over the funding of the centers. The Watergate scandal eventually overshadowed Nixon's plans for mental health cuts, but the issue still resonated in Pennsylvania, where mental health funding was contentious.[16]

Union workers went on strike at institutions across the state, including the state hospital at Byberry. The American Federation of Labor and the Congress of Industrial Organizations even opposed a bill that supported patients' rights, claiming that the state used civil rights protections as a cover to dump people on the streets. The union publicly announced that the bill did not emphasize the right to treatment and that people would go without services, a high price to pay for civil rights.[17] Labor's opposition to the cuts on behalf of people in the hospitals later became a central challenge to the neoliberal deinstitutionalization efforts of the 1980s.

The cost-cutting efforts of the 1970s—along with the history of incarcerating people diagnosed with mental illnesses and the fear-based politics

of the time—did not make it easy for reformers to end the discrimination of these individuals and to provide appropriate services for them. A large swath of the public called for protection of the streets, including protection from people diagnosed with mental illnesses. In 1974 Pennsylvania governor Milton Shapp spoke about the process of deinstitutionalization, which he described as "controversial." He said that many people criticized the state for removing people from mental hospitals, claiming that the community program was "not yet ready for ex-hospital patients."[18] In Philadelphia the Department of Public Welfare reported that many communities did not want these patients released to live among them. A new paternalist model emerged that sought both to protect individuals from involuntary confinement and to protect people from violence—priorities that often conflicted with each other.

Public concern with the threat posed by people who had left mental health institutions shaped the new laws. In their report, the drafters of the Mental Health Procedures Act wrote that the previous law, which allowed institutionalization for treatment purposes, was "the mechanism by which people can be deprived of . . . their essential liberty."[19] The authors acknowledged a need for treatment but stated that this need "must be weighed against untoward intrusions on [people's] privacy. Medical judgments are integral to the process, but discretionary power must be limited in order to prevent an improper exercise of *parens patriae*."[20] They criticized involuntary commitments for being overly dependent on medical judgments and echoed the ideas of vocal antipsychiatry advocates Thomas Szasz and R. D. Laing. Again quoting Judge Bazelon, the authors argued that psychiatrists were conflicted in their commitments both to assist people diagnosed with mental illness and to maintain order in the institution.[21] To counter this conflict of interest, they drafted the new Mental Health Procedures Act, which placed the power of commitment in the hands of the courts. In the new system, the courts decided whether the person posed "a clear and present danger of physical harm, either to himself or others," a standard put forth in *Dixon* and by the Supreme Court in *Jackson v. Indiana*.[22] The report noted, "The mentally ill . . . may be detained on a broader standard—the threat of posing a danger, or even merely a conflict, to society."[23] While the state could no longer commit people solely because of their psychiatric diagnosis, they could commit those whom the state deemed dangerous.

One of the effects of this change in the law in Pennsylvania and nationwide was an increase of individuals in mental hospitals who had experiences with the criminal legal system. One study of six states (Arizona, California,

Iowa, Massachusetts, New York, and Texas) found "an increase in the proportion of male admittees with prior arrests." The rates jumped from 38.2 percent in 1968 to 55.6 percent in 1978. Other characteristics of the people admitted to mental hospitals changed as well in these states. For example, the mean age of admittees fell from 39.1 in 1968 to 33.3 in 1978, and the percentage of people of color increased by approximately 13 percent.[24] This racialization in fact occurred at the national level, as the rates of African Americans in mental health institutions rose by about 7 percent between 1960 and 1980. Notably, it did not rise quite as high in Pennsylvania, as the rates of people classified as nonwhite rose from only 9.9 percent to 12.66 percent during these years.[25] Racialization did occur in many states, however, and it stemmed from the fact that risk assessments of danger often had "the effect of sorting based on race and increasing the racial disproportion within our 'dangerous' populations."[26]

In the late 1960s a sense of liberation pervaded the release of thousands of people from mental health institutions. By the 1970s, however, the public had become much more wary. People who had left Byberry without any support would be nicknamed "Byberry people," individuals whom their communities often discriminated against and who lived in boarding homes nicknamed "mini-Byberries."[27] The dramatic changes in the mental health system had come out of an interest in protecting people. Byberry's administrators sought to protect individuals from warehousing in the mental hospital, and the plaintiffs of the Farview and Dallas cases and their lawyers sought freedoms from involuntary commitment. However, new problems of poor social supports and public resistance in community settings arose in the 1970s.

These changes in Pennsylvania paralleled developments across the country. In 1959, only five states hospitalized individuals against their will because they were deemed dangerous. By 1971 the number had increased to nine, and by the end of the 1970s, every state in the country had the ability to hospitalize people because they were found to be a danger to themselves or others. This litmus test included people deemed "gravely disabled," meaning those who could not meet their basic needs. The commitment laws, when combined with the states' efforts to deinstitutionalize hospitals, fostered a shift away from confining people based on a diagnosis of mental illness and toward confining people based on criminal acts or diagnoses of dangerousness.[28]

As deinstitutionalization proceeded apace and as prisons became more punitive, the jail system increasingly absorbed people from the former mental health system. Contemporaries worried that such a movement would hap-

pen. Their fears came true in Philadelphia: Joseph O'Neill with the Philadelphia Police Department ordered his officers to arrest people showing signs of mental illness. O'Neill stated that "persons who make unreasonable noise, use obscene language, make obscene gestures, engage in fighting or threatening, in violent or tumultuous behavior, create a hazardous or physically offensive condition . . . may be charged with violating Section 5505 of the Crime Code, Disorderly Conduct."[29] In the past, the state would have involuntarily committed many of these individuals to a mental hospital.

The director of psychiatric services at a local prison collaborated with a social work student to chart the changing prisoner population in the wake of the legal reforms. They studied a forensic unit in a Philadelphia prison and compared the number of people who received psychiatric services before the 1976 Mental Health Procedures Act with the number who received such services after it. The researchers found that the number of people diagnosed with mental illnesses in jails increased after the civil commitment changes. The majority of these people had not been imprisoned for violent crimes but instead "crimes such as disorderly conduct, trespassing, and making terrorist threats."[30] While the police and probation officers had sent many of these individuals to jail, a significant subset had had their families—who felt threatened—request their arrest. The researchers found that the arresting officers often identified the people they arrested for nonserious offenses as having mental illnesses. Since the police could not civilly commit them, they sent them to jail.[31]

The researchers ultimately concluded that the blame belonged to the community, and they stated that it was "not prepared" to handle people diagnosed with mental illnesses. In turn, they cautioned other states from making their commitment laws like Pennsylvania's.[32] They did not examine, however, how the police jailed people for committing nonserious offenses. The rates of imprisonment rose in the 1970s, especially in urban African American communities like in Philadelphia. The researchers found that the majority of people in jail who were identified as mentally ill had diagnoses of schizophrenia, a diagnosis that psychiatrists applied more to African American men than to any other group. In the 1960s the psychiatric profession had redefined paranoid schizophrenia in the second edition of the *Diagnostic and Statistical Manual of Mental Disorders*. The new definition tied paranoid schizophrenia to aggression and violent behavior, behaviors that were disproportionately ascribed to African Americans, particularly men. Pharmaceutical advertising repeatedly linked African culture to schizophrenia, and psychiatrists over-

diagnosed black men with the disorder.[33] The criminalization of mental illness disproportionately affected Philadelphia's black community, as people with schizophrenia were often arrested and sent to jail.

This criminalization of mental illness and the "hospital to prison" trend occurred not only in Philadelphia but also nationwide. A myriad of studies found that the number of individuals with a history of mental illness or mental hospitalization grew in the 1970s and 1980s. One of the most famous examples of this shift occurred in California. In 1969 the state passed the Lanterman-Petris-Short Act, creating stringent requirements for involuntary commitments. Over the year that followed, the number of people diagnosed with mental illnesses in the prison system doubled. Marc Abramson, a psychiatrist in San Mateo County, studied this trend in California. He called the phenomenon the "criminalization of mentally disordered behavior."[34] Abramson argued that if mental hospitals released people too quickly, the community would not be able to handle it. Ultimately, the pressure on the criminal legal system to "reinstitutionalize" these people would grow.[35] Abramson exhibited a popular attitude that blamed deinstitutionalization for rising prison rates. Like many, he assumed that the criminal legal system had to respond to deviant behavior with arrest and jailing. By the 1970s the anti-institutional impulse was waning.

Researchers Glenn Swank and Darryl Winer studied the Denver County jail and found similar trends. "The number of psychotic persons encountered in the jail was striking," they said, "as was the number with a history of psychiatric hospitalization, particularly long-term (more than one month) or multiple hospitalizations. . . . Of the jail inmates with a history of long-term psychiatric hospitalization, many had been state mental hospital patients."[36] They also wrote that workers at the jail "believed that there has been a marked increase in the number of severely mentally disturbed individuals entering the jail in recent years."[37] Prior to the 1950s, people diagnosed with mental illnesses had lower arrest rates than the rest of the population. After the deinstitutionalization of the 1960s, the arrest rates for these individuals began to exceed the rates for the general public.[38] The criminalization of mental illness was well underway.

Legal reforms made it harder for the state to hospitalize people against their will. As a result, the Philadelphia Police Department increasingly arrested and jailed people for offenses that might otherwise have led to hospitalization. At the same time, prison, jail, and mental health officials created more secure units, such as forensic psychiatric wards at state hospitals and

psychiatric wards in prisons and jails. Yet, the rising numbers of people in prisons and jails were not just the unintended consequences of deinstitutionalization. This criminalization of mental illness also occurred because of new police and prison policies.

The Rebirth of the Prison

The punitive turn in corrections and the beginning of the rise of mass incarceration coincided with changes in society's response to mental illness. The opposition to rehabilitation in mental health fed a similar distrust of rehabilitation in corrections. People from all sides of the political spectrum questioned the efficacy of the prison system, and a new emphasis on just deserts and more punitive prisons emerged. As a result, furloughs ended and the corrections department in Pennsylvania cut plans to make new community corrections programs. Instead, it planned to build new prisons. The rebirth of custodialism ended the correctional anti-institutionalism of the 1960s, both in Pennsylvania and around the country, particularly in urban centers.

One piece of legislation, the Good Time Bill, illuminated the central challenges to rehabilitative penal policies in Pennsylvania and the centrality of race in these changes. K. Leroy Irvis, the well-known African American politician who had led investigations into mental health institutions in the 1960s, sponsored the bill. By 1970 Irvis had become deeply concerned with the rise in police brutality and city riots. For instance, in 1968 he appeared as a guest on a major television series, *The Urban Battleground*, which documented the growing riots and civil rights protests in Pittsburgh.[39] In response to de facto segregation and urban uprisings in Pennsylvania's cities, Irvis fought for fair housing and civil rights and also changes to the criminal legal system.

Irvis decided that the best way to change corrections was to reform sentencing. At the time, incarcerated people had to wait until they completed their minimum sentences before appearing at the Board of Probation and Parole. If the board chose not to release them, they had no choice but to serve the maximum sentence. After a long period of negotiations, Irvis, the Bureau of Correction, the Board of Probation and Parole, and the attorney general's office developed an alternative means of sentencing: the Good Time Bill abolished minimum sentences for most male prisoners.[40] The legislation did not erase maximum limits, just minimums. In this arrangement, if the prison system found that people in prison were ready to return to society before their maximum limit, they released them. Notably, the new sentencing rules

echoed the old mental health laws that allowed for individuals to be committed until the institutional staff deemed them ready to return to society.

Irvis first introduced the legislation in September 1970 and cast it as "the beginning of hope and the end of despair for many men."[41] He argued that the bill was "certainly not the whole answer to the problems in our correctional system, but it is a very substantial beginning. The principles actualized here of earned credits and individualized treatment can and will offset the dehumanizing conditions, the hardening, the hopelessness, the tragedy of the present situation."[42] Rehabilitative sentences to Irvis meant that the state would view the individuals in prison as people deserving of a second chance.

The Bureau of Correction supported the bill, since the agency had already administered similar programs in its juvenile and women's facilities and liked the model. Ultimately, an indeterminate graduated sentence gave more discretion to the bureau, which governed the treatment programs and helped to determine when inmates could leave the institution.[43] The legislation also fit well with the bureau's new emphasis on rehabilitation and community corrections under the guidance of its head Allyn Sielaff. In the era of liberal prison reforms, the move toward more indeterminate sentencing fit well with the agency's mission.

Nevertheless, the legislation came under attack. Advocates on the left argued that the law gave prisons too much discretion while questioning whether prisons could be rehabilitative at all—the cornerstone of community corrections efforts. Victor Taylor, who had recently left SCI-Graterford, vocally opposed the bill. Taylor had worked at the Barbwire Society, a prisoners' rights group, and at the time of the Good Time Bill he was the executive director of the Prisoners' Rights Council.[44] Taylor served as a program director, providing counseling services for inmates and ex-inmates.[45] As a formerly incarcerated person, Taylor had a deep commitment to the ideals of shorter sentences and prison reform. Nonetheless, he did not support House Bill 680, "the so-called Good Time Bill," and declared it downright "horrible."[46] He explained in a letter to ACLU executive director Spencer Coxe, "From a practical point of view though, we would like to see an ideal 'good time' bill passed. One which diminishes time on the minimum while imprisoned, and off the maximum while on parole. Of course, we want no room for arbitrariness in the criteria. Further, we would like to see, from a practical point of view, a minimum sentence whereby lifers may secure their release. But HB 680 [the Good Time Bill]—Blah!!"[47]

Taylor and the Prisoners' Rights Council fought the bill with the help of

organizations like the Philadelphia Yearly Meeting of Quakers, the Pennsylvania Health and Welfare Council, and the ACLU of Pennsylvania. While both the Yearly Meeting and the Health and Welfare Council supported the movement for prison reform, they ultimately opposed the Good Time Bill because of the issues Taylor had raised.[48] Civil liberties and legal organizations, such as the ACLU, had previously been involved in questions of mental health confinements. In the 1960s the ACLU had opposed the indeterminate confinement of people defined as defective delinquents in the Dallas case. When faced with the passage of the Good Time Bill, the ACLU again mobilized against the indeterminate model. Spencer Coxe argued that giving the parole board too much discretion would create more arbitrariness in a prison system fraught with discrimination. "Reformers who think they know what prisoners want never bother to ask the prisoners, and almost invariably fail to realize that the worst aspect of the prison system is the total uncertainty about release dates and the total feeling of insecurity generated by the unbridled discretion of the Parole Board and the prison authorities."[49] Coxe's second, more damning, charge was that "rehabilitation is impossible in a prison setting," a statement that effectively gutted the notion that the Bureau of Correction could make a positive impact on people's lives at all.[50]

The ACLU's opposition to the Good Time Bill reflected not just its emphasis on civil liberties but also a broader shift within the legal profession. Attorney Alan Davis, who worked on the Mental Health Procedures Act, became the face of the Philadelphia Bar Association's opposition to the bill. Davis had argued the case against the indeterminate sentence for women in 1968, and he relied on the legal challenges in that case to make the bar association's argument here.[51] The Pennsylvania Supreme Court had declared indeterminate sentences in the women's system unconstitutional, he argued, and the comparable law for defective delinquents had "resulted in the long-term warehousing of mentally retarded offenders, and was, therefore, repealed by the legislature. . . . Thus, enactment of an indeterminate sentencing law in Pennsylvania would be a step backward to a philosophy and system already discredited in jurisdictions where it has been tested." Davis's other major critique—in addition to these legal challenges—was that the bill relied on the concept of rehabilitating people *inside* the prison. As he stated, "There is no evidence whatsoever that rehabilitation programs conducted within a prison setting can in fact lead to any significant rehabilitation. . . . Thus, the modern trend is to use prisons for diagnosis and referral, and to depend on community-based programs for actual training, education, and therapy. House Bill 680, if taken

seriously and implemented, *will divert rehabilitative resources into institutions where they have already been proven to fail, and retard the progress toward community based rehabilitation*."[52]

The Pennsylvania Prison Society, an internationally known organization founded in the eighteenth century by such luminaries as Benjamin Rush and Benjamin Franklin, also came out against the Good Time Bill. The Prison Society had stood as a central advocate of rehabilitative reform in the early 1960s, but it became wary of that model after a recent study called California's indeterminate sentence system a failure. Because of the systematic abuses in California, the Prison Society ultimately recommended that the bill should be "rethought in light of recent research and re-evaluation of rehabilitation in the institutional setting."[53] The anti-authoritarian positions on the left challenged government authority over both mental health and corrections. The anti-institutionalism that had come out of the 1960s led civil libertarians, prisoners' rights activists, and legal professionals to oppose additional rehabilitative programs within the prison system, similar to the challenges to rehabilitation in custodial mental hospitals.

While Irvis and Bureau of Correction officials attempted to humanize the system, they did not ally with prisoners' rights advocates, who described a racially discriminatory parole system and who had little faith in rehabilitative sentences. They did not understand that graduated sentences led to longer commitments. Instead, Irvis and the other liberal policy makers maintained their faith that the government could reform its troubled citizens through the criminal legal system. Irvis intended to fight racist penal policies with graduated sentences, which he thought would shorten prison times. Because he did not work with incarcerated people and their advocates, however, he failed to consider their lived experiences of having graduated sentences lengthen their stay. Irvis and other liberal legislators—both black and white—sought to maintain state rehabilitation rather than scale it back.

Soon after Irvis introduced the Good Time Bill in the fall of 1971, news of the Attica prison uprising reverberated across the nation.[54] Following months of activism to improve conditions at the prison, a riot broke out on September 9, 1971, and Attica's incarcerated population took control of the facility. Notably, the men did not demand their release, calling instead for more rights and basic humanitarian conditions. The activists, many of whom were black, used megaphones to broadcast their calls for justice to reporters and other people listening on the outside. As they did so, powerful armed forces gathered outside prison walls, and in just a few days Governor Nelson Rocke-

feller sent 500 armed state troopers to retake Attica by force. These troopers killed 41 incarcerated people and guards and injured almost 100 others while taking back the institution.[55] The mainstream media circulated the myth that the prisoners had slit hostages' throats before state troopers invaded. Even though the medical examiner found no truth to these stories, the media did little to rescind the falsehoods, which caused many whites to blame the incarcerated people themselves for the terrible violence there. These myths distanced a number of people from the charges of injustice made by those inside the prison.[56] The televised footage of the war zone at Attica fed fear among many whites of people convicted of crimes and people in prisons, a fear that had been growing since the 1960s. It also led the public to increasingly call for more punitive—rather than rehabilitative—prisons.

Only one month after Attica, the Good Time Bill came up for debate in the Pennsylvania legislature. The emphasis on humanizing prisoners and rehabilitation came under vehement attack from conservatives. Frank Lynch, a white Republican lawyer from a predominantly white suburban county, spoke out against the bill: "What we are doing is turning over to a bureaucratic agency, whose track record has been very poor in the last few years, the entire discretion that our judges have at the present time. . . . You can see, as one member has already stated, that the prison doors could swing wide if the majority of the members of the Board of Probation and Parole have the same philosophy as, let us say, a William Kuntzler, who does not believe in punishment at all."[57] Lynch charged liberals as soft on crime, and he argued that their policies created more danger on the streets.[58] Other law-and-order conservatives agreed with Lynch, and they vilified state officials as radical liberals who let people convicted of crimes run rampant. These conservatives supported criminal court judges having the power to determine sentences, rather than state officials, whom they viewed as conducting liberal and dangerous experiments.

State Representative Harry Comer, a white Democrat from Philadelphia, took a strong law-and-order position and opposed the Good Time Bill. Notably, when it came to mental health institutions, Comer had supported rehabilitative reforms at the Pennhurst State School. After visiting Pennhurst in 1969, he helped pass a $1.6 million grant to improve and increase the number of staff to make the facility better for the individuals living there.[59] In this case, Comer did not believe that Pennhurst should warehouse people; instead, he wanted the institution to help them gain skills to return to society.

When it came to crime and punishment, though, the "flinty" legislator re-

jected the rehabilitative approach. Comer championed capital punishment, even calling for the reinstatement of the death penalty for people convicted of rape. He was so outspoken on this issue that his 1990 obituary reprinted one of his most famous statements: "The people want these killers and murderers put away, and put away for good. . . . We don't care how we get rid of these kind of people. They gas mad dogs and these are the same as mad dogs."[60] When the Good Time Bill came to the legislature, Comer railed against the proposed reforms. At one hearing, he stood in front of the body and declared, "Fortunately, Mr. Speaker, we have judges and juries back home who have some people who are standing up and are trying to remove the murderers and the rapists from society in order that our families can have some safety. If we should be foolish enough, Mr. Speaker, to pass House Bill No. 680, we will literally be opening wide our prison doors and turning many of these animals loose on society again. If we want to help anyone, it should be the poor victims of these criminals."[61]

Comer played on fears of sexual violence and physical harm by deploying the phrase "murderers and rapists," even though these people made up only a small number of incarcerated people. To Comer and his supporters, prisons should not support people convicted of crimes with job training, education, or addiction counseling but instead should punish and segregate them from society. Comer did not oppose, however, the rehabilitation-based reforms that the Pennsylvania Program for Women and Girl Offenders had proposed for incarcerated females. Comer argued that male criminals particularly threatened their communities and thus needed segregation, which resonated with many legislators.

When Comer deployed the words "murderers and rapists" to argue against the Good Time Bill, he tapped into political discourse that used racially coded language to describe criminals as African American men. In their discussions of the Good Time Bill, Comer and Lynch never said that the incarcerated people in question were black, and at no point did they explicitly use racial terms to describe the criminals. In this way, the language was seemingly colorblind. Yet words like "murders and rapists," "animals," and "jungle" brought a racist undertone into the debate. Criminality was historically associated with African Americans through popular discourse and statistical analyses.[62] The media portrayal of the uprising at Attica in particular had proliferated the image of the dangerous African American person in prison as violent and a threat to society.[63]

The racially divisive conservative responses to the Good Time Bill did not

go unchallenged, and a number of black legislators rallied in Irvis's defense. Hardy Williams, an African American freshman legislator from Philadelphia, read a letter from Graterford prison's Brotherhood Jaycees to the other legislators. By reading the letter, Williams challenged the stereotypical images of incarcerated people that Comer and other conservative politicians offered and argued for the return of these people to their communities. Sarah Anderson, an African American legislator with experience in mental health reform, echoed Williams's sentiments. Anderson spoke from the perspective of a victim. She told the legislature how years before an assailant had hit her with a pipe, seriously injuring her. Still, she humanized her attacker and prisoners. The legislators should, she said, "begin to go out and open the door to take care of other mothers' children. We should rehabilitate them because they are American citizens and we want them to become as near like us as possible."[64] Williams and Anderson did not directly invoke race or racism in their speeches. However, they crafted their positions in direct opposition to the law-and-order position. They called for the continued humanization of people in prisons and their integration into—not segregation from—society.

The final speech of the day came from Irvis, who much more directly fought the notion that people in prison were like animals in a jungle. Irvis pressed the legislature to look at this dehumanizing language and to link it to white supremacist ideologies.

> Is it not interesting that on each side of the aisle we had at least one member remove certain human beings from the category of being human by the name-calling technique? That is an old, old technique and it works, but it is wrong, no matter where it comes from. We have to make up our minds, maybe not today, but some day in our lives—whether we consider the men and women whom we put behind bars as animals or human beings, the same way as we have to make up our minds . . . whether policemen are pigs or human beings. We have to make up our minds, Mr. Comer, whether or not the men and women we put behind bars are animals or human beings. That is a basic consideration, and we have to decide that first before we can go anyplace else.[65]

According to Irvis, the legislature should take a stance of compassion and forgiveness toward people convicted of crimes. He said that by not taking action, the legislators would follow in the footsteps of Adolf Hitler, who had "got rid of people who displeased him," using dehumanization to do so.[66] Here, Irvis spoke as part of a broader black response against a purportedly color-blind

system. To him, the language of "animals" provoked a discourse of fear, which led to the continued segregation of black men in prisons.

Irvis not only fought to make "rehabilitation of the criminal the prime purpose of imprisonment"; he also took the notion of state-sponsored rehabilitation and offered it as a solution to crises of violence in cities, the rise of white law-and-order conservatism, and the placement of large numbers of African Americans in prisons.[67] But in the early 1970s—in the face of Attica, civil challenges to state authority, and the loss of faith in government and law-and-order conservatism—he fought an uphill battle. As a result, while the Good Time Bill passed Pennsylvania's House of Representatives 110 to 73 and went on to the Senate, it ultimately stalled in the Senate Judiciary Committee in 1972 and did not make it out of the committee.[68] By comparison, Irvis's second prison bill, which called to establish women's treatment centers, sailed through both the House of Representatives and the Senate.[69] The law-and-order movement had its first major victory in Pennsylvania with the defeat of the Good Time Bill.

The rejection of the Good Time Bill reflected an impulse that echoed the shift in mental health commitment laws. The legislature kept men's prison sentences so that they had a set period of time in which people could be confined. That mirrored the mental health laws that very specifically defined how and for how long people could be committed to mental hospitals. Second, the rejection of indeterminate sentences established more procedural safeguards that governed the involuntary confinement of people in prisons.[70]

At the same time that the rehabilitative ideal in prisons came under attack, so too did community corrections programs, which resembled efforts to better integrate mental health services into the community. This fight over community corrections became acute in the racially divided city of Philadelphia. Furloughs from Graterford—one of Philadelphia's state prisons—provoked particular public concern. While politicians never blatantly used race to describe individuals on furlough from Graterford, the people held there were predominantly African American, making up 90 percent of the prison population.[71] After the escape of one person (out of hundreds) from Graterford, furloughs came under intense fire from new mayor Frank Rizzo and District Attorney Arlen Specter. Rizzo called the program "a mockery of justice," while a spokesperson for the district attorney's office called it "'absurd' to free hardened criminals to walk the streets."[72] Fears of sexual crimes also inflamed public opposition to community-based programs. In 1973, First Assistant District Attorney Richard Sprague decried the furlough

of a person convicted of burglary, robbery, and assault with intent to ravish and rape.[73] Conservatives blamed liberal prison officials for making the streets more dangerous with community corrections programs.

Judges also came out against the prisoner release program. One survey, for instance, found that 80 percent of judges who responded expressed dissatisfaction with the new reforms. One northern county judge even wrote, "The present attitude of the Bureau of Correction administering the program is such that 'they' need the mental treatment." A small mountain county judge concurred, writing that judges were being "emasculated . . . by the long-haired Utopians of the Bureau of Correction."[74] The judiciary had become a powerful force fighting against the community corrections programs. Notably, neither the judges' nor the district attorneys' offices distinguished between violent and nonviolent offenders. To them, all people convicted of crimes posed the same danger to the public. They did not attempt to create a more nuanced program that addressed varying threats to communities.

People in prison also struggled with the community corrections programs. The Prisoners' Rights Council received numerous letters from incarcerated people, many of which complained about the arbitrary denial of furloughs and participation in work release programs and state officials' power over who got let out of prison and when.[75] When making decisions, state officials could discriminate based on race or class or even on whether they liked the prisoner. Thus, while the organization promoted efforts to give social support to convicts in the community, it did not approve of such support happening under the discretion of the Bureau of Correction. Spencer Coxe believed that community corrections efforts gave "the authorities more ways to coerce prisoners."[76] While in principle, the ACLU and prisoners' rights activists advocated alternatives to the prison, they found the Bureau of Corrections' power discriminatory. Liberals and leftists disagreed over the nature of alternatives to prisons as a larger strategy for change.

In 1973 the Pennsylvania state government faced financial hardship, and its politicians chose to cut government services. In an era of economic crisis, social services cuts, and critiques of rehabilitation, community corrections programs went on the chopping block, even though they saved the government money. That year, the liberal commissioner Allyn Sielaff left his post for a better-paying job in Illinois. Instead of appointing a successor as liberal as Sielaff, however, the governor appointed Stewart Werner, a man who had far less enthusiasm for anti-institutional reforms. Werner expressed doubts about placing incarcerated people in communities, arguing that the state's diagnos-

tic and treatment techniques could not handle such a drastic change. The number of prisoners released on parole plummeted, commutations became rare, and eligibility for community services became greatly restricted. At first, prisoners had to serve at least half of their minimum sentence to leave on furlough. Then, in 1975, the Bureau of Correction tightened requirements even more.[77] And even though the legislature had recently passed a bill to fund regional treatment centers for women, the fiscal crisis put those programs in jeopardy as well.[78] Just as the legislature cut welfare programs seen as serving black women, they also cut these more treatment-oriented corrections programs.

In Pennsylvania, the end of community corrections led to new prison construction. By the mid-1970s the Pennsylvania Bureau of Correction had initiated plans to build new prisons. Although it had recently opened its fourteenth community treatment center, the bureau argued that it had become "more difficult to find a place to put them" due to public resistance.[79] In 1974 Commissioner Werner proposed a new maximum security prison to replace both the century-old Western State Penitentiary and Eastern State Penitentiary, which had closed a few years earlier. The new prisons would not be "huge walled prisons in the old sense, but rather treatment-oriented institutions, which would meet national penology standards."[80] Regardless, the experiments with prerelease programs, furloughs, and community treatment centers had come to a close. Even though Pennsylvania—like the rest of the country—experienced financial turmoil in the early 1970s, the state continued with $60 million of new prison construction.

The changes in Pennsylvania reflected the national rejection of prison rehabilitation and the embrace of the punitive prison in the 1970s. President Nixon's Department of Justice also made a spate of conservative sentencing proposals, including ending parole, compensating victims, and creating a new Sentencing Commission. A young Department of Justice attorney worked on these reforms—Dick Thornburgh. The reforms of the Nixon administration flew in the face of the anti-institutionalism of the 1960s. The proposal to end parole, for instance, would have made it much harder for people to leave prison early. While none of the proposed federal reforms took hold, they reflected a growing backlash against correctional anti-institutionalism in the 1970s. They also were a harbinger of what was to come in Pennsylvania, as Thornburgh brought these conservative ideas back to the state as governor in 1979 and later as attorney general of the United States under President Reagan.[81]

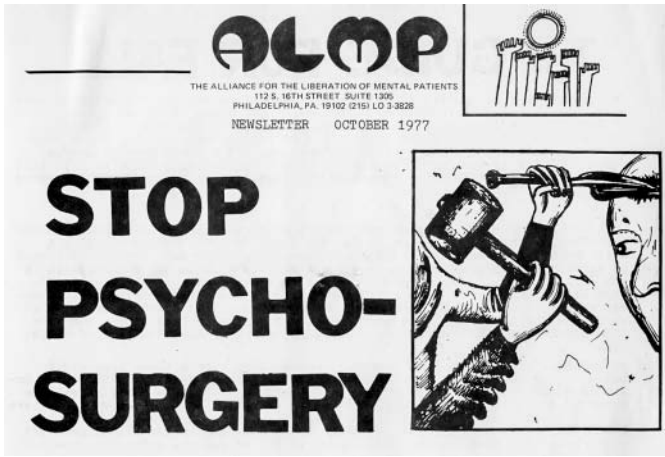
Community-based corrections were particularly reviled in states with large African American urban communities, such as Pennsylvania, New York, and California. In 1973 New York passed the Rockefeller Drug Laws, which instituted harsh penalties for drugs, an issue that had historically fallen under the purview of mental health. In 1976 California governor Jerry Brown signed a law that ended graduated sentences in the state. The state's new penal code read, "The ultimate goal of imprisonment was no longer 'rehabilitation' but 'punishment.'"[82] Reporter Robert Kotzbauer wrote, "When prior leaders New York and California were backing off reforms, Pennsylvania took the nation's spotlight as most progressive. Now, however, there is a decided slowdown in changes. Some disheartened liberal critics even term it a retrenchment. Conservatives, on the other hand, may be happier."[83]

These changes particularly affected the African American community. As prisons became more punitive and as they grew in size, the rates of blacks locked up also rose. In 1940, 27.83 percent of people in Pennsylvania's prisons and jails were classified as nonwhite. That number grew rapidly and by 1980 had reached 52.59 percent—nearly doubling in size.[84] In the aftermath of the civil rights movement, new institutions were disproportionately removing black men from society. The racially charged politics of segregation had spilled over into the debates over prisons, and a racist form of custody began to proliferate.

The lines in the sand had been drawn. These northern and western states—with their histories of progressive penal reforms and large black urban communities—took up the punitive practice of using prisons to remove people from society. After efforts to move away from pure punishment in the 1960s, the prison embarked on its rebirth as an even more punitive and incapacitating place, a shift that caused the system to increasingly respond to individuals diagnosed with mental illnesses through policing and imprisonment.

Resistance to Criminalization

This criminalization of mental illness and the continued reliance on prisons did not occur without significant opposition, however. During the 1970s, the treatment of individuals diagnosed with mental illnesses and significant behavior disorders in the criminal legal system came under intense scrutiny. Controversies erupted about the use of behavior modification and the abuses exposed at Farview State Hospital, issues that concerned people involved in both the criminal and mental health systems.



"Stop Psycho-Surgery" graphic from a newsletter of the Alliance for the Liberation of Mental Patients, October 1977. (Special Collections Research Center, Temple University Libraries, Philadelphia, Pa.)

During this time, prisoners' rights activism coalesced with the emerging mental patients' rights movement. Philadelphia became a center for this activism because of its vocal prisoners' and patients' rights organizations. These included the Community Assistance for Prisoners; the Prisoners' Rights Council; the Prisoners' Defense Coalition; the Pennsylvania Program for Women and Girl Offenders; the Mental Patients Civil Liberties Project, organized by David Ferleger; the Alliance for the Liberation of Mental Patients; and the Pennsylvania Association for Retarded Citizens (PARC), the state branch of the larger national organization that assisted individuals with intellectual disabilities.[85]

Prisoners' rights groups in Philadelphia organized around issues including experimentation with psychotropic drugs, electroconvulsive therapy, and abusive medical testing at the infamous Holmesburg Prison. Since 1951, medical researchers had conducted experiments on the prisoners at the Holmesburg detention center in Philadelphia. The jail's population was 85 percent African American, and the majority of the people there had not graduated from high school. One such researcher was Albert Kligman, a University of Pennsylvania dermatologist. He conducted tests on the prisoners, who provided "acres of skin," as he called it. The tests included the use of products, such as the acne cream Retin-A, toothpaste, detergents, and psychotropic drugs. Because incarcerated people had few resources in Holmesburg, they often rented their

bodies for small amounts of cash. National publicity around the experiments in the 1970s—fueled by the activism of incarcerated people—led to the end of these abusive practices.[86]

The experiments at Holmesburg greatly informed the Philadelphia prisoners' rights movement, strengthening its opposition to abusive medical authority and treatment. Some organizers had themselves been victims of medical experimentation, and from their perspective, the state's use of medicine and psychiatry was not benevolent but deeply problematic. For instance, Leodus Jones—the head of Community Assistance for Prisoners and a prisoners' rights activist for thirty years—had survived medical experimentation at Holmesburg.[87] Activists with Community Assistance for Prisoners and the Prisoners' Rights Council also opposed the indiscriminate use of psychotropic drugs in prisons, which they argued sedated and suppressed the population.

Prisoners' rights organizations also opposed behavior modification units, such as the one at the federal prison in Butner, North Carolina. The activist literature repeatedly compared behavior modification programs to genocide, arguing that it was a way for the government to "deal away with politically conscious Black People" by harassing them, arresting them, and putting them in solitary confinement.[88] Prisoners' rights activists saw behavior modification as a new tool of oppression. Their pamphlets and handouts showed drawings of black men being lobotomized, visually representing programs to "make Black People totally submissive to white rule and authority" through coercive psychiatry in prisons and mental institutions.[89] They charged the government with conducting psychosurgeries, which altered prisoners' brains and took away their control over their actions.

So, when the state announced a plan in 1974 to create a behavior modification unit at Farview, these groups coalesced to oppose it. The Bureau of Correction had proposed a special unit for individuals who posed a serious danger to the residents, staff, or themselves.[90] The bureau suggested that it build the unit at Farview State Hospital for the Criminally Insane and gained support for this plan from the Governor's Justice Commission, the American Correctional Association, the Department of Public Welfare, the governor's office, and the American Federation of State, County, and Municipal Employees (AFSCME). In response, a number of groups formed the Coalition to Reduce the Causes of Prison Violence, which publicly denounced the behavior modification unit at Farview. Along with the ACLU, the coalition wrote letters to the editor and held meetings with the guards, treatment staff, and

union members, stating its opposition to the plan.[91] The pressure campaign succeeded, and in January 1975 the state canceled plans for this unit. Still, while it did not create a new behavior modification unit, it did eventually build a maximum security solitary confinement area.

In the fight over behavior modification, the prisoners' and patients' rights movements did not just challenge coercive psychiatry; they also challenged the very existence of these institutions themselves. The fight over conditions at Farview best exemplified this struggle. Acel Moore's articles about Farview in the wake of Robert "Stonewall" Jackson's death had galvanized activists in the nascent prisoners' and patients' rights movements to work to close the institution down for good. The Alliance for the Liberation of Mental Patients spearheaded this organizing in Philadelphia. A small number of self-described former mental patients formed the group "in order to combat the abuses of which we had been subjected in the name of 'mental health.'"[92] Funded by small grants and private donations, the organization set up an office and phone in order to "provide free factual information about psychiatric treatments and the legal rights of mental patients."[93] The organization also worked on a legal handbook for mental patients and the screening of *Hurry Tomorrow*, a documentary about life in mental hospitals.[94]

The alliance organized against Farview at the grassroots level, getting involved in the state investigations of the facility after Moore and Rawls's news coverage. It also held demonstrations against Farview at hearings that Governor Shapp held on maximum security psychiatric care in the summer of 1976. Its demonstrations received good media coverage, and it kept up the publicity by releasing a report on hospital abuses, titled *The Farview Papers*. The publication kept Moore and Rawls's findings alive and emboldened some activists to contact other individuals in the prisoners' rights community about closing Farview.[95] As the result of the ongoing investigations, press coverage, and activism, the Governor's Task Force and Governor Shapp announced that the state would close Farview by 1980.

Proponents of the closure faced the opposition of rural Wayne County, however. Farview provided a lot of jobs, and not just as state hospital employees. For instance, because the plant burned anthracite coal, people were employed to run the plant. Even as the task force proposed closing the institution, it also recommended that the state work to create economic alternatives in the area and to reuse the Farview facility in some way. The state also faced opposition when it proposed building smaller facilities to replace Farview near Pittsburgh and Philadelphia. State officials chose these cities so the insti-

tutions could sit closer to major medical centers and the communities where many people at the hospitals lived. But they fought an uphill battle with this plan because of "Not in My Backyard" opposition from local communities and because of the high cost of construction. While Governor Shapp had approved the closure of Farview, it ultimately remained open under the administration of Governor Dick Thornburgh.

The politics of mental hospitals and prisons did not occur separately but were intricately intertwined. A public sentiment of distrust of the state and of rehabilitation led to the criminalization of mental illness. In turn, the number of individuals diagnosed with mental illnesses in prisons and jails began to rise. This distrust also led politicians to be suspicious of the effort to deinstitutionalize prisons. While liberal politicians called for more rehabilitative and community-based services, conservative politicians took the opposite approach. They argued that prisoners deserved punishment rather than the reforms that patients in mental hospitals received. While deinstitutionalization continued for people in mental hospitals, it largely ended for people in prisons. In the 1970s the failure of rehabilitation and the rising popularity of law-and-order responses led policy makers to make prisons more confining and custodial than ever before.

This renewed custodialism in turn caused the criminal legal system to absorb some functions of the mental health system. The police increasingly arrested individuals diagnosed with mental illnesses, and the jail rates among this population grew. The criminalization of mental illness expanded, a phenomenon that continued into the twenty-first century. A small group of people—prisoners' rights activists, patients' rights activists, and civil liberties attorneys—critiqued the state's use of psychiatry among its most marginalized citizens, but they also critiqued the state's continued reliance on institutions like Farview. The wave of law-and-order politics only grew stronger in the 1980s, however, making it ever harder to advocate for noninstitutional responses to individuals diagnosed with mental illnesses who also broke the law.

Chapter Five

CRUEL CHOICES

The state policy of releasing patients without adequate support has turned the city's neighborhoods into mental wards and the police into hospital orderlies.

—New York mayor Edward Koch, *Life*, May 1981

In May 1981 an article appeared in *Life* magazine under the headline "Emptying the Madhouse." Its subject was the release of people from Northampton State Hospital in Massachusetts. The hospital had deinstitutionalized, so it now served only about 10 percent of the number it had served two decades earlier. The article featured stories of people such as Neal and Rita DeLuck, a married couple who had met at Northampton State Hospital. The hospital had released them in the midst of deinstitutionalization, and in 1981 they lived in poverty. Neal had a history of schizophrenia; Rita, a history of severe neurosis. The two were living in the unheated attic of a halfway house with a radio as their sole possession. Neal described their life together: "We're two happenstance nuts who cling together. . . . We have no hospital 'cause it's closing. We have nothing outside. But I don't need any follow-up care. I've got Rita."[1]

Rita's view of the relationship was more complicated. Neal was often violent toward her and once broke her jaw. She had called the police on him thirty times, and Neal cycled in and out of jail. Even though they contacted a dozen agencies while on the streets, they received help mainly from a crisis intervention team. The mental health system did not help them, and they suffered through the revolving doors of the hospital, the jail, and the halfway house. Neal had gone to the nearby Veterans Administration hospital twenty-nine times at the writing of the article. New York mayor Ed Koch used choice words to describe the situation in cities across America: "The state policy of

Rita and Neal DeLuck in their attic apartment,
photographed by Michael O'Brien in *Life*, May 1981.
(Used with permission of Michael O'Brien)

releasing patients without adequate support has turned the city's neighborhoods into mental wards and the police into hospital orderlies."[2]

Life's illustrated article came at a moment when the public was deeply concerned about the lack of community mental health services and the increase in the homelessness and imprisonment of people diagnosed with chronic mental illnesses. In the 1940s the magazine had published photographs of neglect within state hospitals; forty years later, it documented neglect on the streets. From all sectors, people offered solutions. The consumer/psychiatric survivor/ex-patient movement envisioned mental health consumers having more control over their own care. Mental health advocates called for a robust, government-funded, community-based mental health system. Prison officials sought to address the need for psychiatric services in their institutions and publicly rejected jails as an appropriate place for these individuals. Still, the 1980s saw these problems get worse, not better. Homelessness plagued the mental health community, and for some people a hospital-to-jail pipeline grew, catching people like Neal in its net.

In the 1980s policy makers and mental health advocates had learned lessons from the waves of deinstitutionalization in the 1960s and 1970s. This process was not new to them, and they understood the repercussions that oc-

curred when people left the hospital and did not receive adequate housing, employment, and medical services. The question is why—when so many people understood the problems and solutions surrounding the downsizing of mental hospitals—did deinstitutionalization continue to pose so many problems? Economics played a central role. The decade of the 1980s was a time of fiscal crisis, as states faced deficits and deindustrialization. In response, neoliberal politicians cut state budgets and shrank the social welfare state. Closing psychiatric hospitals and curtailing community mental health services often made up a central part of cost-cutting campaigns. In Pennsylvania, Governor Dick Thornburgh's administration pushed welfare reform legislation while also closing numerous state hospitals. While advocates called for more community-based funding, the money did not appear. As the sociologist Andrew Scull wrote in the 1980s, "Deinstitutionalization of the mentally ill, while securing the negative right to be free of organized interference in one's life, has all too often meant the denial of the positive right to care and attention."[3]

The rapid rise of the criminal legal system in the 1980s also significantly contributed to these problems of deinstitutionalization, a continuation of the trend begun in the 1970s.[4] During the 1980s, state governments poured money into their prisons, and the number of people in correctional institutions spiked, a development that lasted into the twenty-first century. The government's priorities shifted from social welfare to policing and imprisonment. The push to build prisons drained the money needed for housing, food, employment, and access to medical care for people diagnosed with mental illness. In Pennsylvania, while the state closed hospitals, it allocated hundreds of millions of dollars to build new prisons beds. The state created a task force on mental health and corrections, which recommended expanding psychiatric services in prisons and jails rather than better support services in the community. In the early 1980s, people increasingly encountered state psychiatric services at the point when they broke the law—receiving mental health treatment in prisons and jails. This differed from a system in which people first encountered mental health services at their point of need.

One could conceive of these trends as discontinuous—that social welfare services shrank in isolation from the growth of the criminal legal system. However, a close look at developments in mental health reveals continuities. Mental hospitals had once made up a large portion of the carceral state. As they decarcerated, money shifted to another part of the carceral system—prisons and jails. The confluence of conservative cost cutting, cultural

attitudes of fear regarding criminality and mental illness, the law-and-order movement, and the economic ties that localities had to their institutions fueled the shift from hospital to prison. Deinstitutionalization powered the rise of mass incarceration, which in turn disproportionately affected people with mental health diagnoses.

Personal Ties to Mental Health

Over the course of Dick Thornburgh's term as governor, he pursued a platform of deinstitutionalization, calling for the closure of a spate of mental health institutions. Issues such as disability and mental health were deeply personal for the governor.

In 1960 Thornburgh's wife and three sons suffered a tragic car accident. Thornburgh's wife, Ginny, died, while his infant son, Peter, only a few months old at the time, suffered skull fractures and severe brain injuries. After extensive treatment, Peter survived the accident, but doctors diagnosed him as "mentally retarded," the term used in the 1960s. Three years later, Dick Thornburgh remarried another Ginny. This Ginny Thornburgh became "second mom" to Thornburgh's three sons, and they later had a fourth.[5] The year after Dick and Ginny married, Peter began attending day school at the Home for Crippled Children, now called the Children's Institute. The school served many children with polio, and Peter entered as the first student with a brain injury. Ginny said that the home made an immediate difference in their lives and recalled that Peter "received speech therapy, occupational therapy, [and] physical therapy, and I received an education."[6] In 1968 Peter left the Home for Crippled Children, and Dick and Ginny faced the question of whether to place him in an institution.

Friends and doctors encouraged Dick to institutionalize Peter, but Dick and Ginny ultimately refused. Dick wrote about the decision in his autobiography. "We had always kept in mind the possibility that Peter might someday have to be institutionalized," he said, "but as time went on, we became more and more determined to keep him within the family that he had enriched beyond description and to which he meant so much."[7] The Thornburghs' reluctance to place Peter in a state center reflected the rising sentiment against state mental health institutions during that time. A spate of confessional books by parents, including Pearl Buck's *The Child Who Never Grew* and Dale Evans Rogers's *Angel Unaware*, brought the issue of mental retardation directly into the spotlight. These authors resisted the discrimination that often accompa-

nied mental retardation and argued that many people considered it as both normal and unique in a positive way.[8] Eunice Kennedy Shriver's 1962 article in the *Saturday Evening Post* strengthened this perspective, as she publicly acknowledged that her sister Rosemary Kennedy had mental retardation. This admission from one of the country's most powerful political families made a strong statement about disability as a normal part of the human experience.

Meanwhile, many parents organized support groups and organizations across the country, advocating to make conditions in institutions better and to build more beds to accommodate the long waiting lists. As a result, the number of people in state schools for people with intellectual disabilities grew rapidly between 1946 and 1967. Not all parents sought reform in institutional settings, however. Many drew inspiration from Dale Evans Rogers and argued that children could live at home and receive an education in the public schools. This question became even more pressing with scandals at a number of state schools. In 1965 U.S. senator Robert F. Kennedy publicly attacked the poor conditions at the Rome and Willowbrook State Schools in New York after he made an unannounced visit there. The following year, Burton Blatt and Fred Kaplan published a photographic essay, "Christmas in Purgatory," which *Look* magazine reprinted.[9] Institutions were deeply fraught in the 1960s. In that context, the Thornburghs faced the question of how to help Peter.

Ultimately, they decided to keep him at home and to work within the education and welfare systems to get him community-based supports. After Peter left the Home for Crippled Children, Ginny and Dick enrolled him in public school. When Ginny went to the school, however, she found that the students with disabilities studied in a room in the basement where they all made potholders. "The whole environment [of the school] said low expectations. These children, we do not expect much from them, and we're not going to give them very much. I stormed up the stairs and stormed into the principal's office, and announced that I was probably going to be one of his new parents, and that I found that classroom totally inaccessible . . . and he said words that are burned in my heart. He said, [the children] don't care. They don't care. And it was just—that was the beginning—one of the beginnings of my transformation from being a concerned mother to being an activist."[10] The experience of seeing poor conditions for people with disabilities in the public school system prompted Ginny Thornburgh to join the ARC and become a disability rights advocate.[11] The National Association for Retarded Children (NARC) had formed in 1950, and by 1960 it had 681 locals. Predominantly white mothers

and fathers of school-age children from a range of social classes made up the membership of NARC. Yet even with class diversity in the ranks, many of the local NARC groups focused on issues facing middle-class families rather than impoverished ones.[12]

Ginny Thornburgh first became involved with the Allegheny County chapter of the PARC. Early on, she conducted unannounced tours of public and private institutions with two other mothers and the head of the Allegheny ARC, Bob Nelkin. She thought of them as a group of "mother bears" who visited places such as Western State Center, Polk Center, and Ebensburg, prompted by reports of abuse or neglect they received from staff or family members. They would go to the institutions, inspect the conditions, and then meet with superintendents and state officials and sometimes even contact legislators about making improvements. In an oral history done later in her life, Ginny Thornburgh vividly recalled the toilets at Polk Center. She remembered that they did not have seats and there were no screens between the toilets, giving people absolutely no privacy. She also remembered a room at Ebensburg with tiles on the floor and the walls, which made it easier for staff to hose off feces and urine. When she visited the tile room, about twenty young men sat on the floor with their legs in front of them while a man walked back and forth in front of them "like a prison guard . . . twirling his keychain . . . in a menacing way."[13]

Ginny fought tirelessly to change those conditions. As Bob Nelkin recalled, "Where others would fall by the wayside, Ginny would just keep at it and at it."[14] Ginny became involved in juvenile justice and prison reform at the same time and recalled that at some points, "I was so radical that I really was causing, at moments, some harm. . . . We would go to a dinner party and I would almost cause a scene because the person next to me wasn't sensitive to the handicapped or didn't know about prison conditions."[15] Ginny became committed to reforming state institutions, predominantly focusing on those for people with intellectual disabilities while maintaining a limited interest in correctional institutions as well.

Ginny Thornburgh brought this zeal to the presidency of the Allegheny County ARC in 1974, a time when PARC had become a main challenger of state institutions in *Halderman v. Pennhurst*. Her activism and involvement in these battles around state centers directly connected the Thornburgh family to the anti-institutionalism and disability rights activism of the time.

The Shrinking Social Welfare State

It is impossible to understand the crisis of deinstitutionalization in the 1980s without understanding the simultaneous rise of the neoliberal politics of austerity. Ronald Reagan's presidency marked this ascendancy, as his administration confronted the economic decline of the 1970s by arguing that the way to prosperity was through a smaller government. In turn, the Right advocated deregulation, small government, and tax cuts. Pennsylvania exemplified these political reforms under Dick Thornburgh, a Reaganesque Republican governor. Thornburgh's neoliberal approach led to the closure of mental hospitals without adequate community mental health services to compensate for those closures.

Thornburgh had started his career in law, and after working in the attorney general's office at both the state and federal levels he turned his attention to political office. In 1979 he won the seat of governor in Pennsylvania, supporting the ideologies of limited government and free enterprise that the Republican Party espoused. Thornburgh considered himself a moderate, and he entered the political arena to strengthen the GOP tenets of "the individual, the free-enterprise system, fiscal responsibility, strong state and local governments, and a combination of toughness and compassion at home and abroad."[16] To him, conservatism was protecting people from the "bigs," including big government. As he later reflected, "Society is best served by limiting government interference in the day-to-day affairs of individual men and women who are trying to make a living, raise their families, worship their God and improve their quality of life."[17] Herein lay a central tension. Thornburgh and other Republicans opposed government interference, but they promised to protect people deemed law-abiding citizens. They did this by expanding police departments and criminal justice systems. While conservatives often did not support large social welfare services, they did support the state's security apparatus, a distinction that was later a major part of Thornburgh's statecraft.

Within months of taking office, Thornburgh faced a national crisis after one of the nuclear reactors at Three Mile Island had a partial meltdown. He received accolades for his response—including from President Jimmy Carter, who visited the site.[18] Thornburgh used this popularity to implement dramatic reforms in the state's domestic policies. Pennsylvania was struggling economically in the 1980s, as was the rest of the country. The 1979 oil crisis had caused a recession, and deindustrialization in the mining regions hit the

state hard. In this time of economic turmoil, Thornburgh's primary goal became balancing the budget, with attention given to reducing the state's social welfare bureaucracy. He announced that the "best social program is a good economy" and touted his commitment to a "smaller and more efficient government."[19]

Thornburgh focused on cutting social services to people whom the state failed to see as "truly needy." The governor's particular target was the General Assistance program, which provided money to nondisabled people without children who could not receive federal benefits. Many people accused General Assistance recipients of being "healthy young adults who could find work."[20] Because of this assumption, Thornburgh passed legislation—nicknamed "Thornfare"—that eliminated "any childless person considered able-bodied or employable" from the General Assistance rolls.[21] The Thornburgh administration was not alone in cutting social welfare services this way in the late 1970s, as a number of states—including Massachusetts and New York—did the same.[22] These welfare policies hinged on cutting money for people deemed not in need of services. Instead, legislation such as Thornfare focused on proving that the General Assistance funds went to the "truly needy"—a widespread term in welfare reform that often focused on the elderly, people with children, and people with disabilities.[23] This concept of being "truly needy" was informed by Thornburgh's experience with his son Peter, a person with intellectual disabilities. Peter Thornburgh received social welfare funds and services—personal information that became public news—while Thornburgh implemented social welfare cuts.[24]

The largest cuts came from the budgets of the Department of Public Welfare and the state's psychiatric hospitals. The reductions to the Department of Public Welfare alone accounted for nearly half of the state's cuts, over $473 million. The cuts in welfare came from investigating welfare fraud, closing the state hospitals and state centers, pursuing third party liability for medical claims, and removing people deemed able-bodied and employable from General Assistance.[25] The state's responses to deinstitutionalization happened within this context of neoliberal efforts to shrink the state and to fight the movement for the civil rights of people with physical, intellectual, and psychiatric disabilities.

Thornburgh linked his personal experiences with state services for people with intellectual disabilities to his administration's mental health policies. In a speech Thornburgh gave to PARC, he captured these connections between the personal and the political. Thornburgh began the speech by sharing his

knowledge of the "problems and joys of Pennsylvania families who have members with mental retardation."[26] He spoke about the pride he felt in Peter's "ability to live relatively independently of his mom and dad in a group home in Harrisburg," and he also acknowledged, "Peter's progress has depended on the efforts of countless individuals and organizations, public and private, who were there to give the Thornburghs a much-needed hand along the road."[27] He translated those feelings into policy, continuing, "And that's why, at my urging, our state budget for community services for the mentally retarded should soon be more than double what it was when I first took office."[28]

The Thornburgh family had benefited from community services for Peter. As a result, Dick Thornburgh's administration increased community funding for people diagnosed with mental retardation, even as he cut other social services. During his time as governor, state funding for community-based services exceeded money spent on institutions for the first time, as the state created centers for independent living, hired attendant care providers, and supported work initiatives. In Thornburgh's final budget, he allocated $243 million toward improving and expanding community-based programs for people.[29]

While Governor Thornburgh pushed for major funds for people with disabilities, issues of mental illness did not fall into this category. His administration proposed an executive budget in 1979–80 that allocated only $1.9 million for community-based residences for people diagnosed with mental illness across the state. This amount hardly scratched the surface of the cost of these services. The lack of funding for these community-based programs stemmed from a belief that mental illness should be cured rather than supported long-term. In 1978, Thornburgh gave a speech reflecting this perspective. In it, he recounted his and Ginny's experiences with their son Peter. "Through him," he said, "I know the problems that handicapped people face. I also know their potential for growth, their potential for independence—for I have seen it first-hand."[30]

In another talk, Governor Thornburgh discussed how people with disabilities needed supportive services to stay in their homes and called for a "variety of living arrangements" for individuals with disabilities and their families from which to choose.[31] This mentality, however, did not affect Thornburgh's view of mental illness. He repeatedly used the term "mentally restored" to describe people who had received mental health treatment. He stated, "Many citizens who have suffered from an attack of mental illness, but are now mentally restored, are already educated or trained in skills. But the public needs

to be educated to accept the mentally restored back into jobs suitable to those skills." He concluded the speech with a series of intentions, including, "I want a state that recognizes mental illness is not a stigma, but an illness from which a person can be fully restored."[32]

To Thornburgh, a person was sick with mental illness. He or she would receive treatment, and the state would help reintegrate the person back into society. This was markedly different from the state's response to disabilities. By thinking of mental illness as mostly curable, it failed to help people diagnosed with chronic mental illnesses, who often needed cash assistance, housing, work programs, and access to medical care.[33]

Richard Lonsdorf, president of the Mental Health Association of Southeastern Pennsylvania, wrote to the governor in protest of the inadequate funding for programs for people diagnosed with mental illness. He cited a Temple University study that found "an estimated 6800 persons with emotional or mental problems in Philadelphia's boarding homes."[34] Lonsdorf focused on people whom the local Mental Health Association called "the deinstitutionalized," and he stated that $15 million or more was needed to provide adequate services. This was many times the amount that Thornburgh had allocated in his executive budget.[35]

Charles Thomas, president of the Mental Health Association of Pennsylvania, wrote, "'This is just more of the same.' We are angry and frustrated that there continues to be no long-range planning for increased support of the community MH/MR system—no innovations to shift fiscal focus from the institution to the community."[36] The Mental Health Association leaders spoke out of concern for people like Rita and Neal DeLuck, who had found almost no access to housing, psychiatric services, or employment. They saw how easy it was for people diagnosed with chronic illnesses to fall through the cracks, and they argued that the state was obliged to provide community resources for them. But in an era of shrinking state services, they faced a Sisyphean task.

The opposition to this deinstitutionalization without adequate social services came not only from the left, however, but also from the right. In 1979, for example, Charles Krauthammer blasted antipsychiatry advocate Thomas Szasz in the *New Republic*. Krauthammer trained as a doctor and later became a political writer. In "The Myth of Thomas Szasz," he called the antipsychiatric psychiatrist "a polemicist" who "spawned an entire movement of antipsychiatry, complete with schools, sages, and, of course, schisms," and ac-

knowledged that Szasz's work had led to the altering of commitment laws, creation of self-help groups, and establishment of legal defense funds for people in mental hospitals and patients' bills of rights.[37] Krauthammer described Szasz's work as "compassionless libertarianism," which offered no assistance for individuals with disabling mental illness. Krauthammer argued that Szasz's stance against paternalist psychiatry was like watching someone fall off a bridge and doing nothing.[38] The advent of civil rights abandoned people who experienced homelessness and mental illness rather than freed them, according to Krauthammer. His solution—which he spelled out in a *Washington Post* essay—was to roll back the involuntary commitment laws. Changing the laws would facilitate committing people to asylums where they would at least receive housing, food, and treatment.[39]

Gerald Weissmann, another medically trained commentator, also vehemently critiqued antipsychiatry. In "Foucault and the Bag Lady," published in *Hospital Practice*, he opened by narrating the story of a woman he called Mrs. Kahaner. Mrs. Kahaner was admitted to the emergency room at Bellevue Hospital with frostbite. She had a diagnosis of chronic schizophrenia and sclerodoma, a debilitating and potentially fatal disease. Mrs. Kahaner had lived on the streets except for short stays at hospitals, during which she received brief treatments for her physical and mental illnesses. Weissmann told her story to illustrate that society, after the waves of deinstitutionalization, no longer provided what he considered the benefits of asylums and that people diagnosed with mental illness had lost a retreat in which to heal. He blamed that loss on new drug treatments and fiscal cuts such as the ones proposed under Thornburgh. The people he blamed most of all, though, were the "well-meaning advocates of civil rights."[40]

Weissmann's and Krauthammer's essays reflect an early conservative assault on antipsychiatry and the rise of patients' civil rights. They both directly tied these movements to the failures of deinstitutionalization. Neither took into account the work of the consumer/psychiatric survivor/ex-patient movement. While many of this movement's activists had disavowed psychiatric treatment, others—especially in the aftermath of Judi Chamberlin's book *On Our Own*, which argued for services controlled by psychiatric survivors—advocated for mental health services and supports implemented by such survivors, consumers, or ex-patients. For the most part, Weissmann and Krauthammer ignored the alternative treatments that were emerging in the 1980s. These antipsychiatry commentators marginalized the work of con-

sumer/psychiatric survivor/ex-patient activists, failed to acknowledge the serious problems with psychiatric power, and limited the rights of people in mental hospitals, which harkened back to the old mental health system.

From both the left and the right, advocates, activists, and political commentators offered alternative visions of how deinstitutionalization should proceed and how best to benefit people with psychiatric issues. These views, however, were overtaken by two elements of neoliberal policies. First, 1980s efforts to shrink the social welfare state led to the escalating closure of mental hospitals without adequate community mental health services to absorb the people in need of treatment. Second, prison construction campaigns restricted state funds for social welfare and led to the growth of psychiatric services within the prison system.

At the same time that advocates argued for more community-based services, Governor Thornburgh's interest in cost cutting led his administration to close public psychiatric hospitals. Psychiatric hospitals had undergone deinstitutionalization for years before Thornburgh took office, and the process was still underway when he became governor. At the beginning of his term, the state faced pressure to consolidate and eliminate state hospitals and hospital beds. First, changes in psychiatry and popular conceptions of mental health continued to promote providing psychiatric services in the least restrictive environment possible. Second, not all of the state hospitals met the standards set by the Joint Commission on Accreditation of Hospitals and Medicare, putting tens of millions of federal dollars at risk. Between 1979 and 1987, then, the Department of Public Welfare closed the Dixmont, Retreat, Embreeville, Hollidaysburg, Marcy, and Lawrence Frick State Hospitals, and it gave up control of the Eastern Pennsylvania Psychiatric Institute. By the time Thornburgh left office, only 8,000 people remained in state mental hospitals, and only 5,300 remained in developmental centers.[41]

The story of the Retreat State Hospital illustrates the reality of this wave of hospital closures. In March 1980, Governor Thornburgh announced that the state would close Retreat and transfer the people housed there to other facilities. Retreat was located outside the northeastern Pennsylvanian city of Wilkes Barre, nicknamed the "Diamond City" for its anthracite coal reserves. The hospital had opened in 1900 on the site of a former county poorhouse, and it predominantly served people diagnosed with mental illnesses. The facility reached its largest population in the mid-twentieth century, but by 1980 the hospital held fewer than 300 people, each of whom stayed thirty days on average.

Around this time, Retreat came under the scrutiny of the Department of Public Welfare. First, the hospital failed to meet the compliance requirements for Medicare, raising questions about the quality of its services.[42] In order to meet Medicare requirements, the Department of Public Welfare would have had to increase the budget for the facility by 16 percent, which ran into the cost-cutting mandate under Thornburgh. Second, the hospital had far fewer individuals than others in the state did. Because it sat near Danville and Clarks Summit, government leaders believed that those two institutions could absorb the people from Retreat.[43]

Relying on popular notions of fiscal conservatism and anti-institutionalism, Thornburgh and the Department of Public Welfare justified Retreat's closure as serving the interests of the taxpayers.[44] They claimed that the closure would save $4.6 million, along with $4.25 million in savings from a cancelled construction program. The administration even touted the closure in its yearly report, *Cost Reduction 2: Accomplishments and Actions*.[45]

The economic savings from closing Retreat State Hospital dovetailed with Thornburgh's commitment to reducing institutional care. PARC came out supporting the Retreat closure as part of its efforts to promote deinstitutionalization broadly. In the 1970s the organization had moved toward a "No New Institutional Construction" platform, and it opposed the state's building of new developmental centers.[46] In 1980 PARC was still embroiled in efforts to close Pennhurst—among other facilities—and the Retreat closure was another instance where the organization worked to reduce the state's reliance on institutional care. Members of PARC wrote letters to the editor, and other members appeared on TV and radio to advocate for the closure of Retreat.[47] The Thornburgh administration and the ARC came together around deinstitutionalizing psychiatric hospitals, even though they had different approaches to closing Pennhurst. The right to freedom from institutional living and the right to be part of a community permeated their positions.

Thornburgh's plan to shutter Retreat still raised significant questions for many about the lack of community-based social services for people diagnosed with mental illness. AFSCME, the union that represented Retreat State Hospital employees, came out against the closure. The union argued that the closure would hurt the people in the hospital themselves, particularly since the state was making so many cuts to social services. Richard Kirschner, the father of a person at Retreat and an AFSCME attorney, became a spokesperson for the cause. He called the closure "insensitive" and argued that "'this case is being solely dictated by . . . economic expediency and nothing else.'"[48]

AFSCME aligned itself with the individuals at Retreat, arguing that it acted on behalf of the workers, the community, and the people at the hospital, and the union's message focused on saving union jobs, helping the local economy, and continuing to provide care for people diagnosed with mental illnesses.[49]

This AFSCME-led coalition made up one part of a broader national effort by public sector workers to challenge anti-institutional policies as threats to public welfare. Ultimately, these opponents lost, and Retreat State Hospital closed in 1980. Still, the organized resistance reflects how the administration's anti-institutionalism and cost-cutting measures were complicated endeavors—with plenty of opposition.

Even as the state hospitals closed, the government did not allocate as many resources for people diagnosed with chronic mental illnesses as it had done for people deemed mentally retarded. The Mental Health Association of Southeastern Pennsylvania wrote to the governor and pointed out this discrepancy. The organization's representative declared, "Such a line item [for community residential services] in the budget would be no different than that which has been maintained over the years for community living arrangements required by those suffering mental retardation."[50] The group then called for the state to allocate $15 million instead of the $1.9 million recommended in the 1979–80 Executive Budget. Ultimately, funding for community living arrangements for people diagnosed with chronic mental illness fell far short of what was needed. The Mental Health Association of Southeastern Pennsylvania's annual report summarized the lack of funds, stating, "If the decade of the 1960's is lauded for its dramatic public support of broad entitlements (rights) in the interest of social and economic justice, then the 1980's—if current trends continue—should be viewed as an era of benign neglect; an era when those least able to help themselves were trampled under pious rhetoric about self-help; an era in which economic realities, colored by political expediency, led voters to seek simple answers to complex problems."[51] The difficulty with those simple answers, however, was that people like Rita and Neal DeLuck had to live the consequences on a daily basis.

The Prison Boom

Thornburgh responded to the issues in the criminal legal system far differently than he responded to the issues in the mental health system. While the Thornburgh administration deinstitutionalized mental health facilities, he

built up correctional institutions, reversing his anti-institutional stance when it came to people convicted of crimes.

By the early 1980s the move to deinstitutionalize prisons had ended, and states across the country witnessed a rise in the number of people in prison. This spike in incarceration rates partially stemmed from harsher sentencing policies. For example, in 1973 New York had passed the Rockefeller Drug Laws, which set mandatory sentences for drug offenses and reduced opportunities for plea-bargaining, and Massachusetts and Michigan passed mandatory minimum laws for crimes committed with firearms. Prison populations also rose because police were arresting more people and prosecutors were making more convictions.[52] While arrests and convictions shot up, fears about crime did as well. A *Philadelphia Evening Bulletin* survey found that respondents listed crime as the city's most pressing problem and that many people were afraid of individuals with psychiatric disorders.[53] In Pennsylvania, the Bureau of Correction's 1980 budget had increased 40 percent from five years earlier, and the number of people in prisons rose by 20 percent.

Because of this rapid rise, the state's prisons were in turmoil. The correctional system was officially 400 people over capacity. In response, 1,200 incarcerated people went on strike, refusing to work because of the poor conditions and overcrowding. They continued the strike for nine days, bringing Graterford prison to a halt and creating a state of emergency. This strike happened at the same time that three people convicted of murder escaped from prison, causing many to question the effectiveness of the state's correctional facilities.[54] These incidents—coupled with rising crime rates and overcrowding—put pressure on the Bureau of Correction to make some major changes.

In the midst of this prison crisis, Governor Thornburgh made Pennsylvania a national leader in the law-and-order movement. In 1981 he announced a "war on crime" in Pennsylvania, and he proposed new laws to back it up. Thornburgh argued that his legislation was a response to the state's 9.9 percent rise in crime. That crime rate was less than the national average, but it was still increasing. He then proposed a criminal justice plan "designed to put fear to work for people . . . and to put punks and thugs and pushers firmly within the walls of a prison."[55] At this time, states around the country were passing mandatory minimum laws, giving longer sentences, eliminating parole boards, and building new prisons.[56] What made Pennsylvania different, though, was that Thornburgh's war on crime did not propose engaging in only one or two of these actions—rather, he recommended implementing all of them. "It is

high time that we put fear to work for our citizens, not for the criminals," the governor said.[57] Separately, he stated, "This is probably the toughest approach that has been taken at the state level in this nation's history."[58] Here, Thornburgh's focus on harsher sentencing echoed his work at the Department of Justice under the Nixon administration and President Reagan's emphasis on harsher sentencing with laws such as the Sentencing Reform Act. Governor Thornburgh's previous involvement in conservative sentencing reforms at the national level influenced his actions in Pennsylvania.

Thornburgh embraced a new institutional model with this legislation. He proposed a package of sentencing bills in 1981, which formed the core of his crime-fighting effort. For example, House Bill 1803 eliminated the probation and parole board. Instead, the state would release people from prison only after they had served their minimum sentence. As the *Evening Bulletin* reported, the concept was "a sentence given is a sentence served."[59] Thornburgh also encouraged longer prison sentences and proposed legislation to raise the minimum sentences for a host of crimes. The legislature passed Act 54, which established mandatory minimum sentences of five years for all repeat violent offenders for crimes like murder, rape, assault, robbery, arson, and kidnapping. The law also gave a five-year minimum sentence for using a firearm while committing a crime.

While Act 54 specified that judges must impose the sentences that the law prescribed, House Bill 1803 directed that incarcerated people be automatically released after serving their minimum sentences, which were no longer less than half the maximum sentence.[60] With this shift toward longer prison terms, Thornburgh further reduced the weakening concept that prisons could rehabilitate people. Instead, these new laws made prisons even more restrictive, incapacitating people and separating them from society.

A few major opponents stood up to these punitive proposals. One source of antagonism came from prison reform groups, politicians, and the state's Sentencing Commission, which had worked on prison issues since 1978. The Sentencing Commission advocated changing sentencing guidelines but in a way that would keep prison populations low. Its position flew in the face of the governor's proposals. The governor's representative Alfred Blumstein argued, "It is important to realize that punitiveness—like the proverbial 'free lunch'—does not come free. If we want to lock up more people or lock them up for longer times, then we have to be willing to pay for that."[61] The second major opposition came from a small group of legislators led by African American leaders Hardy Williams and David P. Richardson. Williams and

Richardson argued that the sentencing changes were unfair to minorities. Richardson had experienced police brutality at a demonstration in 1967. He opposed Thornburgh's proposals in 1981, stating that mandatory minimum laws for gun possession made it easier for police to plant guns on defendants after arrest. Here, Richardson's own experiences at the hands of the police made him suspicious of the harsh policies of the governor.[62]

These opponents ultimately lost, however, and the new tough-on-crime approach prompted the administration to expand corrections, even during a time of state downsizing. In 1984, Thornburgh elevated the Bureau of Correction to a full Department of Corrections. As a result, the attorney general's office no longer oversaw the corrections system; instead, corrections became a branch unto itself, overseen by the governor. The new Department of Corrections built thousands of new prison cells. Thornburgh publicly stated that, without money for new prison cells, "our war on crime will only be a war of words."[63]

In response to these new laws and policies, the Pennsylvania Department of Corrections and other agencies around the country requested more prison beds and new prison construction. Still, this expansion was not a foregone conclusion. In previous decades, policy makers had considered alternatives to imprisonment, such as group homes, halfway houses, and smaller rehabilitative prisons. Those concepts had significantly weakened by the 1980s, however, and instead Departments of Corrections focused on building beds in "warehouse prisons." These prisons were intended to incapacitate people rather than rehabilitate them.[64] In 1974, 218,000 people resided in federal and state prisons throughout the country. With the creation of new prison beds, that number climbed to 1.3 million in 2000. This nationwide construction campaign became one of the largest public works projects of the twenty-first century.[65] The leaders in the construction of new prison beds were Florida, California, and Texas. These three states had the highest rate of prison growth during the 1980s and 1990s. The northeastern and midwestern states of New York, Illinois, Michigan, Ohio, and Missouri were not far behind, since they were also in the top ten states with the highest prison growth.[66]

Amid this prison boom came a particular fear concerning individuals diagnosed with mental illnesses. On March 30, 1981, the newly elected president Ronald Reagan gave an address to the AFL-CIO in Washington, D.C. As he left this run-of-the-mill event and walked to his limousine, shots rang out, wounding the president, press secretary James Brady, a police officer, and a Secret Service agent. Agents immediately apprehended the shooter, John W.

Hinckley Jr. The public soon learned that Hinckley had not pulled the trigger because of political reasons or on behalf of a terrorist organization. Instead, he had attempted to assassinate the president in order to win the heart of Jodie Foster, a young actress who had recently starred in the psycho-thriller *Taxi Driver*, a film with which Hinckley had become obsessed.[67]

Hinckley went to trial in 1982. The defense argued that Hinckley was insane, providing evidence of his interest in violence and obsession with Foster. As a result of his psychiatric condition, the defense argued, society could not hold Hinckley accountable for his actions. The prosecution refuted these claims by calling two psychiatrists to the stand. They diagnosed him with narcissistic personality disorder and argued that he did have control over his actions. Ultimately, the jury decided in the defense's favor and found Hinckley not guilty by reason of insanity. Because he was determined to be insane and dangerous, the court system sent him to St. Elizabeth's Hospital, where he remained until 2016.

The verdict of not guilty by reason of insanity caused an outcry from the public. The shootings of San Francisco supervisor Harvey Milk and Mayor George Moscone in 1978 and John Lennon in 1980 further fanned the flames of the controversy over insanity and dangerousness. By 1984 Congress had passed the Insanity Defense Reform Act, which made it harder for those accused to invoke the insanity defense. In Pennsylvania, for instance, the legislature created the term "guilty but mentally ill," which allowed for the jury to acknowledge a defendant's psychiatric disorder while still finding that defendant guilty and sentencing him or her to prison rather than a mental hospital.[68]

The shift from not guilty by reason of insanity, which came with a commitment to a mental hospital, to guilty but mentally ill, which brought a prison sentence, did not happen just because of Hinckley's 1981 assassination attempt. The shooting came during a tectonic shift in society's approach to mental illness. The public had grown increasingly concerned with people released from mental hospitals, particularly people who exhibited violence toward community members. Crimes by people deemed seriously mentally ill went viral in the media. People across the country resisted attempts to place community mental health centers, group homes, and halfway houses in their neighborhoods, an attitude that came to be known as "Not in My Backyard." This fear-based politics fueled prison construction.

The burgeoning prison construction influenced the administration's approach to the Farview State Hospital for the Criminally Insane, which had

received such intense scrutiny in the 1970s. In 1980, only one year after the administration and the Department of Public Welfare barely funded community residences, they allocated twice as much to renovate Farview. This decision was an about-face from three years before, during Governor Milton Shapp's administration, when the task force on forensic mental health recommended closing Farview and building institutions in Philadelphia and Pittsburgh, closer to the residents' homes. When Thornburgh took office he formed a new group that considered a few alternatives, including keeping the hospital open and building new state or regional prisons on the grounds.[69]

Policy makers in the governor's office opposed correctional construction not only because of the cost; they also objected to pouring more money into an aging institution located so far from the communities it was intended to serve. One policy maker noted, "It is incredible that the Commonwealth would consider a capital investment of over $44.0 million (combined forensic and correctional facility cost) at an old isolated institutional site, when public policy is to move to community based facilities and more specifically, it was recommended that the Farview site be abandoned."[70] The prospect of locating a prison far from the friends and family of those inside was also a matter of concern. Walt Plosila, a staffer in the Thornburgh administration, wrote in a memo that Rendell Davis of the Pennsylvania Prison Society had recently heard incarcerated people's demands during the Graterford prison riot. One of the two main complaints was a lack of access to their friends and family.[71]

Even though the previous governor had closed the institution because of abuses, Thornburgh wanted to keep it open. He announced a new multimillion dollar plan to renovate the hospital instead of phasing it out slowly. In order to address the accusations of abuse, Thornburgh proposed to create a review committee and a patients' rights adviser. One reason to keep the hospital open was financial. As he said at a press conference, "At a time when the Commonwealth's ability to provide basic services is strained by limited resources, the renovation and improvement of an existing facility—Farview—is simply more realistic than constructing new facilities."[72]

The state spent the money on making the facility more prisonlike, adding bulletproof glass, electric locks, better outside lighting, and a barrier at the front of the institution.[73] Just as the Thornburgh administration was closing state centers and psychiatric hospitals, it was also building up a large and remote state hospital for people the state had labeled criminally insane. As inappropriate as this institution may have been for people deemed innocent,

it was still regarded as appropriate for people labeled criminal or dangerous. Consequently, this hospital did not deinstitutionalize.

The task force's decision to keep Farview open represented the beginning of a new era of prison growth and construction. While in the 1970s the state had sought to move away from the outmoded institution, by the early 1980s it was seeking to renovate it. And while reformers in the 1980s were concerned about connecting people diagnosed with mental illness to community-based services, the Farview renovations demonstrated that these priorities did not extend to people diagnosed with mental illness whom the state also deemed dangerous or whom the courts had convicted of crimes.

Farview was not the only correctional-style institution that the Thornburgh administration supported. In 1980 the governor allocated $37 million to the Bureau of Correction for renovations, including $20 million for the historic Western State Penitentiary, a facility targeted for closure by legislators since the 1940s because of its age.[74] The next year Thornburgh created a $112 million government bond that would finance 2,705 new cells.[75] The Bureau of Correction also proposed a new $27 million medium security prison at Graterford. Graterford was a prison farm, only a few miles away from Pennhurst State School, which faced closure. The choice of location was not a coincidence. Sitting on the outskirts of the Philadelphia metropolitan area, Pennhurst had provided employment for the area. With the fate of Pennhurst in limbo, building a prison would provide jobs in the rural community.[76] So while social services faced the chopping block, the 1980s proved a boom time for corrections.

The Asylum Becomes the Prison

At the center of this correctional boom stood the psychiatric hospitals that deinstitutionalization had emptied. Once shuttered, these institutions left behind land, buildings, and workforces—a surplus infrastructure the state could readily use to build new prisons. Also left behind were rural communities, upon which every hospital closure took a major economic toll. These rural communities became instrumental in shifting the resources of former asylums to corrections, largely because of local economic interests. In particular, they helped facilitate the conversion of numerous hospitals into prisons, a trend that primarily occurred in the Northeast and the Midwest.

The cry for correctional institutions was loudest in areas that were economically distressed and largely white, such as the Pennsylvania coal region,

the struggling west Texas oilfields and farm regions, and rural areas in Rust Belt states like Illinois.[77] Deindustrialization created surplus labor and land and a dearth of capital income in these flagging regions. The deinstitutionalization of mental health institutions often exacerbated the flight of capital and jobs from these small rural towns.

While mental hospitals waned, many politicians and residents of rural areas viewed prisons as a "growth industry" that could provide jobs and bring state money to their hometowns. The area of Retreat became one of these places where people looked to corrections as a boon for the region. Notably, scholars in the early twenty-first century have found that prisons did not help these rural economies as much as people had hoped they would. In California, for instance, fewer than 20 percent of new prison jobs went to current residents. Researchers have also found that prisons did not help local businesses.[78]

Retreat State Hospital sat in one of the regions that fought hard for a new institution to replace the hospital. Almost immediately after the state closed Retreat, it began talks to repurpose it for other governmental uses. In 1981 the state proposed building a regional prison there, run by counties and serving the northeastern sector of Pennsylvania. The proposal addressed the need for more consolidated prison space in the Northeast. Frank O'Connell, the politician who had fought so hard against the closure of Retreat, played an instrumental role in bringing the shuttered facility to the Justice Department's attention. "If justice were not looking at Retreat, the place would be closed up," John Yasoweak, the hospital's personnel manager, said.[79] A feasibility study on the conversion found that the government would need to demolish multiple buildings but that it could also remodel others, saving millions of dollars.[80] Yasoweak said that the community objections were not strong, and the neighbor closest to the property approved of it.[81] While some residents had concerns about the new prison's safety, the economic advantage of new jobs outweighed them.[82]

Notably, some policy makers in the Thornburgh administration proposed a solution that was radically different from the plan to convert Retreat. Administration officials wrote that the state could create community-based correctional centers—such as group homes—rather than build more prison cells. They argued that the community corrections centers would be much less expensive and more rehabilitative. Ultimately, these recommendations never saw the light of day because they did not fit with Thornburgh's lock-them-up policies. Officials in Thornburgh's administration thought that this might

hurt his image as a tough-on-crime proponent and also had concerns about local opposition to group homes and to using the resources of local governments. In the end, their primary recommendation was to convert Retreat—the cheaper option that they believed also provided more jobs.[83]

The state's 1981 plan for a regional county correctional facility fell through. In its place came a plan to create a new state prison on the land. Soon after Thornburgh announced his crime package, he visited the Retreat area to publicize how Retreat State Hospital would be part of his crime legislation. In addition to mandatory minimums, new prison cells, and a stronger corrections branch, the governor proposed converting Retreat into a state correctional institution. His office announced that the "conversion of the former Retreat State Hospital into a 350-cell prison is an integral part of [Governor Thornburgh's] comprehensive sentencing and prison legislation."[84] The conversion would cost less than building a new facility, and "the prison would eventually provide an estimated 150 jobs and an annual payroll and operating cost of about $4 million."[85] The governor proposed that the new facility hold "prisoners with special needs," which meant the elderly and people with mental retardation.[86] Since a large portion of the people at Retreat were over sixty and had psychiatric disabilities, the proposal brought the institution full-circle.[87] It ultimately took seven years for the new prison to be approved and built. It reopened in 1988 as the State Correctional Institution–Retreat.

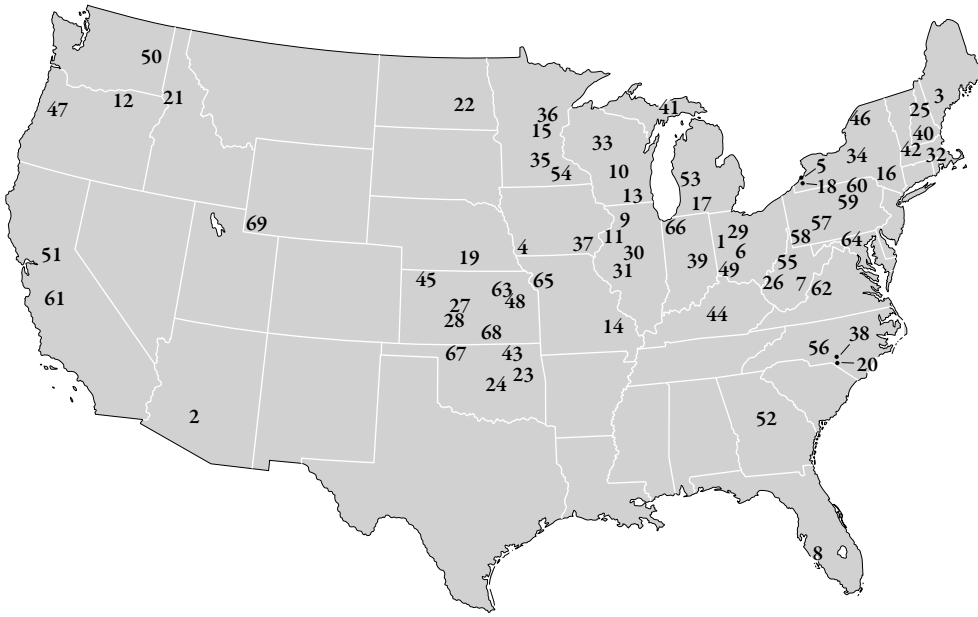
Retreat was not the only welfare institution that became a prison during the war on crime. In addition to Retreat, Governor Thornburgh proposed major construction at multiple mental health and correctional facilities as part of his anti-crime legislation. He recommended building new cells at prisons in Huntingdon, Dallas, Mercer, and Greensburg. He also proposed converting Marcy State Hospital and Cresson State Center—a developmental center—into prisons.[88] The resistance to converting Marcy State Hospital proved too great, so the administration dropped those plans. The leaders went ahead, however, with plans to convert the Cresson State Center, which officially opened as SCI-Cresson in 1987. The facility closed in 2013. The Bureau of Correction also converted a youth development center—operated by the Department of Public Welfare—into a minimum security prison for women in 1984. It became an adult male facility in 1992 and eventually closed in 2003.[89] Ultimately, a host of prisons had roots in the health and welfare systems, including SCI-Dallas, SCI-Waymart, SCI-Retreat, SCI-Cresson, and SCI-Waynesburg.

People often use the term "deinstitutionalization" to describe the downsiz-

ing and closures of mental health institutions. But when we look carefully at prisons such as SCI-Retreat, we find a far more complicated story. While some mental health institutions closed, some remained open well into the twenty-first century, taking on new life as correctional institutions. So, in rural areas, a reinstitutionalization occurred. For instance, in 1960, the northeast region of Pennsylvania was a mental health institution hub, as it held Farview State Hospital for the Criminally Insane, Clarks Summit State Hospital, the White Haven Center, the Dallas Institution for Defective Delinquents, and Retreat State Hospital. Over the next fifty years, during the process of deinstitutionalization, the region remained a bastion of state institutions. Clarks Summit State Hospital and the White Haven Center both remained open and are still open today. The other three mental health institutions closed, only to reopen as prisons.

This recycling of institutional infrastructure occurred across the state, enabling the construction of prisons in the 1980s, which the state would not otherwise have been able to afford. The combined factors of the mental health infrastructure and the loss of jobs from deinstitutionalization facilitated the building of prisons in former institution towns and on the land of old mental health facilities. This institutional recycling was not limited to Pennsylvania; prison construction in the late twentieth century reveals recycling in the early stages of the large-scale building of prisons across the country. At least seventy state hospitals, developmental centers, and tuberculosis sanatoriums were converted to adult and correctional institutions beginning in the 1970s and continuing into the twenty-first century: fourteen in the Northeast, thirteen in the Great Plains, eleven in the Southeast, twenty-five in the Midwest, six in the West, and one in Alaska.[90] These numbers do not include the creation of prisons in former institution towns. As a Rust Belt state, Pennsylvania was at the center of this trend. The Northeast and Midwest had numerous asylums as part of their welfare departments. States that had deindustrializing rural areas especially experienced this institutional recycling, as shown by the high rates in the Midwest.

During the deinstitutionalization period, people diagnosed with mental illnesses received poor—and often abusive—treatment in prisons and jails. In 1982 *Philadelphia Inquirer* staff writer Stephan Salisbury reported that hundreds and perhaps even thousands of these individuals were in solitary confinement in prisons. Salisbury found that approximately 6 percent of the people in the state's prisons were diagnosed as severely mentally ill and an additional 10 percent needed psychological assistance. He also reported that



1. Allen Oakwood Correctional Institution
2. Arizona State Prison Complex
3. Central Maine Pre-Release Center
4. Clarinda Correctional Facility
5. Collins Correctional Facility
6. Correctional Reception Center
7. Denmar Correctional Center
8. Desoto County Juvenile Correctional Facility (closed)
9. Dixon Correctional Center
10. Dodge Correctional Institute
11. East Moline Correctional Center
12. Eastern Oregon Correctional Institution
13. Ethan Allen School for Boys (closed)
14. Farmington Correctional Center
15. FCI Sandstone
16. Fishkill Correctional Facility
17. Florence Crane Correctional Facility (closed)
18. Gowanda Correctional Facility
19. Hastings Correctional Center
20. Hoke Correctional Institution
21. Idaho Correctional Institution–Orofino
22. James River Correctional Center
23. Jess Dunn Correctional Center
24. John H. Lilley Correctional Center
25. Lakes Region Facility (closed)
26. Lakin Correctional Center
27. Larned Correctional Mental Health Facility
28. Larned Juvenile Correctional Facility (closed)
29. Lima Correctional Institution (closed)
30. Lincoln Correctional Center
31. Logan Correctional Center
32. Massachusetts Correctional Institution–Bridgewater
33. McNaughton Correctional Center
34. Mid-State Correctional Facility
35. Minnesota Correctional Facility–Faribault
36. Minnesota Correctional Facility–Moose Lake
37. Mt. Pleasant Correctional Facility
38. Neuse Correctional Institution
39. New Castle Correctional Facility
40. New Hampshire Correctional Facility for Women
41. Newberry Correctional Facility
42. North Central Corrections Institute
43. Northeast Oklahoma Correctional Center
44. Northpoint Training Center
45. Norton Correctional Facility
46. Ogdensburg Correctional Facility
47. Oregon Department of Corrections Office
48. Osawatomie Correctional Facility (closed)
49. Pickaway Correctional Institution
50. Pine Lodge Corrections Center (closed)
51. Placer County Jail and Juvenile Center
52. Rivers State Prison (closed)
53. Riverside Correctional Facility
54. Rochester Federal Medical Center
55. Saint Marys Correctional Center
56. Sandhills Youth Center (closed)
57. SCI–Cresson (closed)
58. SCI–Laurel Highlands
59. SCI–Retreat
60. SCI–Waymart
61. Stanislaus County Juvenile Justice Center
62. Staunton Correctional Center (closed)
63. Topeka Correctional Facility: Pre-Release Center
64. Victor Cullen Center
65. Western Reception, Diagnostic, and Correctional Center
66. Westville Correctional Facility
67. William S. Key Correctional Center
68. Winfield Correctional Facility
69. Wyoming Women's Center (closed)

the state provided little to no psychiatric assistance—no full-time psychiatrists, no training for guards, and no proper living arrangements. Instead, people with diagnosed mental illness either lived within the general population or in solitary.[91]

Even considering these terrible conditions, the number of people diagnosed with mental illness in prisons and jails rose. The American Correctional Association described the problem in a public statement: "With the trend towards deinstitutionalization, the mentally ill are being discharged from state mental institutions, with no place to go. So, they go to the bus station, the subway, and the streets. When they act crazy at midnight, someone calls the police or the sheriff. The police officer, with no place else to take them, takes them to jail. And there they languish with no help—charged with disorderly conduct or trespassing."[92] To accommodate this rise, the Pennsylvania Bureau of Correction planned new mental health facilities in its prison construction plans. At Graterford, for instance, the bureau estimated that the mental health facility would cost nearly $1.5 million. The planning of mental health facilities in prisons was a first and continued in the 1980s.[93] At the same moment that the state closed state mental hospitals, it built new mental health facilities in prisons and jails.

Governor Thornburgh's personal experiences with disability led him to advocate for the deinstitutionalization of mental health facilities. Still, he took a harsh stance on criminal justice and called for more restrictive environments for people convicted of crimes. Unfortunately, people diagnosed with mental illnesses were increasingly caught up in the legal system and held behind bars—a reinstitutionalization rather than deinstitutionalization.

Thornburgh's differing approaches to mental health and crime reveal a central contradiction of neoliberal policies in the 1980s. When deinstitutionalization occurred in the 1960s and 1970s, it came from a desire to increase state social services for the client population. The federal government and the court system also held far more power in the earlier stages of deinstitutionalization, guaranteeing people with mental health disorders an array of civil rights. By comparison, deinstitutionalization in the 1980s came as part of a broader effort to reduce social services. Institutionalism in the criminal sys-

(Opposite) U.S. Correctional Institutions Built on Sites of Former Medical and Mental Health Institutions. This map shows the locations of prisons that state governments built on the land of former developmental centers, mental hospitals, and tuberculosis sanatoria. See the appendix for more information on these sites.

tem, on the other hand, grew exponentially, flourishing in some of the buildings and properties once inhabited by the mental health system. Rather than scaling back state infrastructure, neoliberal politicians like Thornburgh advocated for more restrictive environments in prisons.

Closing Byberry

For all the commonalities in the stories of Retreat and Farview during the 1980s, deinstitutionalization was ultimately not a monolith. The closure of the Philadelphia State Hospital at Byberry offers a view of what could happen when mental health advocates and the courts played a larger role in deinstitutionalization.

Much had changed at the Philadelphia State Hospital at Byberry since the 1940s. The number of people had dropped dramatically, and the hospital operated on a far smaller scale than it once had. Still, when mental health activist Joseph Rogers visited the hospital in the 1980s, he found conditions that were still troubling. Rogers had been helping to grow a self-help mental health consumers' movement when he took a job with the Mental Health Association of Southeastern Pennsylvania. In that role, he visited Byberry and was struck by the smell of the place. The people there had little privacy, as about six or seven people lived together in a single room. Rogers described Byberry as a "place of last resort," the place that people would go to if they could not recover in other mental health facilities. Anna Jennings, who was at Byberry as a patient, fought tirelessly against the system. When she would witness abuse at Byberry, she'd speak out against it to hospital administrators even in the face of punishments, and she also passed information along to her mother, who worked at the Mental Health Association of Southeastern Pennsylvania.[94]

Anna Jennings helped bring the problems at Byberry to light, and Rogers and other advocates decided that the Philadelphia State Hospital at Byberry could not be reformed. But they did not want to close it down and just force people onto the streets. Rogers recalled, "We'd seen state hospitals close around the country, and not a lot of planning would necessarily go into it. And we wanted to make sure we . . . set some goals of what we wanted to see that people got, the level of services they needed to live successfully in the community."[95]

Byberry became a rallying point for advocates who sought not only to close

institutions but also to do it in a more equitable way. In the 1980s a group of advocates, family members, consumers, and service providers formed the Coalition for the Responsible Closing of Philadelphia State Hospital. The group waged a tireless campaign—staffed by Joseph Rogers and Mary Hurtig of the Mental Health Association of Southeastern Pennsylvania—to close the historic Byberry hospital. And not only that, but members hoped, in their words, "to seize upon the closing of Byberry as an opportunity to put in place a humane, comprehensive system of care *in the community* for people with serious mental illness."[96]

The organization protested the discrimination that consumers of mental health services faced on a regular basis. Joseph Rogers became a spokesperson for the group, which fought in 1987 against discrimination in employment, higher education, and housing. "They are not given the same access to education as others are given and halfway houses are kept out of communities," Rogers told one reporter.[97] Fighting to change attitudes was part and parcel of improving mental health services.

In response, Governor Robert Casey and Secretary of Public Welfare John White Jr. created the Blue Ribbon Task Force, which investigated the hospital. The task force concluded that the state should close Byberry. A city-state management team was created, the state assisted people discharged from the hospital, and the city developed services to maintain people who otherwise might have gone there had it remained open.

Throughout the process, the Coalition for the Responsible Closing of Philadelphia State Hospital argued that the state government needed to focus on the people directly affected and meet their needs. The state began to take some steps toward change, creating new affordable housing, programs that helped people to access their income, and long-term structured residences for about sixteen people who needed intensive care. It also created new consumer-run programs in self-help, advocacy, vocational education, and social support. The pace of change was slow, however, and the advocates who sought to close Byberry faced an uphill battle.

In 1988, advocates filed a class-action suit seeking the right to treatment in the community for the former Philadelphia State Hospital residents. Both sides eventually filed a settlement agreement in 1990 "that entitle[d] patients to court-enforced community services."[98] Many of the services that were provided were run by mental health consumers themselves. The benefit of these consumer-run programs was that they were staffed by people who had "been

there"—meaning they themselves were consumers of mental health services. Now, the city and state were not merely serving hundreds of people at Byberry—they were serving thousands of people in the community.[99]

Ultimately, however, the story of Byberry's final years offers a glimmer of what can happen when the state moves resources away from custodial institutions and into the community. Byberry had repeatedly struggled with exposés and scandals over the course of the twentieth century. The story of its closure, though, offers lessons for policy makers and advocates about more responsible ways to decarcerate custodial institutions and to serve the people inside of them.

EPILOGUE

SCI-Retreat stands on the site of the former Retreat State Hospital. When I visited in January 2016, I met a staff member who along with his sister had worked at the prison for many years. The siblings' unique connection to the place went back decades, as their father had worked at the Retreat State Hospital years before, the family had lived in employee cottages located on the site, and they had grown up on the very same grounds where they still worked. The employee remembered old buildings that once stood on the property—such as the greenhouse—and recollected playing with the residents. When Retreat State Hospital closed in 1981 during the state's deinstitutionalization efforts, the state offered his father another job at a nearby prison. He turned it down and instead took a job at a distant hospital, choosing to commute rather than work at a correctional institution.[1]

Just a year after my visit, the institution again faced possible closure. The Pennsylvania Department of Corrections had announced that it would conduct a review of five prisons with the intention of closing two institutions that year. SCI-Retreat was now on the chopping block, along with the jobs of the employee I spoke with and the many other staff members whom I had met there.

The Pennsylvania Department of Corrections had decided to close two prisons for budgetary reasons but also in response to the state's falling prison population. In 2012 the state held 51,757 people in correctional institutions. Five years later that number had fallen by 2,400.[2] This drop came because of

reforms to the parole system that limited the reincarceration of people who violated terms of their parole. It also stemmed from the creation of new drug courts, mental health courts, and veterans' courts, which created alternatives to incarceration. Finally, Department of Corrections secretary John Wetzel had committed to addressing overincarceration and participated in the search for community-based alternatives.[3]

Concrete proposals to reduce incarceration by Pennsylvania's Justice Reinvestment Initiative formed the basis of bills introduced during the 2017–18 legislative session. One proposal shortened sentences for most criminal convictions by two to three months, potentially reducing the number of people in prisons without making major changes to sentencing policies. Another recommended shifting to "presumptive parole" for people with less than a two-year sentence. People would automatically get parole when they hit their minimum date.[4] Consistent advocacy by groups such as the ACLU of Pennsylvania, which had previously supported the deinstitutionalization of mental hospitals, and activism by Decarcerate PA, a prison abolitionist group, kept pressure on the state to fight overincarceration. The ACLU of Pennsylvania, for instance, has argued that Pennsylvania's Justice Reinvestment Initiative should go even further, reducing the use of prison sentences for drug offenses, thefts, and empty home burglaries—crimes it deems low-level and nonviolent.[5]

Pennsylvania is slowly moving toward deinstitutionalizing its prisons as it once did its mental hospitals. In the 1960s, Dr. Daniel Blain's efforts to reduce the high numbers of people at the Philadelphia State Hospital at Byberry signaled the changing tide toward deinstitutionalization. Similarly, the 2017 plan to close prisons in Pennsylvania reflects a nascent statewide and national decarceration movement. More than thirty states—including Pennsylvania—have begun exploring reforms to reduce their heavy reliance on imprisonment. In 2010 South Carolina reformed its sentences for drug and property offenses, lowering the number of people in prison, and New York has also overhauled its drug laws, reducing its prison population by 23 percent since 2000. In only the past six years, California has released 37,000 people from prisons. Notably, the state has not seen an increase in crime.[6]

The proposal to close prisons in these states directly affected the communities where those prisons sit. In Pennsylvania, some of the prisons facing closure included SCI-Retreat (formerly Retreat State Hospital) and SCI-Waymart (previously Farview State Hospital). In 2017 lawmakers toured the facilities in order to review which would be the best ones to shut down.

SCI-Retreat, for instance, had come under scrutiny because it had significant flooding issues, it needed a new bridge, and it had fewer people in confinement than other state prisons. But the possibility of closing SCI-Retreat and SCI-Waymart met with instant opposition from locals. Gary Waters, a retiree of SCI-Waymart, said, "There's a lot of people in this area that work there. Any closing that involves that amount of jobs will have an effect on this area." This opposition to closing SCI-Waymart echoed local resistance to closing the mental hospitals in the name of saving jobs and protecting the local economy.[7]

In a strange twist of fate, the psychiatric functions of SCI-Waymart and SCI-Retreat—which both had long histories as mental health providers—complicated the Department of Corrections' decarceration efforts at these facilities. People argued that SCI-Retreat should not close because half of those held there had mental health diagnoses. The Department of Corrections itself made a similar argument about SCI-Waymart, stating that "it would be difficult to close SCI Waymart because it handles some inmates who have serious mental health conditions."[8] The institutions' long-standing functions as mental health providers—first as hospitals and then as prisons—factored into the decision about whether to shutter them or to keep them open.

This was not the first time that the communities surrounding Retreat and Waymart had faced the closing of their institutions. Retreat State Hospital had closed before, and then local politicians brought a prison to the site. Farview State Hospital had faced closure in the late 1970s but then survived, only to later become a prison. A second federal prison had been built on the Farview hospital land as well. Ultimately, the Department of Corrections decided against closing the two institutions. Instead, it shut down SCI-Pittsburgh, partly because the unemployment rate in the area surrounding that prison was lower than it was in the far northeastern part of the state, where SCI-Retreat and SCI-Waymart sat. Because SCI-Pittsburgh was on the Ohio River in the larger Pittsburgh metropolitan area, it offered more possibilities for redevelopment, and policy makers proposed that the facility could be repurposed for housing or light industrial use. Because of arguments such as this one, the northeastern region of Pennsylvania so far has been somewhat bulletproof concerning proposals to close correctional facilities there. As a result, it continues to serve as an institutional hub for the state, with multiple prisons and a state mental hospital.

Just as the United States faced an overinstitutionalization of people in

mental hospitals in the 1940s, it faces a crisis of overincarceration in prisons today. States are looking for ways to reduce their reliance on correctional institutions, just as they searched for alternatives to mental hospitals in the decades after World War II. This book has responded to a central question that faces us today: What can the history of deinstitutionalization teach us as our society begins to decarcerate prisons?

As we confront today's crisis of mass incarceration, the history of deinstitutionalization offers three key lessons. The first is that restrictive environments such as prisons and asylums are often inappropriate places to hold human beings, much less individuals with psychiatric disabilities. Frequently, these individuals have little access to treatment; they are held in poor conditions; and their incarceration—and often segregation in solitary confinement—exacerbates their mental health disorders.[9] The histories of the Byberry, Farview, and Retreat State Hospitals illustrate how mental hospitals and prisons have repeatedly taken major tolls on society, whether through abuse, the dehumanization of the people held or treated in them, or the high cost of running those facilities. Mental health advocates over the past few decades have often lobbied for better psychiatric services behind bars. It is important that individuals with psychiatric disabilities have the mental health services they need while incarcerated. *From Asylum to Prison* also raises the possibility that mental health advocates also work to reduce the overall number of people in prisons, alleviating the problems through decarceration. In the 1970s and 1980s, the rise of people with psychiatric disorders did not just happen because psychiatric treatment modes and mental health laws changed; increased policing and mass incarceration throughout the country also played a part. A central component of helping individuals with psychiatric disabilities in prisons, then, is to reduce mass incarceration.

The second lesson in *From Asylum to Prison* focuses on funding. Recently, conservatives like the Koch brothers and former Texas governor Rick Perry have supported alternatives to incarceration as a way to cut costs. Perry, for instance, supported sentencing reform and drug courts that divert people away from jail.[10] The history of deinstitutionalization, however, shows that cost cutting cannot be the driving force for change. In the 1960s and 1970s, many state hospital officials discharged people without adequate aftercare services in place. In the case of Byberry in the 1980s, advocates worked tirelessly with politicians and policy makers and even went to the courts so that the money from the hospital would not just disappear but would be shifted to services that would benefit the people being released. The same principle

holds true for closing prisons. All too often, individuals leaving prisons cannot access mental or physical health care, they are discriminated against in job searches, and they cannot find housing. As we work to decarcerate prisons in the United States, it is imperative for the well-being of these individuals—and the communities that they return to—that we provide social supports that allow them not only to survive but to thrive outside of the prison walls. This shift in money would require that we work to make affordable and accessible housing, medical and mental health care, and social services available to people with psychiatric disabilities—providing a state response at the point of need rather than at the point of lawbreaking.

Finally, as state governments around the country look to decarcerate their prisons, they must grapple with the question: will another form of institutionalization emerge? The third lesson *From Asylum to Prison* offers is that the process of deinstitutionalization was actually a reinstitutionalization in which prisons absorbed the functions of custodial mental hospitals. The continued criminalization of people of color and individuals with disabilities fueled the rise of this new form of confinement. During the height of law-and-order movements—the 1960s through the 1980s—fear-based politics drove the construction of prisons and the overincarceration of people with psychiatric disabilities. As policy makers work to improve the lives of people with mental health disorders in prisons and jails, it is critical that they also work to change attitudes that lead to this overincarceration. When Joseph Rogers and other activists argued for better community mental health services, they also argued that society needed to change the way it approached mental health consumers and to stop discrimination in its tracks. The roots of fear against individuals with psychiatric disabilities who commit crimes run deep, however, and public education campaigns are needed to foster the understanding that is needed to create lasting change.

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APPENDIX

U.S. Correctional Institutions Built on the Sites of Former Medical and Mental Health Institutions (Arranged by State)

This list includes adult and juvenile correctional prisons, jails, and correctional agency offices that stand on the site of former psychiatric hospitals, developmental centers, and tuberculosis sanatoria. Except where indicated, all facilities were open as of November 2017. The list also includes one site, the Central Maine Pre-Release Center in Hallowell, Maine, that was built on the site of a former industrial school for girls; the school held young women who had not committed crimes. The list does not include hospitals that primarily serve forensic commitments or the criminal legal system. It also does not include localities that once held mental health facilities but now hold prisons. The correctional institution had to have been built on the former site of a mental health or medical institution. This list was compiled through research on websites of state agencies that operate prisons and mental hospitals, as well as an exploration of newspaper and magazine articles.

CORRECTIONAL INSTITUTION	CITY	STATE
Arizona State Prison Complex	Phoenix	Arizona
Placer County Jail and Juvenile Center	Auburn	California
Stanislaus County Juvenile Justice Center	Modesto	California
Desoto County Juvenile Correctional Facility (closed)	Arcadia	Florida
Rivers State Prison (closed)	Milledgeville	Georgia
Idaho Correctional Institution–Orofino	Orofino	Idaho
Dixon Correctional Center	Dixon	Illinois
East Moline Correctional Center	East Moline	Illinois
Lincoln Correctional Center	Lincoln	Illinois
Logan Correctional Center	Lincoln	Illinois
New Castle Correctional Facility	New Castle	Indiana
Westville Correctional Facility	Westville	Indiana
Clarinda Correctional Facility	Clarinda	Iowa
Mt. Pleasant Correctional Facility	Mt. Pleasant	Iowa
Larned Correctional Mental Health Facility	Larned	Kansas
Larned Juvenile Correctional Facility (closed)	Larned	Kansas
Norton Correctional Facility	Norton	Kansas
Osawatomie Correctional Facility (closed)	Osawatomie	Kansas
Topeka Correctional Facility: Pre-Release Center	Topeka	Kansas
Winfield Correctional Facility	Winfield	Kansas
Northpoint Training Center	Burgin	Kentucky
Central Maine Pre-Release Center	Hallowell	Maine

CORRECTIONAL INSTITUTION	CITY	STATE
Victor Cullen Center	Sabillasville	Maryland
Massachusetts Correctional Institution–Bridgewater	Bridgewater	Massachusetts
North Central Corrections Institute	Gardner	Massachusetts
Florence Crane Correctional Facility (closed)	Coldwater	Michigan
Newberry Correctional Facility	Newberry	Michigan
Riverside Correctional Facility	Ionia	Michigan
FCI Sandstone	Sandstone	Minnesota
Federal Medical Center, Rochester	Rochester	Minnesota
Minnesota Correctional Facility–Faribault	Faribault	Minnesota
Minnesota Correctional Facility–Moose Lake	Moose Lake	Minnesota
Farmington Correctional Center	Farmington	Missouri
Western Reception, Diagnostic, and Correctional Center	St. Joseph	Missouri
Hastings Correctional Center	Hastings	Nebraska
Lakes Region Facility (closed)	Laconia	New Hampshire
New Hampshire Correctional Facility for Women	Goffstown	New Hampshire
Collins Correctional Facility	Collins	New York
Fishkill Correctional Facility	Beacon	New York
Gowanda Correctional Facility	Gowanda	New York
Mid-State Correctional Facility	Marcy	New York
Ogdensburg Correctional Facility	Ogdensburg	New York
Hoke Correctional Institution	Raeford	North Carolina
Neuse Correctional Institution	Goldsboro	North Carolina
Sandhills Youth Center (closed)	Raeford	North Carolina

CORRECTIONAL INSTITUTION	CITY	STATE
James River Correctional Center	Jamestown	North Dakota
Allen Oakwood Correctional Institution	Lima	Ohio
Correctional Reception Center	Orient	Ohio
Lima Correctional Institution (closed)	Lima	Ohio
Pickaway Correctional Institution	Orient	Ohio
Jess Dunn Correctional Center	Muskogee	Oklahoma
John H. Lilley Correctional Center	Boley	Oklahoma
Northeast Oklahoma Correctional Center	Vinita	Oklahoma
William S. Key Correctional Center	Fort Supply	Oklahoma
Eastern Oregon Correctional Institution	Pendleton	Oregon
Oregon Department of Corrections Office (closed)	Salem	Oregon
SCI–Cresson (closed)	Cresson	Pennsylvania
SCI–Laurel Highlands	Somerset	Pennsylvania
SCI–Retreat	Hunlock Creek	Pennsylvania
SCI–Waymart	Waymart	Pennsylvania
Staunton Correctional Center (closed)	Staunton	Virginia
Pine Lodge Corrections Center (closed)	Medical Lake	Washington
Denmar Correctional Center	Hillsboro	West Virginia
Lakin Correctional Center	West Columbia	West Virginia
Saint Marys Correctional Center	Saint Marys	West Virginia
Dodge Correctional Institute	Waupun	Wisconsin
Ethan Allen School for Boys (closed)	Delafield	Wisconsin
McNaughton Correctional Center	Tomahawk	Wisconsin
Wyoming Women's Center (closed)	Evanston	Wyoming

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NOTES

Abbreviations

PEB	*Philadelphia Evening Bulletin*
NYT	*New York Times*
PI	*Philadelphia Inquirer*
PSA	Pennsylvania State Archives
SCPC	Swarthmore College Peace Collection
TUSCRC	Temple University Libraries, Special Collections Research Center
UPASC	University of Pittsburgh Library System Archives and Special Collections

Introduction

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16. Simon, *Governing through Crime*.

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23. "Keeping the Maniacs off the Streets," *PEB*, December 5, 1980.

24. This idea of mental hospitals as carceral spaces emerged in scholarly circles during the 1960s and 1970s, the height of social criticism. A broad framework of the carceral institution appeared exactly when governmental bodies began to find alternatives to mental health and correctional sites. See Foucault, *Folie et Déraison*; Foucault, *Madness and Civilization*; Goffman, *Asylums*; Szasz, *Myth of Mental Illness*; and Scull, *Decarceration*. David Rothman also studied mental hospitals and prisons in tandem. Rothman, *The Discovery of the Asylum*. At the center of this scholarly work was the question of power and how mental hospitals can serve as places of social control. See Martin Summers, "Suitable Care of the African When Afflicted with Insanity: Race, Madness, and Social Order in Comparative Perspective," *Bulletin of the History of Medicine* 84, no. 1 (2010): 60–66. Summers makes a powerful

point that race was not a central part of this discussion, and that the histories of psychiatry in colonial Africa point to how power and race lay at the center of psychiatric asylums. We need this kind of analysis, since race and incarceration are inextricably intertwined in American society.

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29. Davis, *Are Prisons Obsolete?*; Shigematsu, *Visions of Abolition*; Nagel and Nocella, *End of Prisons*; Molly Ball, "Do the Koch Brothers Really Care about Criminal Justice Reform?," *Atlantic*, March 3, 2015.

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34. Ben-Moshe, "Institution Yet to Come"; Ben-Moshe, "The Tension between Abolition and Reform." *From Asylum to Prison* does not study institutions for individuals with intellectual and developmental disabilities because of the massive size of these systems and the diverse issues that emerge in each of them. They are interconnected, however, and this book highlights some of these links, such as in chapter 5.

35. Grob, *From Asylum to Community*; Scull, *Decarceration*; Shorter, *History of Psychiatry*.

36. American Psychiatric Association and the Pennsylvania Mental Health Survey Committee, *Mental Health Program for Pennsylvania*, IV:3.

37. U.S. Department of Justice, Bureau of Justice Statistics, *Correctional Population in the United States, 2015*, 12–13.

38. Perkinson, *Texas Tough*; Alex Lichtenstein, "Flocatex and the Fiscal Limits of Mass Incarceration: Toward a New Political Economy of the Postwar Carceral State," *Journal of American History* 102, no. 1 (June 2015): 119; Lynch, *Sunbelt Justice*.

39. Numerous penal historians have incorporated the perspectives of people in prisons. See H. Thompson, *Blood in the Water*; Berger, *Captive Nation*; Lynd, *Untold Story of a Prison Uprising*; and Chase, "'Slaves of the State' Revolt." Scholar-activists have also emphasized the importance of including the perspectives of the people

who had psychiatric disabilities and experienced institutionalization. See Burch and Joyner, *Unspeakable*; Geoffrey Reaume, "Teaching Radical History: Mad People's History," *Radical History Review* 94 (Winter 2006): 170–82; Lewis, "Mad Fight," 115–31; Judi Chamberlin, "The Ex-patients' Movement: Where We've Been and Where We're Going," *Journal of Mind and Behaviour* 11, nos. 3–4 (1990): 323–36; Support Coalition International, *Psychiatric Survivor Oral Histories*; Jackson, "In Our Own Voice"; and Taylor, *The Last Asylum*. In addition, historians of psychiatry have called our attention to the agency of people living in mental hospitals in the nineteenth and twentieth centuries. See Tomes, *Generous Confidence*; Dwyer, *Homes for the Mad*; Carlisle, *Elizabeth Packard*; and Lunbeck, *The Psychiatric Persuasion*. Finally, Steven J. Taylor spotlighted an overlooked group in the history of psychiatry: conscientious objectors who worked in mental hospitals during World War II. See S. Taylor, *Acts of Conscience*.

40. Rafter, *Creating Born Criminals*.

41. The Arc, "What Is People First Language?"; La Vigne, "People First." In 2016, the Pennsylvania Department of Corrections began to use people-first language. See Tom Jackman, "Pennsylvania Dept. of Corrections to Discard Terms 'Offender,' 'Felon,' in Describing Ex-Prisoners," *Washington Post*, May 25, 2016. I'd like to particularly thank Susan Rogers and Susan Burch for teaching me about these issues.

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Chapter 1

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2. Wendt, "Novelist Finds Her Writing a Luring Task."

3. M. Ward, *Snake Pit*, 26.

4. Healy and Shorter, *Shock Therapy*, 11–14.

5. Healy and Shorter, 22–30, 54.

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7. Shorter, *History of Psychiatry*, 222–23; Grob, *The Mad among Us*, 185.

8. Pressman, *Last Resort*, 48–50, 53, 77–78; El-Hai, *Lobotomist*, 111–33; Shorter, *History of Psychiatry*, 225–29; Grob, *From Asylum to Community*, 130.

9. Shorter, *History of Psychiatry*, 195–96.

10. Stern, *Eugenic Nation*, 98–100; Dorr, *Segregation's Science*, 168.

11. Grob, *The Mad among Us*, 192–94.

12. Grob, 197–202; Herman, *Romance of American Psychology*, 1–14.

13. Klein and Hoogenboom, *History of Pennsylvania*, Martin quoted on 427, 422–28; Beers, *Pennsylvania Politics Today and Yesterday*, 167–68.

14. "Accomplishments of the Republican Party in Pennsylvania," 1943, box 12, folder 15, Subject Files, Governor Edward Martin Papers, PSA.

15. Deutsch, *Mentally Ill in America*, 446–47. Even though the federal Public Works Administration allocated $12 million to state mental hospitals in select states, it did little to stem the tide of deterioration at institutions nationwide.

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17. Pennsylvania Department of Public Welfare, 3.

18. Pennsylvania Department of Public Welfare, *Report of the Committee . . . to Survey the Penal and Correctional System*.

19. Deutsch, *Mentally Ill in America*, 450.

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23. Klein and Hoogenboom, *History of Pennsylvania*, 427; Governor Edward Martin to Mr. Wood, August 22, 1946, box 6, folder 14, Subject Files, Governor Edward Martin Papers, PSA.

24. Taylor, *Acts of Conscience*, 79, 174–75, 180, 229.

25. Taylor, 78–79, 88, 100–101, 199, 217–22, 229.

26. Taylor, 217–22, 246–48, 253–54.

27. Taylor, 272–73; "Decree in re. Application for Incorporation of the National Mental Health Foundation Incorporated," April 26, 1945, box 2, folder 2, Harold Barton Papers, SCPC. The interconnected structure of the Civilian Public Service units enabled the NMHF to collect photographs and reports from mental hospitals across the nation. Taylor, *Acts of Conscience*, 206, 260–61.

28. Albert Q. Maisel, "Bedlam 1946," *Life*, May 6, 1946; Albert Deutsch, "Filth-Infested Byberry Cured Only Two Out of 5900 Patients in Year," *PM*, April 18, 1946; Albert Deutsch, "Byberry Horror Camp," *PM*, April 17, 1946; Kozol, *Life's America*, viii.

29. Maisel, "Bedlam 1946," 102.

30. Maisel, 102–3, quote from 102.

31. Deutsch, "Filth-Infested Byberry," 9.

32. Maisel, "Bedlam 1946," 107.

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34. Maisel, 118.

35. In the early twentieth century, new neurological findings and desires to move beyond mental asylums of years past led psychiatrists to replace the term "insanity" with "mental disorders," "psychoneuroses," "psychoses," "mental illness," and "mental sickness." The legal profession, on the other hand, retained the word "insanity" to determine competency in courtroom proceedings. Janet A. Tighe, "'What's in a Name?' A Brief Foray into the History of Insanity in England and the United States," *Journal of the American Academy of Psychiatry and the Law* 33 (June 2005): 252–58.

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40. Maisel, 118.

41. See the following in box 6, Subject Files, Governor Edward Martin Papers, PSA: Harold F. Beech to Governor Edward Martin, May 7, 1946; S. E. Lorrens Fleming to Governor Martin, April 20, 1946; and George McHenry to Governor Martin, May 5, 1946, all in folder 12; Hamilton A. Porter to Governor Martin, May 14, 1946, folder 13; and Caroline L. Stevenson to Governor Martin, Easter Day, 1946, folder 14. One group collected signatures and filed a petition to reform the conditions at Byberry and other hospitals. Pennsylvania Hopetown Association, petition to Governor Martin, 1946, folder 13.

42. Vincent Gilpin to Governor Edward Martin, May 7, 1946, box 6, folder 12, Subject Files, Governor Edward Martin Papers, PSA.

43. Gilpin to Martin, May 7, 1946.

44. Miss Gertrude Sadler to Governor Martin, May 12, 1946, box 6, folder 14, Subject Files, Governor Edward Martin Papers, PSA.

45. Wilson, *Borderland Minds*; MacLeish, *Between Us and the Dark*; Winslow, *If a Man Be Mad*. For more on the autobiographical accounts of people in mental hospitals, see Shannonhouse, *Out of Her Mind*; Geller and Harris, *Women of the Asylum*; and Hubert, *Questions of Power*.

46. M. Ward, *Snake Pit*, 53.

47. Deutsch, *Mentally Ill in America*, 418–41; Meyer and Weaver, *Law and Mental Health*, 128–29; Geller and Harris, *Women of the Asylum*; Grob, *From Asylum to Community*, 289–91.

48. Sandy Grady, "The Man the World Forgot," *Ebony*, October 1971, 158.

49. M. Ward, *Snake Pit*.

50. On the enthusiasm for these new therapies, see Grob, The *Mad among Us*, 178.

51. Carmel McCoubrey, "Obituary of Gerard Chrzanowski," *NYT*, November 12, 2000; M. Ward, *Snake Pit*, 3.

52. M. Ward, *Snake Pit*, 173–83.

53. M. Ward, 43–44.

54. D'Antonio, *State Boys Rebellion*; Reverby, *Examining Tuskegee*; Susan M. Reverby, "'Normal Exposure' and Inoculation Syphilis: A PHS 'Tuskegee' Doctor in Guatemala, 1946–1948," *Journal of Policy History* 23 (November 2011): 6–28; Hornblum, *Acres of Skin*.

55. M. Ward, *Snake Pit*, 216–17.

56. Capua, *Anatole Litvak*, 71–72.

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61. Scull, *Insanity of Place*, 99–100; Grob, *From Asylum to Community*, 72–77.

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63. Deutsch, *Shame of the States*, 30–31.

64. Angela Davis, "Masked Racism: Reflections on the Prison Industrial Complex," *ColorLines* 1 (October 1998): 1.

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66. Deutsch, *Shame of the States*, 41; Smith, *30th Anniversary Commemorative History*, 36–38.

67. Deutsch, *Mentally Ill in America*, 457.

68. National Institute of Mental Health, *Patients in Mental Institutions*, 16.

69. Pennsylvania Department of Public Welfare, *Pictorial Report on Mental Institutions*, 1–2, 6, 65.

70. National Mental Health Foundation, *For These We Speak*, 1946, box 2, folder 3, Harold Barton Papers, SCPC.

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72. Taylor, *Acts of Conscience*, 146–51, 403–4; National Mental Health Foundation, *For These We Speak*; Cortner, "Owen Josephus Roberts," 612–14.

73. Taylor, *Acts of Conscience*, 403–4.

74. Although Eleanor Roosevelt opposed the internment of Japanese Americans, she ultimately failed to dissuade her husband from ordering it. G. Ward, "Eleanor Roosevelt," 812–15.

75. Dorsen, "Roger Nash Baldwin," 61–63.

76. Adams, *Best War Ever*, 114–35; Wall, *Inventing the "American Way,"* 3–12, 177–87.

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82. Harold Barton, "Notes of Harold Barton," February 13, 1947, box 2, folder 10, Harold Barton Papers, SCPC.

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84. Charlie R. Barber to Governor Duff, December 1, 1947, box 25, folder 8, Subject Files, Governor Duff Papers, PSA.

85. Description of construction projects at Philadelphia State Hospital, box 4, Graphic Materials, Philadelphia State Hospital Collection, PSA; description of buildings at Philadelphia State Hospital, box 9, Maps folder, Graphic Materials, Philadelphia State Hospital Collection, PSA.

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87. Ross W. Sanderson Jr., "What's the Score in Mental Health?," *Currents in Pennsylvania's Health and Welfare* 2, no. 3 (1951): 4–7.

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89. Albert Q. Maisel, "Scandal Results," *Life*, November 12, 1951, 140–54.

90. Maisel, "Scandal Results," 154.

91. Mrs. C. B. Kahler to Governor Duff, March 17, 1949, box 25, folder 7, Subject Files, Governor Duff Papers, PSA.

92. J. C. Heinz to Governor Duff, February 28, 1949, box 25, folder 7, Subject Files, Governor Duff Papers, PSA. Heinz does not appear to have been a direct descendant of H. J. Heinz, the founder of the Heinz Company.

93. Some researchers have argued that, in the late twentieth century, a more punitive and southern approach became popular nationwide, explaining the rapid rise of imprisonment in the North. See Perkinson, *Texas Tough*; and Alex Lichtenstein, "Flocatex and the Fiscal Limits of Mass Incarceration: Toward a New Political Economy of the Postwar Carceral State," *Journal of American History* 102, no. 1 (June 2015): 113–25.

Chapter 2

1. In 1950, new leadership of the NMHF had consolidated with the National Committee for Mental Hygiene and the Psychiatric Foundation to form the National Association for Mental Health. Taylor, *Acts of Conscience*, 340–51.

2. "The Mental Health Bell," Mental Health America, accessed July 7, 2016, http://www.mentalhealthamerica.net/bell.

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4. The practice of using medicine to treat mental illness was not new, but in the early 1950s it underwent a revolution with the introduction of tranquilizers. Hale, *Rise and Crisis of Psychoanalysis*, 245–56; Moskowitz, *In Therapy We Trust*, 149–50; Shorter, *Before Prozac*, 34–73; Herzberg, *Happy Pills in America*, 3–4, 8, 15; Tone, *Age of Anxiety*, 79–80; Grob, *From Asylum to Community*, 181–238. Grob does not posit that mental hospitals deinstitutionalized in the 1950s and early 1960s, but he does argue that this is when the psychiatric profession advocated for new community-

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14. Spillane, *Coxsackie*, 130–37.

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Chapter 4

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Chapter 5

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