Re-Institutionalizing America:
The Politics of Mental Health and Incarceration, 1945-1985

BY

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<td>c.o.</td>
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SUMMARY

This dissertation tracks a peculiar “re-institutionalization” between 1945 and 1990, showing how involuntary confinement in psychiatric hospitals and prisons transformed in both significance and scope. The project focuses on these changes in Pennsylvania and argues that during the post-war era, the public sector relied primarily on custodial psychiatric hospitals rather than prisons to handle social problems. In subsequent decades, the state government increasingly sought rehabilitative alternatives to custodial institutions such as community mental health centers and work-release prison programs. This anti-institutionalism came to a halt in the 1970s as conservative politicians rejected alternatives to prisons and transferred supervision of people in the mental health system to the criminal system. Highlighting this previously unstudied process, the dissertation argues that policymakers replaced involuntary confinement in mental health institutions with imprisonment. In this way, it recasts the rise of mass incarceration as part of a larger history of confinement in the U.S. rather than the sudden product of the late twentieth century.

This re-institutionalization challenges the narrative of the rise of conservatism as primarily a rejection of state welfare responsibilities. Instead, new conservative policies shifted priorities away from welfare and medical authority and towards security and punishment, dramatically altering the state’s relationships to its citizens in ways determined by notions of race, gender and class. Drawing on disability history and public history, the dissertation employs research focused on local people, places and communities and collections on mental health and corrections in Pennsylvania previously unused by historians. The research has uncovered how many former mental hospitals converted into prisons in the 1980s, a national phenomenon the
project identifies through local examples. The dissertation challenges the narrative of
deinstitutionalization as a largely federal development and instead focuses on the changes at the
state and local levels, where the politics of mental health and imprisonment most often
intersected.
CHAPTER I

INTRODUCTION

This project explores the politics of confinement, in particular the deinstitutionalization of mental hospitals and the changing notions of incarceration in America between 1945 and 1985. I argue that during these years, policymakers and the public rejected large, state-run custodial facilities for people with psychiatric disorders and intellectual disabilities while sanctioning them for people convicted of crimes. My narrative of re-institutionalization, rather than de-institutionalization, shows how the ascendancy of conservatism shifted state priorities away from welfare and towards security. I focus on mental hospitals rather than developmental centers, and show how in the 1970s, while mental-health officials instituted community-based initiatives for white women and men diagnosed with mental illnesses with relatively little opposition, corrections officials faced major opposition to people returning from prisons to their communities, many of whom were African American. Rising law-and-order politics from conservatives led corrections officials to stop creating community-based treatment programs, furloughs, and halfway houses by the mid-1970s. While community-based social services for people deemed non-dangerous expanded, the same types of programs in the criminal legal system weakened. I argue that involuntary institutionalization has been a central feature of U.S. governance since the nineteenth century, and the late twentieth century brought its reworking rather than its abolition.

This shift from asylum to prison in the late twentieth century is significant because the United States currently outpaces all other countries in its rates of incarceration. The Pew Charitable Trusts reported that in 2008, federal and local governments locked up 2,245,189
Americans in prisons and jails, a staggering rate of one in 100 citizens. The incarceration of its citizens has literally become an international hallmark of American government in the late twentieth century. U.S. institutionalization sets it apart from the rest of world politically, and for this reason, scholars have begun to study how and why the carceral state grew so quickly. One of the central issues surrounding the rise of imprisonment has been the large infrastructure that has accompanied it.

Institutionalizing people has historically been one of the largest and most intrusive enterprises a government can undertake. State prisons and mental health institutions housed, fed, clothed and supervised large numbers of people. These efforts required vast amounts of money, staff, and planning, and have made up a crucial piece of American government and democracy in the twentieth century. U.S. states have maintained prisons and mental health institutions since the 1800s, but the twentieth century has marked a new era of institutionalization. As historian David Rothman charted, the mid-nineteenth century gave birth to the asylum and the prison and by the Progressive Era, these institutions had spread throughout the country. By the 1950s, the rates of people housed in these spaces dwarfed the numbers of the nineteenth century. The immense infrastructure of these places underscores how they comprised a large and crucial portion of twentieth-century American state governments.


The study of mental asylums and incarceration dates to the social criticism of the 1960s. In 1962, Erving Goffman published *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* in which he closely studied St. Elizabeth’s Hospital in Washington, DC, arguing that the institution there resembled prisons and military barracks in their regimented and anti-individualist nature. State custodial institutions threatened the individuality of their wards, regardless of the type.\(^4\) The most scathing critique came from Thomas Szasz in *The Myth of Mental Illness*. In that work, Szasz argued that mental illness was not a medical disease, but instead behaviors that society judged as deviant. Under this model, involuntary commitments to mental hospitals equaled incarceration.\(^5\) A minority of people in mental hospitals voluntarily committed themselves, while the majority was involuntarily committed, and welfare officials often wielded power over when and if they were released. The individuals also lost a host of freedoms once inside the institutions: the freedom to choose the duration of their hospitalization, power over the treatments they received, and the ability to live independently. Involuntary confinement comprised the lived experience of hundreds of thousands of people in mental-health institutions, even if the sites’ stated intention was to provide social welfare services.

These conceptions of carceral institutions spilled over into historical research. Philosopher and historian Michel Foucault viewed these spaces together when tracing genealogy of Western European confinement in the name of social control. In *Discipline and Punish*, he charted a shift from corporal punishment to the modern prison’s bodily and psychological

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control; in *Madness and Civilization*, he studied how confinement came in many forms. In 1971, David Rothman broke new ground in American history with *Discovery of the Asylum*, which located the origins of American institutions in Jacksonian reform when American social reformers created asylums and prisons in response to social disorder. State and local governments provided services for people in these segregated institutional sites.

The search for origins did not serve to legitimize mental hospitals, prisons, or institutions for people with disabilities. Instead, the broad framework of the carceral institution appeared at the very moment when governmental bodies began searching for alternatives to these sites. Since World War II, the ideology of separating people from society had weakened dramatically as psychiatrists saw the benefits of brief treatment periods and community service and as new treatments such as psychiatric drug therapies became available. Counter-cultural anti-institutionalism resisted the practice of removing people from society for the purposes of social disorder, a sentiment which fueled the broader search for community-based services for people with mental illness. Rothman wrote his *Discovery of the Asylum* in this milieu and, in 1972, he weighed in on the debates with his essay, “On Prisons, Asylums, and Other Decaying Institutions.” In it, Rothman reported that the numbers of people in psychiatric hospitals and prisons had dropped precipitously between 1955 and 1970, and that poorhouses and orphan asylums had also disappeared.

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7 Rothman, *The Discovery of the Asylum*.


However, the study of asylums and incarceration diminished through the 1980s and 1990s. It has only been in the past few years that scholars have again picked up this framework to review the changes of the late twentieth century. The political scientist Bernard Harcourt in 2006 published “Asylum to Prison: Rethinking the Incarceration Revolution,” in which he began to look at the possibilities for deinstitutionalizing prisons. Most recently, Harcourt has become interested, along with political scientist Marie Gottschalk, in looking at the process of deinstitutionalization in mental hospitals and how that process could inform efforts to decarcerate prisons. To them, the phenomenon of deinstitutionalization offers a political map of how politicians and the public today might reassess the government’s reliance on large institutions in favor of more community-based alternatives. The other area of study has come from Disability Studies scholars such as Liat Ben Moshe and Michael Rembis. In their work, they show how the institutions for people with disabilities were places of confinement, and in this way should be compared to imprisonment. Ben Moshe in particular studies the activist movement to abolish institutions for people with disabilities and studies how it intersects with the prison abolition movement.

This dissertation is part of this renewed effort to look at the politics of confinement and mental health institutions both for people with intellectual and psychiatric disabilities. I argue that the process of deinstitutionalization in mental hospitals was deeply embedded in the rise of

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imprisonment, through the legal renegotiation of confinement, the politics of fear and mental illness and the infrastructural legacy. In particular, this work explores the years between 1945 and 1985, the decades during which the most intensive deinstitutionalization occurred, and looks at how politics, policies and activism intersected, and caused a re-institutionalization. I have chosen to focus on mental hospitals and not institutions for people with intellectual disabilities, otherwise known as state schools or developmental centers. While many similarities exist between these types of facilities, such as infrastructure, removal from society and efforts to rehabilitate people, they also have a host of differences. For instance, the commitment procedures governing mental hospitals varied greatly from that of state schools, and the processes by which involuntary commitment law changed in the 1960s and 1970s also was markedly different. Second, a discourse of danger and criminality did not emerge nearly as much around releases from state schools as it did to people released from mental hospitals in the 1970s and 1980s. Because of these significant differences, I chose in the dissertation not to study these institutions together, but instead to focus primarily on mental hospitals, although I do at points incorporate the changes occurring in the field of intellectual disabilities.

Secondly, I look at how mental health and correctional policy changes of the period affected people differently based along the lines of gender and race. Elizabeth Lunbeck, in *Psychiatric Persuasion*, and Jonathan Metzl, in *Protest Psychosis*, have made important interventions by studying the history of mental health and each author has found that gender and race has greatly influenced the diagnosis and treatment of people with mental illnesses. Many people from both groups were also institutionalized because of these highly racialized and gendered diagnoses. For instance, Metzl tracked how psychiatrists disproportionately diagnosed white women with schizophrenia in the 1940s and 1950s, and then in the 1960s and 1970s, over-
diagnosed African American men with it. These historians show how diagnoses did not just arise because of behaviors. In the dissertation, I look at the Department of Welfare and the Bureau of Corrections’ public policy language and imagery to evaluate the racial and gendered limits of who could and should receive treatment in institutions or in community settings in the late nineteenth and early twentieth centuries.

The third contribution of the project is that it blends policy and political history with the history of the agency of people living in mental hospitals and prisons. A number of penal historians have written about prisons in the twentieth century and have incorporated the perspectives of people in prisons, including Staughton Lynd and Robert Chase. A few disability studies scholars including Geoffrey Reaume and Bradley Lewis have begun to write the history of the activism of people diagnosed with psychiatric disorders. Similarly, beginning to write this neglected history has become a project for a number of mental health activists, including the late Judi Chamberlin and Vanessa Jackson. These scholar-activists emphasize the importance of bringing in the perspective of the people who embodied madness and imprisonment.


Additionally, with the advent of social history, historians of psychiatry have taken more interest in the experiences and the agency of people living in mental hospitals in the nineteenth and early twentieth centuries, particularly in the late 1980s and 1990s. In *A Generous Confidence*, Nancy Tomes described the nineteenth-century world of Thomas Kirkbride’s asylum, telling the story of both Kirkbride and the people in his institution, whom he treated while dodging lawsuits filed on behalf of the people living there. Ellen Dwyer described in *Homes for the Mad* the lived experiences of the people in mental hospitals, revealing the world of the asylum from many perspectives. The 1990s brought a renewed inquiry into the dimensions of power, as Lunbeck pushed past the power of the institution and focused on the construction of power within psychiatry’s conceptual apparatus. To Lunbeck, power flowed between patient and staff in the creation of psychiatric diagnoses and hierarchies. Martin Summers has also emphasized the importance of the experience of people with mental illness in the study of race and psychiatry. Building on the work of historians of colonial psychiatry, Summers acknowledges the centrality of power in the profession, while at the same time arguing that “the experiences of African Americans in mental institutions cannot be reduced to instances of the enactment of state power upon black bodies.” Finally, an interest in lawsuits by people in mental hospitals has returned with the publication of Elizabeth Packard’s nineteenth century biography and her successful fight against her commitment to an asylum and subsequent rise as a

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18 Lunbeck, 153.

19 Summers, 66. Summers here draws on the work of historians of colonial psychiatry Harriet Jane Deacon and Jonathan Sadowsky.
nationally recognized advocate for the rights of women and the insane in nineteenth-century America.20

Building upon this literature, I seek to weave in the perspectives of people who lived in prisons and mental hospitals into the narrative. The project is largely a policy history and political history of these spaces, and to that end, governors, psychiatrists, and superintendents play a major role. However, in each chapter I have sought to bring in alternative perspectives, whether through the writings of Mary Jane Ward who lived at a state hospital, the activism of conscientious objectors who worked in mental hospitals, members of the patients’ and prisoners’ rights movements, and family members who worked in groups such as the Pennsylvania Association for Retarded Citizens. The repeated marginalization of these voices in the policy and legal debates, however, reveals both the structures of power and the barriers that self-advocates faced when they tried to affect change in the political arena.

The project begins in the post-World War II era, the height of mental health institutions in America. The practice of institutionalizing people in mental hospitals and prisons had a long tradition in U.S. governance. Since the nineteenth century, charity boards and state welfare departments ran public asylums that held people with psychiatric disorders and developmental and physical disabilities. These agencies not only aimed to provide treatment services, but also to house and feed those people for years or sometimes decades. The individuals often lived there involuntarily, placed there by families, doctors, or the courts. Government services were not on the whole available to individuals with mental-health disorders or disabilities in their own communities, but instead were available in segregated settings. Psychiatric institutions have historically been deeply entwined with race and ethnicity, and the rise of eugenics during the

Progressive era both built upon and reified the links between mental illness, feeblemindedness, race and ethnicity. Because of this ideological and diagnostic framework, these places disproportionately held working-class men and women and immigrants in the late nineteenth and early twentieth centuries.21

The years immediately after World War II marked a time of crisis and growth in state mental hospitals and the involuntary confinement within these spaces. The Great Depression and wartime exigencies had brought both overcrowding and limited resources for state institutions. In response to these dilemmas, many states appropriated large sums of money into their custodial facilities in the late 1940s and early 1950s. Mental hospitals held far more people than prisons during this period, politicians gave them more attention and the majority of funds went to their improvement. As a result, the practice of involuntary confinement continued and flourished in the decade after the war.

The 1950s and 1960s ushered in a broad-based search for alternatives to mental health and penal institutions. Building upon new psychiatric ideologies of the fifties, in the early sixties, policymakers worked to create alternatives to mental-health institutions. Guided by the American Psychiatric Association, Congress passed the Community Mental Health Centers Act in 1963, which funded psychiatric services in local communities rather than far-off mental hospitals. By the late 1960s, liberal penologists, influenced by psychiatrists, created community-based alternatives such as half-way houses, drug-treatment centers, and the increased use of probation as a way to replace imprisonment. David Garland, in *The Culture of Control*, used the term penal-welfarism to describe these reforms, emphasizing how correctional institutions in this

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period valued rehabilitation as their primary purpose.\textsuperscript{22} By the early 1970s, mental patients’ and prisoners’ activist groups had formed to challenge institutions, and advocated for better treatment of the people living in them. Although the activist movements remained largely separate from each other, they both fought for better conditions of confinement and against over-institutionalization. Their tactics also overlapped, as both movements took legal action, created organizations, and used protests to fight for the rights of institutionalized people. Lawsuits against the mental health system in particular were effective in stopping the longstanding practice of involuntary commitments.

As a result, in the early 1970s, the number of people in mental hospitals, state schools and prisons in America had reached its lowest point in decades.\textsuperscript{23} Rothman described the changes in the following words. “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.”\textsuperscript{24} To some extent Rothman was correct. Even as the federal government greatly increased police expenditures with the Wars on Crime under Presidents Johnson and Nixon, large custodial government institutions appeared to be collapsing. This peak of the rehabilitative and community-based ideal in both psychiatric hospitals and prisons echoed 1960s’ liberal ideology that looked to local communities as a resource in alleviating the social problems of health, education, and poverty.


However, ultimately, Rothman’s hope did not come to pass. As deinstitutionalization proceeded apace in mental hospitals, it stalled in prisons. By the 1980s, each took very different roads; as the number of people in mental-health institutions dropped precipitously while the number of people in prisons tripled. Imprisonment in the late 1970s and 1980s arose in response to deinstitutionalization in mental health. The criminal legal system took on the responsibilities of dealing with issues previously handled in mental health: people deemed criminally mentally ill, sex offenders, and substance abusers in particular. Also, in the 1980s, state governments converted many deinstitutionalized asylums into prisons, often citing the economic needs of their communities as reasons for recycling the facilities. The growth of prisons affected the process of deinstitutionalization, as resources which might have gone into an alternative community-based system were swept into the new carceral state. The American government’s movement away from liberalism in the 1980s was, as legal scholar Jonathan Simon has argued, not a rejection of government, but instead its transformation.25 In the last decades of the century, state and federal governments devalued social welfare programs while prioritizing crime control and the construction of new prisons.

My work incorporates law-and-order politics from the 1960s to the 1980s into the process of deinstitutionalization. Law and order was a term coined by Barry Goldwater and used during these decades to call for stricter measures against crime such as increased police forces, stricter sentencing and the increased use of institutionalization to contain people deemed dangerous and violent. After state courts had overturned involuntary commitment laws, releasing tens of

25 Jonathan Simon, Governing Through Crime: How the War on Crime Transformed American Democracy and Created a Culture of Fear (New York: Oxford University Press, 2007); For a discussion on the impact on criminology of changing notions about the welfare state, see Garland, The Culture of Control, 75–96. Simon argued that, “The vast reorienting of fiscal and administrative resources toward the criminal justice system at both the federal and state levels has resulted in a shift aptly described as a transformation from “welfare state” to “penal state.” The result has not been less government, but a more authoritarian executive, a more passive legislature, and a more defensive judiciary than even the welfare state itself was accused of producing.” Simon, 6.
thousands of people in mental hospitals back to their communities, fears of these releasees, along with fears of rising crime rates fed the cry for law-and-order politics. Newspapers raged over stories of furloughed people committing crimes, or releasees considered dangerous and mentally ill attacking members of the public. In particular, the public and media went into frenzies over stories of African American males with schizophrenia who committed crimes after their release. The experiment with deinstitutionalization in both psychiatric hospitals and prisons took a turn. Because of new laws that attempted to protect people with mental illness, de-hospitalization could not be reversed. Instead, Pennsylvania and other states began building psychiatric wards in prisons and jails to accommodate people with mental illnesses, and incarceration rates of people with mental illnesses rose significantly. Recent studies have also shown that the state increasingly incarcerated men they considered “dangerously mentally ill” and African American men in particular.\textsuperscript{26} Over the course of this period, a number of states passed measures that criminalized drug offenses and created harsh mandatory minimums that made long-term incarceration widespread, while at the same time cutting substance abuse services in mental health. The era of medical- and psychiatric-based institutionalization gave way to punishment and security.

The dissertation also explores how legal changes in the period shifted response to a number of classes of people who committed crimes. For instance, in the 1960s and early 1970s, the sentencing of people convicted of sex offenses to mental hospitals ended, and instead prisons became the place to hold them. Similarly, the practice of placing people deemed criminally mentally ill and defective delinquent in mental-health institutions ended, and instead those classes of people entered prisons in large numbers. Many people with drug and alcohol

\textsuperscript{26} Metzl, \textit{The Protest Psychosis}. 
addictions struggled to receive services in their communities. Instead of the expansion of social services for addiction, the criminal legal system became a central site of drug and alcohol rehabilitation. As mental hospitals deinstitutionalized, prisons and jails built psychiatric wards and the number of people with mental-health diagnoses living in prisons and jails jumped: Prisons and jails became some of the largest mental-health providers in the country, provoking a commensurate increase in funding.\textsuperscript{27} In the late twentieth century, as welfare services were scaled back, the criminal legal system became a key way that state governments provided social services. If those services were not easily accessible in the “free” world, as envisioned in the community mental health model, they became available at the point that people entered into the criminal legal system.

This work centers on the Northeast region of the United States, rather than a Southern or Western state. Some historians have argued that the late twentieth century has seen the rise of Southern conservatism taken up by the entire country. For instance, Bruce Schulman in his book \textit{The Seventies} described the age of rising conservatism as the “Southernization” of the United States. He argued that the Southern tendencies toward lower taxes, fewer public services, and military preparation have become the watchwords of the late twentieth-century conservative dominance.\textsuperscript{28} This shift toward state power certainly allowed states to increase their criminal justice systems at will, and did not indicate an “anti-state” position. The other feature of the South is its history of punishment and prisons. While the Southernization of the United States encompassed a push-back against the federal government, it did not encompass a push-back against the state.

\textsuperscript{27} Pete Earley, \textit{Crazy: A Father’s Search through America’s Mental Health Madness} (Berkeley: Berkeley Trade, 2007).

\textsuperscript{28} Bruce Schulman, \textit{The Great Shift in American Culture, Society, and Politics} (New York: Free Press, 2001); Perkinson, \textit{Texas Tough}. 
Schulman’s study points to a national acquisition of some key conservative Southern ideologies in the 1970s. My work explains why the Northeast so readily embraced this system of crime and punishment by identifying a Northeastern tradition of incarceration embedded within the welfare state itself. I argue that involuntary confinement permeated the expansive mid-twentieth century mental health systems of the Northeast. In these regions, state institutions such as mental hospitals and state schools for the feebleminded predominated, particularly in New York, Massachusetts, and Pennsylvania. Historically, the number of mental hospitals in the Northeast dwarfed the number of these institutions in the South, Southwest and South. Because these facilities relied so heavily on involuntary confinement to treat patients, it meant that the Northeast was a particular center of mental health incarceration from the late nineteenth through the mid-twentieth century. This Northeastern system gave this region nearly a century of experience of confinement that informed the rise of mass incarceration in the late twentieth century.

I have chosen to study one state in the Northeast, namely Pennsylvania. Other historians have studied the history of twentieth-century mental health either at either the federal level or the micro level by studying single institutions; these studies have been incredibly useful. I have chosen to study a state because in the mid-twentieth century, mental hospitals and prisons were greatly influenced by legal, political and policy changes by politicians, bureaucrats, activists, judges and professionals. While the federal government did have some influence over state policy, particularly through federal funds, state governments had the main oversight role over the mental health and correctional systems in the U.S. Because of the significant state power over these institutions, I focus on how state-level actors implemented the changes in the mental-health and prison systems. Focusing on the state and the changes within many of its institutions also
allows me to more directly study the patients’ and prisoners’ rights movements on the ground, changing public attitudes towards welfare, and shifts in more local conservative and liberal governance.

Pennsylvania offers unique assets as a location of study. The state is not unusual or special in the way that California has a history as both a rehabilitative center and a major prison center and it has much to offer a political historian. Pennsylvania has major metropolises, including Philadelphia which has served as a center for medical knowledge throughout the twentieth century. Yet at the same time, it was largely prototypical in representing the deinstitutionalization that occurred in the Northeast. The state also has smaller cities, and vast swaths of rural land, places where custodial institutions played a large economic role in the community. Because of these geographic variations, the state also has very strong late twentieth-century traditions of conservatism and liberalism. In this way, Pennsylvania provides an excellent site to track how conservatives and liberals approached confinement and the role of government in the twentieth century. Finally, Pennsylvania has one of the few relatively open archives of the late twentieth-century mental-health system. In Pennsylvania, many mental hospitals closed and donated their materials to the Pennsylvania State Archives. Some of the collections are processed and others are unprocessed. However, the archives has made all of them open to researchers, while still limiting access to confidential materials regarding people who lived in those places. The unprocessed Philadelphia State Hospital collection has been particularly useful for news clippings, photographs and periodicals for this project.

I have worked in this project to be specific in my language regarding mental illness, criminality and their related institutions. As an historian, I have chosen to use language of the period, and so throughout the text use the terms mental hospitals, mental illness, criminal,
prisons and corrections which were the most common words used in the second half of the twentieth century. At the same time, I have learned from disability studies scholars, prison historians, mental health consumers and prisoners’ rights activists to bring an understanding of the social construction of these categories into language. So, while I employ the terms of the period such as mental illness or criminal, I have attempted to use the terms “people with criminal histories/backgrounds/convictions” and “people with mental illness” rather than “criminals/prisoners” or “the mentally ill.” One exception to this practice has been when activists have self-described themselves as prisoners and patients. I should note that even these terms have limits, however, as mental illness and law-breaking are both historically specific and constantly changing concepts, and indeed many “people with criminal histories” never committed any crimes and many “people with mental illness” did not identify as mentally ill. However, because this is a history of the state and political responses to individuals in these categories, I have made the choice to use these terms even in the face of these problems.

Finally, I use the term institutionalization and institutionalism throughout the text. In *Discipline and Punish*, Michel Foucault used the term “complete and austere institution” in reference to prisons, and wrote that they constituted both the “deprivation of liberty and the technical transformation of individuals.” I deploy this notion in my understanding of mental-health and penal institutionalism. The word describes both the practice of forcibly removing individuals from their communities and placing them into large, custodial facilities. It also captures the notion of these spaces as rehabilitative, which although it ebbed and flowed over time, also marked the state’s responses to both mental health differences and criminality. When I

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use the term “incarceration,” I am focused more on the confining aspects of these spaces rather than their transformative power.

Chapter I studies the last hurrah of mental health institutionalism in the mid-twentieth century. In 1940, the Pennsylvania Department of Welfare oversaw the custody of people with mental illnesses and developmental disabilities. Less well-known, however, is that the Department of Welfare also supervised people in prisons and people deemed defective, delinquent, or criminally mentally ill. During and after World War II, Hitler’s sterilization campaigns and subsequent genocide of people with mental-health disorders undermined explicit eugenics projects in the United States that included sterilization, immigration laws, and segregation in institutions. This is not to say that eugenics died entirely during this period. Indeed, in some ways eugenic ideas flourished after World War II as the historian Wendi Kline has shown in her book *Building a Better Race.*\(^30\) However, the discursive de-linking of mental health and race, along with discoveries in psychiatric therapies and treatments prompted a focus on the new possibilities for the “cure” of people with mental illnesses. Additionally, psychiatric and social-service professionals emphasized the humanity of people with disabilities instead of their innate deviance and potential threat. Yet both mental-health and correctional institutions had fallen into grave disrepair due to the fiscal crisis of the state government during the Great Depression and the costs of World War II. While prisons and mental hospitals had long histories of being both overcrowded and inhumane, by 1945 these conditions had become particularly bad.

In 1946, a searing account of confinement by Mary Jane Ward and conscientious objector activism based in Pennsylvania caused a national publicity campaign against what was

considered concentration-camp conditions at mental hospitals. Seeking to decouple the associations between criminality and mental disorder, the conscientious objectors focused their efforts on reforming the system of care for people with mental illnesses.\textsuperscript{31} This action had a large impact in the context of postwar liberalism. With booming economies, Pennsylvania, along with many other states across the country, poured huge sums of money into improving and building up mental hospitals as a way to help the people inside the institutions. As a result, the building campaigns expanded the infrastructure of mental hospitals and institutionalization and increased the power of the state’s medical authority. The postwar era thus marked a time when the state addressed the crisis of mental hospitals by building up custodial institutions, constituting the last hurrah of mental-health institutionalism. Concurrently, because of the focus on people with mental illness, prisons were neglected further, which led to prison riots in Pennsylvania and across the country in 1953. The Pennsylvania state government turned its attention to prisons, and it removed prisons from the supervision of the Department of Welfare and created a new Bureau of Corrections.

In Chapter II, I examine how in the mid-1950s, psychiatric advances in drug therapies and the postwar expansion of mental hospitals rejuvenated government efforts to rehabilitate people with social disorders. However, between 1955 and 1965, an ethos of rehabilitation and community cures imbued the reforms, and served to weaken the government’s reliance on large, custodial institutions as a response to mental illness and juvenile delinquency. The Pennsylvania state government, under the leadership of Governor George Leader was one of the first states in the country to work with the national American Psychiatric Association to create new community programs to both cure mental illness and move away from the mental-hospital

system. I study these early efforts towards deinstitutionalization that set out to cure social disorders and criminal behaviors through the mental-health system and community programs. I chart how these developments in Pennsylvania led to the beginnings of the release of people from mental hospitals in the late 1950s and early 1960s, one of the first states to do so.

The zeal in psychiatry not only revived the mental health system, but it also spilled over into the criminal legal system. During the late 1950s and early 1960s, the number of arrests and the amount of police surveillance rose. I study how during these years, criminal and deviant behaviors, particularly among juveniles, increasingly became the target of the state. At the height of this trend, forensic psychiatry (which looked at criminality) mushroomed and psychological tools were used to reduce deviant behaviors. As a result, penologists began imagining the use of quasipsychiatric community-based programs such as forestry camps, diagnostic centers, and alternatives to the prison to solve the problem of all types of crime. In the years between 1955 and 1965, revitalized psychiatric ideologies infused both the mental health and correctional systems, laying the groundwork for the more large-scale deinstitutionalization efforts of the late 1960s and early 1970s. Yet, still, the changes relied on a notion of state power to rehabilitate individuals.

Between 1965 and 1973, a number of forces converged to challenge the practice of involuntary state confinement based on medical and legal authority. In Chapter III, I begin by studying the efforts by the Department of Welfare to begin releasing people from mental hospitals in Pennsylvania. The chapter focuses on the Philadelphia State Hospital at Byberry, where a former President of the American Psychiatric Association implemented a number of policies to release people from the hospital to the community. In an age of anti-institutionalism, embodied by Ken Kesey’s *One Flew Over the Cuckoo’s Nest* in 1962 and the countercultural and
civil rights activism of the period, the efforts of the state to release people were celebrated as progressive and liberatory. However, there were limits to the deinstitutionalization effort. While policymakers released people, they did not attempt to change the involuntary commitment laws that governed the mental health system. Those changes happened in part because of the people in mental hospitals and prisons themselves.

The period was rife with court cases that redefined freedom and desegregation. During the 1960s, people in prisons filed lawsuits for better conditions in prisons, citing inhumane treatment at the hands of wardens and guards. They had won a host of rights to constitutional treatment by the early 1970s, although the system of imprisonment for law-breaking was not fundamentally challenged. Mental-health commitments, however, were another matter: People at hybrid mental-health-penal institutions filed lawsuits for their release. People convicted of sex offenses and people diagnosed as defective delinquents challenged their commitments to mental institutions and filed for their release. In each case, the courts ruled in the individuals’ favor and ruled it unconstitutional to involuntarily commit these classes of people to mental institutions. Then, in 1970, people at the Farview State Hospital for the Criminally Insane filed a landmark lawsuit charging that the state had illegally committed them after they finished their prison terms. The class, which was largely working-class and African American men, eventually won, and the courts overturned the commitments of not only them, but thousands of other people held in non-forensic mental hospitals. By the mid-1970s, confinement based on the decisions of medical authorities had weakened greatly. The courts could no longer commit people to the mental health system merely because of a diagnosis of sexual psychopathy, defective delinquency, or mental illness. In prisons, the lawsuits had a very different impact. The courts’ ruling that prisons had unconstitutional conditions led to new construction programs to improve
penal institutions. The legal foundation for confinement in mental hospitals crumbled while imprisonment for crimes committed remained legally viable. As a result, the treatment of people with intellectual disabilities (called defective delinquents), mental illnesses, and sex offense convictions began to be treated primarily in the criminal system, rather than the mental health system. Also, the reliance on custodial institutions and rehabilitation as a part of governance was directly challenged.

Chapter IV examines how just as the psychiatric profession and legal activists was challenging the use of institutions to hold people with mental illnesses and criminal convictions, public safety again came to the forefront of political discourse, just as it had in the early twentieth century. In the 1960s, policymakers viewed rehabilitation as the central goal of corrections, and worked to make that a priority. Influenced by changes in psychiatry, liberal penologists created community-based services such as halfway houses, furlough programs and drug-treatment facilities to reform convicts rather than merely imprison them. Around 1970, the reformist vision became so popular that leading black legislator K. Leroy Irvis tried to abolish minimum sentences for men in prison entirely. The intention was that people should go to prison, be rehabilitated, and be released when they were “cured.” Law-and-order conservatives from both parties fought these reforms by depicting all people in prison as dangerous people who needed punishment and segregation from the community, not placement within it. In this chapter, I explore how law-and-order politics and racially charged segregationist language stopped the shift towards the “deinstitutionalization” of the prison. The loss of faith in government programs coupled with this conservative action to stop the shift towards more community-based responses to crime: By the mid-1970s, Pennsylvania began cutting back on its experimental prison alternatives and began new prison-construction programs. The number of people living inside the
state’s prisons began rising after over a decade of decline. While deinstitutionalization continued apace in the mental health system, it came to a stop in the criminal legal system.

The dissertation concludes with Chapter V, which charts the continued deinstitutionalization of mental hospitals in the 1970s and early 1980s. During these years, a discourse of fear emerged around the release of people from mental hospitals. While a discussion of liberation imbued the early efforts in the late 1960s, by the mid-1970s, the law and order politics shaped not just correctional policies, but mental health policies as well. As a result, Farview State Hospital for the Criminally Insane and the issue of criminal responsibility for people with mental illnesses became flashpoints of political discussion. This chapter charts the public’s fear-based reactions to people with mental illness in the 1970s and early 1980s and the move to institutionalize people defined as dangerous. It is important to note that this was not an entirely new enterprise, as people with mental illness had been considered threats for centuries, and particularly in the late nineteenth and early twentieth centuries. However, it re-emerged as a central strategy in the 1970s and 1980s in the midst of deinstitutionalization. These changes at Farview happened in tandem with the creation of smaller psychiatric wards in prisons and jails across the state. Psychiatrists regarded community-based treatments as the best method to help those with mental illness, but public safety trumped psychiatric care. The concept of “deinstitutionalization” did not apply to people with mental illness deemed dangerous or criminal.

The second half of the chapter examines the cuts to the mental health system in the early 1980s under the conservative Governor Richard Thornburgh. These community mental health services were being cut at a particularly important time, as many people who had been released from mental hospitals needed assistance. Advocates fought to get adequate money to help people
live on their own in communities. However, while these mental-health activists called for additional money to serve people with mental illness, Pennsylvania poured its money into prisons. Governor Thornburgh in particular passed a series of mandatory sentencing laws as part of a law and order campaign, largely targeted at drug abuse. While he cut state mental health, substance abuse and welfare services, he increased the state police and prison structures. Here, the mental health system played another role: the conversions of state hospitals.

The chapter ends with a study of the conversion of the Retreat State Hospital into a prison in 1980. This conversion reflected the reprioritizing of prisons even at a time when the state was cutting mental-health and social services. The construction of a prison at Retreat also reflected a trend in America in the 1980s by which many state governments recycled emptying asylums and military bases into prisons. The era of mass incarceration in prisons began on the back of the asylum industry that was deinstitutionalizing. A new paternalist industry emerged, with largely male inmates and masculine and male-dominated staff. The race of the inmates also shifted, as African Americans were disproportionately incarcerated whereas asylums had held predominantly white inmates. Studying the reallocation of resources away from social services and towards public safety and the conversion of mental hospitals into prisons sheds a new light on the re-emergence of incarceration in the 1980s.
CHAPTER II

THE LAST HURRAH OF MENTAL HEALTH INSTITUTIONALISM

When many people think of pop culture critiques of mental hospitals in the U.S., Ken Kesey’s 1962 book *One Flew over the Cuckoo’s Nest* often first comes to mind. Yet, *Cuckoo’s Nest* was not the first work to totally challenge the coercive and prison-like aspects of mental hospitals in the mid-twentieth century. In 1946, Mary Jane Ward published *The Snake Pit*, a semi-autobiographical account of the involuntary commitment of a woman at the impoverished Rockland State Hospital, where she described the people in mental hospitals as being treated like “criminals” and less than human. The book became a bestseller and later an award-winning film with an Oscar nomination. In the decades since the book’s publications, people have used the term “snake pit” to describe the more sordid aspects of the history of psychiatric institutions.¹ The popularity of *The Snake Pit* stemmed in large part from the major public interest in mental hospitals and the treatment of people with mental illnesses in the immediate post-war era. In the same year the book came out, a group of conscientious objectors published a scathing series of photographs in *Life* magazine that compared the conditions in mental hospitals to the concentration camps of Europe. Yet, even with the prominence of *The Snake Pit*, mental hospitals in fact expanded in the late 1940s and early 1950s, leading to a last hurrah of mental hospital institutionalism in U.S. history. By the mid-twentieth century, mental hospitals represented one out of every two hospital beds in the United States, and these held around 600,000 people. The majority of the people in these hospitals lived there involuntarily, as in

Mary Jane Ward’s case. The Snake Pit prompted significant growth in the mental health system, helping it to become the large system attacked in Kesey’s book.

The story of these two books raises the question of how, after The Snake Pit and the Life articles raised such serious doubts about psychiatry, mental hospitals continued to grow in the late 1940s and early 1950s? How did they continue to be places of both treatment and confinement as described in One Flew over the Cuckoo’s Nest? This chapter seeks to answer these questions and in doing so, fills in a neglected part of post-war American history: the history of mental health.

Because of the sheer size of the mental-hospital enterprise and the invasiveness of its actions, one would imagine that mental-health historians had already written and rewritten the history of this form of involuntary confinement. However, only a small number of scholars have written histories of mental hospitals in the years between 1945 and 1955. In From Asylum to Community, Gerald Grob focuses on medical developments in psychiatry and policy changes at the federal level as the beginnings of deinstitutionalization, and as a result, he largely avoids the question of involuntary confinement. In this context, the rise of institutionalism in the late 1940s appears to him a curious, but ultimately marginal, footnote to history. In Acts of Conscience, Steven Taylor studies the activism of conscientious objectors who worked in mental hospitals during and after World War II. While Taylor acknowledges the complexities of this period and the problems of institutions, he focuses his attention on the employee-activists and does not fully face the issues of involuntary confinement and treatment. For the most part, historians of post-

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war mental hospitals have presented more Whiggish interpretations that celebrate the midcentury as a time of progress towards community mental health rather than a peak of institutionalism.

I examine post-war mental hospitals as custodial institutions, studying the politics of these spaces and the surrounding language of incarceration. Just as there exists a prison–industrial complex in twenty-first century America, there was a mental-hospital–industrial complex in the postwar period. It is particularly important to locate carceral strategies in mental hospitals in the mid-twentieth century as prisons were comparatively small in this period. In the 1950s, America’s state and federal prisons and jails held about 120,000 people, less than a quarter of the number of people in state mental hospitals.\(^5\) In studying the custodial aspects of these places, I find that the years after the war were marked by self-doubt in the mental health system, sparked by cultural events such as the *Life* publication and *The Snake Pit*. In response to these publications, mental health advocates and policymakers took two main tacks. First, they attempted to delink mental illness and a eugenics-based criminality in order to argue for better treatment services for people with mental health disorders. To this end, they largely ignored the problem in the state’s prisons at the time, and eventually removed prisons from the agency that also oversaw mental hospitals. Second, optimism in science and medical authority fostered the expansion of mental hospitals, even in the face of deep challenges. As a result, in the late 1940s and early 1950s, state mental hospitals vastly eclipsed prisons and marked the peak of the mental health system’s infrastructure of the twentieth century.

\(^5\) Harcourt, 6.
Conscientious Objectors Charging the State with Neglect

Mental hospitals were a central, albeit struggling, component of welfare services during World War II. Because of major financial cutbacks during the Great Depression and wartime exigencies, state hospitals and prisons across the country became immensely overcrowded and understaffed, while their buildings’ infrastructure fell into disrepair. In Pennsylvania, the Department of Welfare had absorbed a number of county mental hospitals in 1941; by 1943, the Commonwealth housed more than forty-nine thousand people in its mental-health institutions and prisons, excluding the resident staffing of about eight thousand. Scarce appropriations to mental hospitals and prisons throughout the United States in the 1940s caused them to deteriorate rapidly. Even though the number of people in mental institutions was higher than it had ever been, the amount of money spent per person per day was inadequate to take care of the people living there. These cuts made it particularly hard for hospitals to implement new treatment methods such as insulin, fever, and electroconvulsive therapies to help cure mental illness. While tens of thousands of people received these treatments, overcrowding and funding limitations prevented psychiatrists from implementing the new techniques as much as they wanted. When they did, they were largely implemented without the person’s consent.

Particularly during wartime, these expensive institutions caught the eye of conservative politicians, including Pennsylvania’s Republican Governor Edward Martin. During the late 1930s, Pennsylvanians elected their first Democratic governor since 1890, Governor Earle, who instigated a Little New Deal in the state to national acclaim with policies similar to the President’s. Scandals riddled Earle’s administration, and, starting in 1939, Pennsylvanians

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7 Grob, From Asylum to Community, 171–78.
returned to their traditional political roots, electing four Republican governors in a row. Martin was the second of these governors, and came into office in 1943. Governor Martin, a long-time politician and veteran who had served in the Spanish American War and both world wars, won on a platform promising low state taxes, support for the war, and an anti-New Deal stance, calling it “un-American.” He won handily with the support of businessmen such as Joseph N. Pew of Sun Oil, and his constituents were native-born Protestants in small towns and rural communities. Upon election, Governor Martin focused on cutting domestic government spending and inefficiencies, fretting, “At a time when every dollar is needed for war, our social experiments go on and on.” For the 1943–1944 biennium, he sought a major tax cut and focused on stripping down potential extravagances in government agencies such as the Department of Welfare. In response to what he saw as social program excesses, Martin ordered surveys of the state’s prisons and mental hospitals to make government more efficient.

In 1944, Governor Martin appointed two separate committees – one to study the state’s mental hospitals and the other its prisons. The mental-hospital committee, called the Petry Committee after its chair, surveyed the hospital directors for their input and then visited each institution to see them in person. The Petry Committee found that the mental hospitals had resorted to housing people in basements, corridors, and attics due to overcrowding. The hospitals teemed with people in dilapidated buildings, many of which dated to the nineteenth century and

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9 “Accomplishments of the Republican Party in Pennsylvania,” 1943, fol. 15, box 12, Subject Files, Governor Edward Martin Papers, PSA.

put the people there at great risk of fire or sewage hazards.\textsuperscript{11} The Ashe Committee to study prisons found similarly decaying institutions, a number over a century old.\textsuperscript{12} While the governor had commissioned the studies to reduce the money given to prisons and mental hospitals, the committees found that these places did not have nearly enough money, and that the people living in them suffered greatly for it.

When the committees presented their findings, Governor Martin was far from pleased. The Petry Committee recommended that the Department of Welfare repair its mental hospital buildings immediately, and called for a large-scale construction program to build thousands of new beds and to improve the psychiatric programs at the state mental hospitals. The Ashe Committee recommended that the state abandon the antiquated Eastern and Western State Penitentiaries, and build two new medium-security prisons to replace them.\textsuperscript{13} Such programs came with a steep price tag. The governor reeled at the proposals, writing to the Secretary of Welfare, “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.”\textsuperscript{14} The governor here did not just reveal his callous side to the Secretary of Welfare. Additionally, Martin’s language more broadly reflected the contemporary belief that citizens should not seek out mental hospitals as places of refuge, but places of last resort. Many people in the 1940s believed that mental hospitals served a more custodial rather than curative purpose, in order to segregate people considered threatening.

\begin{itemize}
\item \textsuperscript{11} Ibid., 3.
\item \textsuperscript{13} Ibid.; Commonwealth of Pennsylvania Department of Welfare, \textit{Report of the Committee Appointed by the Honorable Edward Martin to Make a Complete Study of the Mental Hospitals of the Commonwealth of Pennsylvania}.
\item \textsuperscript{14} S. M. R. O’Hara, “Letter to Governor Martin,” January 29, 1945, fol. 16, box 25, Subject Files, Governor Edward Martin Papers, PSA. Governor Edward Martin, Letter to S. M. R. O’Hara, April 15, 1944, fol. 13, box 25, Subject Files, Governor Edward Martin Papers, PSA.
\end{itemize}
Therefore, the facilities were expected to not consume large amounts of taxpayer money, particularly during the war. The committees’ reports, then, flew in the face of the governor’s cost-cutting vision, and he did not support the appropriations recommendations. The Legislature joined the governor in rejecting the Petry and Ashe Committees’ plans, ultimately approving only $8 million each for mental-hospital and prison construction projects.\(^{15}\)

After the war ended, Governor Martin changed little from his fiscally conservative stance. Because of the booming economy, he submitted a budget with $200 million in postwar building and improvement projects and a $345 million highway construction program. Even considering these appropriations, the state of Pennsylvania still had a $171 million surplus. However, Martin granted only an extra $44 million to the Department of Welfare, with about $16.5 million earmarked for mental-hospital construction, revealing Martin’s focus on infrastructural development rather than welfare services.\(^{16}\) After the months of committee work to survey institutions, the wartime neglect and fiscal conservatism allowed the terrible living conditions in mental hospitals to continue for another two years and in prisons for another decade.

While state officials and politicians in Harrisburg debated institutional spending, thousands of conscientious objectors (c.o.’s) entered mental hospitals as part of their service during the war. In World War I, many c.o.’s served time in prison, but in World War II, the U.S. government sent them to fight forest fires, participate in medical experiments, plant trees, and work in mental hospitals. The Civilian Public Service placed approximately three thousand c.o.’s

\(^{15}\) Governor Edward Martin, Letter to S. M. R. O’Hara, September 26, 1945, fol. 15, box 25, Subject Files, Governor Edward Martin Papers, PSA; Public Charities Association of Pennsylvania, “Mental Health in Pennsylvania,” February 1947, fol. 11, box 2, Harold Barton Papers, Swarthmore College Peace Collection (SCPC).

\(^{16}\) Klein and Hoogenboom, 427; Governor Edward Martin, Letter to Mr. Wood, August 22, 1946, fol. 14, box 6, Subject Files, Governor Edward Martin Papers, PSA.
at mental hospitals and training schools across the country during the war, purposely putting these men out of sight and out of mind. The male c.o.’s, along with a number of women volunteers, mostly worked as untrained attendants who supervised and helped care for the people in the institution.\(^\text{17}\) The c.o.’s found themselves becoming activists against the racial segregation of the hospitals. While a majority of c.o.’s were white, a significant number of blacks also opposed the war and, like the other c.o.’s, served in the Civilian Public Service. Even though most mental hospitals were racially segregated in the 1940s, and even though most did not employ black attendants, the Civilian Public Service still assigned both black and white c.o.’s to attendant jobs. Even from the beginning, then, the interracial workforce of c.o. attendants had an activist bent as it began racially desegregating state mental hospitals across the country.\(^\text{18}\)

The pacifists also became activists against the terrible conditions while working in the hospitals. Many c.o.’s later recalled in oral histories how when they walked into the wards for the first time, the stench immediately struck them. Huge wards held 250 to 300 people, and the c.o.’s often had only one or two other attendants to help them oversee the chaotic and sometimes violent rooms.\(^\text{19}\) Many c.o.’s faced a particularly complicated issue when they entered the wards. Because many of them opposed violence, force, and coercion against other people, they tried to use nonviolent and humanitarian tactics to help the individuals and to keep order.\(^\text{20}\) A small number of c.o.’s went even further and took their stories to the press in places like Cleveland, Ohio, and Mount Pleasant, Iowa.\(^\text{21}\) But these news stories remained largely local news.

\(^{17}\) Taylor, 79, 229.

\(^{18}\) Ibid., 78–79, 88, 100–101, 229.

\(^{19}\) Ibid., 199, 217–22.

\(^{20}\) Ibid., 217–22.

The nature of the Civilian Public Service made it possible for the c.o.’s to make the mental hospital crisis a national news story. The exposés in Ohio and Iowa prompted four white c.o.’s at Byberry in Philadelphia to incorporate the National Mental Health Foundation (NMHF) in 1945. The interconnected structure of the Civilian Public Service units enabled the Byberry-based NMHF to collect and collate photographs and reports about the mental hospitals from camps across the nation in order to expose not just one mental hospital, but many. The c.o.’s, without ties to the government and with a national network, became unique spokespeople for change and it took its findings to two journalists – Albert Deutsch, who had authored *The Mentally Ill in America*, and Albert Q. Maisel, who worked for *Life* magazine. Deutsch and Maisel culled through the c.o.’s reports; in May 1946, they published separate articles in the leftist journal *PM* and *Life*, respectively, reaching millions of readers. Pennsylvania’s neglect, exacerbated under Governor Martin’s administration, became national news as the reporters targeted Byberry as one of the worst hospitals in the country. The horrific conditions the c.o.’s faced and the financial neglect of Pennsylvania’s government was no longer the secret of a few in the state capitol of Harrisburg, but the scandal of the country.

Deutsch and Maisel used analogies of incarceration to critique the mental-hospital wards. On the first page of Deutsch’s article loomed a photograph of the exterior of the Cleveland State Hospital, a dark and ominous old brick building with impenetrable metal screens over the windows, physically resembling a prison. Maisel opened his article “Bedlam 1946,” by

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22 Ibid., 272–73; “Decree in re. Application for Incorporation of the National Mental Health Foundation Incorporated,” April 26, 1945, fol. 2, box 2, Harold Barton Papers, SCPC.

23 Taylor, 206, 260–1.

describing “a dilapidated overcrowded, undemanned 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 [sic] here 1937.’” Deutsch reported that such murders and beatings occurred regularly, one of many “indignities we have heaped upon most of the 400,000 guiltless patient–prisoners of over 180 state mental hospitals.” They also took aim at restraints, documenting how thousands of people spent long periods of time in leather handcuffs, canvas camises, “muffs,” or “mitts.” Deutsch even published a photograph of a white woman wearing a restraining camisole, the sleeves tied behind her sitting in abject neglect. Prison and mental-hospital staff used such restraints to control people, and in the 1940s most individuals had little recourse to protect themselves.

In addition to prison analogies, Maisel and Deutsch used the Holocaust as a touchstone in their reporting. In the aftermath of World War II, coverage of the Holocaust horrified the American public as it learned about the Nazis’ mass segregation, sterilization, and genocide of non-Aryan people and people diagnosed as mentally ill or mentally deficient. In October 1939, Hitler had signed a decree authorizing their extermination, causing the Germans to build gas chambers at castles, prisons, and a clinic, and then later killing people with starvation, toxic injections and mobile gas units in Germany and in the occupied countries. News of the genocide reached American ears from news correspondent William L. Shirer’s Reader’s Digest article about it in June 1941. Later, after the war, Americans again learned of the atrocities in April and May 1945, when the Allies liberated the concentration camps. National media outlets

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25 Maisel, “Bedlam 1946.”
26 Deutsch, “Filth-Infested Byberry Cured Only Two Out of 5900 Patients in Year.”
28 W. J. Shirer, “‘Mercy Deaths’ in Germany,” Reader’s Digest, June 1941, pp. 55–58, as quoted in Pichot, 204.
brought readers the ghastly images of Buchenwald, Bergen-Belsen, and Dachau, to name only a few, showing countless black-and-white images of corpses, death camps, and emaciated survivors. In the photographic chronicles of Holocaust images, the pictures themselves became the text.29

In 1946, references to the Holocaust evoked fresh memories of the previous year’s liberation. Deutsch titled his article “Byberry Horror Camp,” and wrote, “Byberry, along with too many of our state hospitals, can be compared only to Buchenwald and Belsen.”30 Deutsch echoed the photographs of liberation that had appeared in 1945 with his own photographic montage. “Nakedness” showed men wandering around a ward in Byberry without clothes, living “in filth.”31 “Idleness” described two oversize photographs with thin men sitting naked on the ground, heads in their hands on “refuse-covered floors,” looking as if left to die. Under the caption “Despair,” a naked woman sits on a wooden chair with her head bowed, entirely naked with a distended stomach, emaciated arms and legs and shrunken breasts in full view.32 In Life, Maisel lambasted the state hospitals by arguing that “Through public neglect and legislative penny-pinching, 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 then closed the essay with a call to action. “Given the facts, the people of any state will rally, as have the common people of Ohio, to put an end to concentration camps that masquerade as hospitals


30 Deutsch, “Filth-Infested Byberry Cured Only Two Out of 5900 Patients in Year.”

31 Ibid.

32 Ibid.

33 Maisel, “Bedlam 1946.”
and to make cure rather than incarceration the goal of their mental institutions.” In this way, the reporters charged the U.S. state governments with resembling Nazi policies by incarcerating people diagnosed as mentally ill.

In order to strengthen their claims, the journalists went to great lengths to depict the people living in mental hospitals as sick rather than threatening or dangerous. First, Maisel and Deutsch chose to use the words “patients” and “mentally sick” rather than “insane,” which dated to a past era. In the early twentieth century, new neurological findings and an attempt to break with the mental asylum past had caused 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 in order to determine competency in the courtroom and in criminal proceedings. Second, the reporters did not discuss people in mental hospitals with criminal backgrounds. In the 1940s, many states around the country had wards or hospitals dedicated to people diagnosed as “criminally mentally ill” or “defective delinquent,” meaning that they had mental defects and a propensity for crime. The journalists represented the people in mental hospitals as having committed no crimes and posing no danger to society. While prisons and hybrid mental-health–penal institutions had greatly deteriorated during the 1930s and 1940s, the media did not report that story. The journalists also did not make any mention or comparison to the mass internment of Japanese Americans during World War II. The U.S. government had ordered the segregation of these people due to perceived security threats, but even as Maisel and Deutsch drew analogies to concentration camps, none of them mentioned the Japanese internment camps set up during the war.

34 Ibid.
Finally, the reporters consciously eschewed the language of danger and racial threat that had clung to mental illness in the first part of the century. Insanity had historically been bound up with eugenic efforts to improve the white race since the late nineteenth century, culminating in immigration restrictions on people with mental illness and laws that allowed for their sterilization to prevent them from reproducing. However, particularly in the aftermath of the Nazis’ Final Solution, psychiatry distanced itself from the explicit language of heredity and racial, class, and biological hierarchies. Maisel and Deutsch, in turn, also did not use the language of eugenics to describe the people in mental hospitals in order to strengthen their case that they deserved better conditions. The public should not fear them, but help care for them. In this model, though, both the NMHF and the journalists relied on racial notions of danger and threat. Neither the journalists nor the NMHF included African Americans in their portrayals of poor conditions at mental hospitals. Blacks did live in mental hospitals in the mid-twentieth century, but from viewing the photographs in Life and PM, readers would hardly know; they did not appear. African Americans were also far more disproportionately institutionalized in places for people deemed as having criminal propensities which did not get news coverage and remained marginal to the national narrative. Ultimately, the c.o.’s and journalists’ purposeful avoidance of the themes of racial threat and danger led them to rely on racial and gendered notions of innocence to depict the individuals as victims of neglect.

Having depicted the individuals in mental hospitals as innocents in need of care, the journalists lambasted the institutions for failing to give them treatment. “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 in the United States for every one hundred patients, only twelve percent left their hospitals annually because of improvement, and that of the eight “special therapies” such as electroconvulsive therapy, hydrotherapy, and psychotherapy, many state hospitals, particularly in the South and West, used only two to four as of 1939.\(^ {39}\) Regardless of region, Maisel and Deutsch lambasted state mental hospitals across the country for institutionalizing people without treatment, a state sanction equivalent to incarceration.

In May 1946, the news articles struck a resonant chord in the ears of the American public. The publication of these articles caused citizens to flood the Pennsylvania Governor’s Office with letters, many of which used the analogies from the news articles. One man protested:

> 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.\(^ {40}\)

In the letter, the 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

\(^{38}\) Maisel, “Bedlam 1946.”

\(^{39}\) Ibid.

\(^{40}\) Vincent Gilpin to Governor Edward Martin, May 7, 1946, fol. 12, box 6, Subject Files, Governor Edward Martin Papers, PSA.
provided we should not even consider any other public works,” he wrote. This letter represented one of many that denounced the financial neglect of mental hospitals. Maisel and Deutsch’s evocation of the Holocaust became a rallying cry for Pennsylvanians and citizens around the country to reform state mental hospitals.

A rejection of biological racism, eugenics, and the atrocities of the Holocaust pervaded the changing notions of mental illness in the postwar period. During World War II, freedom permeated the American discourse as a myriad of publications pronounced America’s uniqueness, and its “Four Freedoms:” freedom of speech, freedom of worship, freedom from want, and freedom from fear. In the postwar era, American liberty stood in direct opposition to the Nazi’s “master race” ideologies, which undermined ethnic and racial inequality, and facilitated the development of a more pluralist vision that promoted tolerance and assimilation as a contrasting American virtue. Although tolerance often did not extend to blacks, Latinos, and Japanese Americans, the language of freedom inspired early civil rights activism against government segregation, job discrimination, and the denial of government benefits. The advocacy for mental-hospital reform thrived in this framework of social justice and rights. The NMHF and journalists shunned the language of eugenics that adhered to mental illness and sought to eliminate the incarceration of people in mental hospitals without criminal histories. Yet, at the same time, they ignored racial inequalities and injustices in the mental-health system. Using this model of justice, their claims gained significant traction in the immediate aftermath of World War II.

\[41\] Ibid.

State-Run Snakepits

But the c.o.’s, Deutsch, and Maisel were not the only muckrakers on the scene. In the 1940s, a few people who had formerly lived in mental hospitals wrote scathing autobiographical accounts of their experiences. The most famous publication of the period was Mary Jane Ward’s third novel, a semiautobiographical account of life as a person in a mental hospital titled *The Snake Pit*. Reflecting the lack of historical work on involuntary commitments in twentieth century U.S. mental hospitals, almost no historians have written about Mary Jane Ward even though her book has been published many times and her work cited repeatedly. Born in 1905 as a white upper-class woman in Indiana, Ward loved writing from an early age. In 1928, she married statistician and playwright Edward Quayle and, while in Chicago, she published two books. The couple moved to Greenwich Village, where Ward suffered from a nervous breakdown, and her husband committed her involuntarily to Rockland State Hospital in New York City that at the time held sixty-eight hundred people in a space that allowed for only forty-seven hundred. Ward, an author with a history of publications held a unique position as an insider in the closed world of mental hospitals. Leaving the hospital after a year, Ward decided to use this experience to write a novel about the treatment of people with mental illness, a topic that “many people shun,” she has said. But unlike the c.o.’s, Ward’s story came from the patient perspective, and she had more to lose. She did not write an autobiography, but instead the story of Virginia Cunningham, an act in which she still took a leap of faith as it could expose her as a person struggling with mental illness, something associated with stigma and fear. As she wrote, “Silly Mary, they call

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her. Harmless graduate of an institution, but they call her Silly Mary. I would rather be Silly Virginia shut up than Silly Virginia at large.\footnote{Mary Jane Ward, \textit{The Snake Pit} (New York: Random House, 1946), 53.} Living in upper-class society, married to a statistician struggling to keep his job, the fact that she wrote the book about mental illness, sold it to a publisher, used her own name (albeit her maiden name), and acknowledged its autobiographical nature reflected her courage in the face of social rejection.

Ward also risked the wrath of state governments and politicians, as her book offered a scathing critique of mental hospitals. In \textit{The Snake Pit}, Ward depicted one year in the life of a white, married, middle-class woman named Virginia Cunningham, who struggled with an unnamed mental illness in a state mental hospital. The book opened with Cunningham in a confused state, trying to understand her surroundings in a stream of consciousness that brought to life her confusion and distress. Cunningham first noticed the “zoo-smell” of the hospital, a permanent odor emanating from the women, who wore the same dresses day after day. She then shifted from thinking of the place as a zoo to a prison. She analogized the hospital to a prison because of the locked doors, her loss of freedom and because the woman in charge “treats the women as if they were criminals.”\footnote{Ibid., 26.} The depiction of the hospital as a prison was not new, and other former patient–authors used a similar analogy. Until the 1970s, the majority of people living in mental hospitals had been committed involuntarily by physicians or the courts without due process. Once committed, many individuals often lived for many years there, with little chance to seek their freedom in the courts.\footnote{Grob, \textit{From Asylum to Community}, 289–91.} Ward raised the important issue of involuntary institutionalization – the loss of liberty and due process rights – an issue the NMHF, Deutsch, and Maisel had avoided.
In *The Snake Pit*, Ward also criticized the modern treatments she received while in the hospital. In the 1930s and 1940s, the psychiatric profession discovered and expanded more intensive treatments such as hydrotherapy, electroconvulsive therapies, and insulin shock treatments. These findings gave psychiatrists renewed optimism for curing mental illness: In the postwar era psychiatrists worked to use them even more in the mental-hospital environment.\(^{48}\) By 1941, for instance, more than seventy-five thousand individuals had received some form of shock therapy.\(^{49}\) In midcentury state mental hospitals, psychiatrists initiated treatments largely without the consent of the people who had neither the protections nor the right to refuse treatment. Ward wrote from the patient’s perspective about these involuntary treatments. While at the hospital, Virginia received therapy from a well-meaning but ultimately insensitive Dr. Kik, whose diagnoses seem unfounded, even to his supervisor. (A psychiatrist misdiagnosed Ward herself as schizophrenic, and later another diagnosed her as bipolar.) The book opened, “‘Do you hear voices?’ he asked. 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.”\(^{50}\) Even at the end, when a psychiatrist literally held the key to release her, Virginia watched her every word to make sure that she sounded sane enough to leave. The image of her sanity became literally and figuratively the key to her freedom.

The most disturbing moments in the book came from the forced physical treatments Virginia underwent. She described the attendants wrapping her tightly in blankets and then restraining her and forcing her to stay in a tub as part of her hydrotherapy. The treatments caused


\(^{49}\) Ibid., 182.

\(^{50}\) Ward, 3.
her psychological distress, and she only found solace in her wild imaginings.\textsuperscript{51} Ward also described the experience of the most cutting-edge therapy of the time, shock therapy.

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.\textsuperscript{52}

Through Virginia’s distraught stream of consciousness, she wondered what crime caused such a punishment. Particularly in the immediate post-World War II era, her invocation of a dictatorial system out to punish leftists who “voted for Norman Thomas,” blurred the lines between American democracy and totalitarianism. Her references to political dissidence also resonated at a time when fascism and communism were linked with amorality and mental instability.

Ward’s account of mental hospitals gave a far more complicated critique than those of Maisel and Deutsch, as reflected in her title. \textit{The Snake Pit} did not just refer to an awful place for a person to be kept. Instead, Ward chose the title from a historic story.

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

\textsuperscript{51} Ibid., 173–83
\textsuperscript{52} Ibid., 43–44.
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.\textsuperscript{53}

Virginia’s traumatic experiences at the hands of her caretakers ironically helped her get well by scaring her straight rather than curing her with new therapies. Ward’s ambivalence towards treatment and reform also came through in the form of a hospital nurse, a compassionate character who argued for reform and change. In Ward’s story, the nurse did not ultimately save the day. Instead, she eventually became a patient herself.

In contrast, in “Bedlam 1946,” Albert Maisel had argued that these institutions could become more curative places. Maisel posited that focusing on treatment produced better results as the majority of people in hospitals could improve and then live 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.”\textsuperscript{54} In the histories of mental health, scholars have often merged Ward’s far more radical critique of psychiatry and mental hospitals with the accounts of the c.o.’s, Maisel, and Deutsch.\textsuperscript{55} But Ward’s writings, and the writings of other people who had lived in mental health institutions such as Margaret Aikins McGarr and Frances Farmer, showed far less optimism in the power of state-sponsored mental hospitals to alleviate suffering. While both Ward and the journalists

\textsuperscript{53} Ibid., 216–17.

\textsuperscript{54} Ibid.

\textsuperscript{55} Andrew Scull, The Insanity of Place / The Place of Insanity: Essays on the History of Psychiatry (New York: Routledge, 2006), 99–100; Grob, From Asylum to Community, 72–77.
critiqued the state’s neglect, Ward moved beyond neglect to question involuntary commitments, treatment, and psychiatry itself.

There is also some evidence in the Governor’s papers about how people in Pennsylvania resisted the victim depiction. One man who was institutionalized “through pressure groups,” who lived at Allentown State Hospital for over two years, wrote that he had seen the hospital from a patient’s point of view. From his perspective, he did not agree with the journalists’ stories, and urged the governor to defend the mental hospitals. Another woman who had lived in mental hospitals wrote to Secretary O’Hara and said that she found Deutsch’s reporting full of errors and misstatements. She wrote that she had contacted Deutsch about her concerns, but that he did not take them seriously. These writings point to the different perspectives on behalf of people living in mental hospitals. Not all of them necessarily thought as Mary Jane Ward did, and not all celebrated the work of Maisel and Deutsch. The majority of letters that I found at this time, however, appeared to accept Deutsch’s account as true.

Ward’s account ultimately became the most famous account by someone who had lived as a patient in a mental hospital. The book became a national bestseller, a Book of the Month selection, and within the first month generated $100,000 in sales. Reader’s Digest published the story and reviewers praised its inside glimpse into the life of a person dealing with mental illness and living in a mental hospital. Almost immediately, Jewish émigré director Anatole Litvak purchased the film rights to the book and the movie came out a mere two years after the book’s publication. Ward herself showed surprise at the book’s popularity, particularly as she thought that The Snake Pit had “no plot, no love story, and it concerns a subject most people find

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56 Leo C. Gaumer to Governor Edward Martin, July 22, 1946, fol. 12, box 6, Subject Files, Governor Edward Martin Papers, PSA.
57 Anne O’Sullivan to S. M. R. O’Hara, July 3, 1946, fol. 14, box 6, Subject Files, Governor Edward Martin Papers, PSA.
disagreeable.”

Why, then, did it become so successful? *The Snake Pit* offered a rare first-person account behind the locked doors of the mental hospital, making it particularly appealing to the public. The popularity of Ward’s book also reflected the paternalist attitudes towards white, upper-class women in the 1940s. The public responded with shock to the experiences of a white, upper-class woman in an institution for working class people. Most of the accounts of people who had lived in mental hospitals published in the period and that still circulate today came from white women, which some historians have linked to the sexism of psychiatry in the period. I would also argue that their popularity stems from the linkage between notions of victimhood and white womanhood.

The critical writings of individuals such as Ward pointed to an imbalance of power, not just between the people who lived in mental hospital and psychiatrists, but between the medical establishment and subjects more broadly in the postwar era. Mental hospitals were not just places for people diagnosed with psychiatric disorders, but also places where state psychiatrists, family members, and the courts sent people with social disorders. Psychiatrists committed people identified as homosexuals to mental hospitals, as well as people who defied social norms, yet committed no serious crimes. The New York City police, for instance, picked up a young Allen Ginsberg one day and instead of spending time in jail, the court sent him to a mental hospital. The postwar era was also a time when many people did not have protections in the face of unwanted medical procedures. In the late 1940s in Tuskegee, doctors withheld penicillin from a

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59 Geller and Harris, *Women of the Asylum*.

group of African American men with syphilis, and government-sponsored U.S. doctors purposely infected Guatemalans in prisons and mental hospitals with the same disease between 1946 and 1948. 61 At Philadelphia’s Holmesburg Prison in 1951, University of Pennsylvania researchers experimented with new medicines and chemical agents on people in prison, most of whom were black, for a small wage. 62 State-sponsored medical power had few limits during the postwar era, as Mary Jane Ward’s account so vividly revealed.

**The Last Hurrah of Mental Health Institutionalism**

Confronted with cries of concentration camps and snake pits, state policymakers and politicians responded with a variety of reforms so that state governments ceased to appear so neglectful and brutal. The Pennsylvania Department of Welfare responded to the charges of poor conditions by issuing its own pictorial report. While the Department admitted that that some institutions suffered from overcrowding and understaffing, particularly Byberry, it held that those worst wards did not represent the state’s mental hospitals as a whole. Overall, though, it acknowledged some serious problems, and used the crisis to call for more community involvement and more funds from the Legislature to improve the conditions. “The emergency must be overcome. The future must be met,” it announced. 63 The emergency empowered the Department of Welfare to again ask for the funding plans that Governor Martin and the Legislature had denied in 1944.

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The NMHF joined the Department in supporting government spending to make mental hospitals more curative. In 1946, the NMHF published a public-education pamphlet, “For These We Speak,” in which it blamed the concentration-camp–like conditions of public mental institutions on “lack of funds and personnel,” and called for “higher standards of care and treatment in mental institutions.” Other organizations joined this effort as well, including the Public Charities Association (PCA) and the League of Women Voters. Appropriations topped their list of requests, and these organizations, along with the NMHF called upon the Legislature to almost double its appropriations for the Department of Welfare budget for people diagnosed as mentally ill, mentally defective, or epileptic in the 1947–1949 biennium. The money would fund a large-scale construction project of institutional expansion to accommodate more beds in order to relieve overcrowding. Here, the organizations’ advocacy echoed New Deal ideologies that called for increased government spending to help people in need. To them, the terrible conditions in mental hospitals had occurred because of the fiscally conservative policies of politicians like the Republican Governor Martin, whose failure to spend money on mental hospitals had led to the suffering they witnessed at hospitals such as Byberry.

To strengthen their calls for reform, the NMHF envisioned making change around the country, not just in Pennsylvania, so it sought out national celebrities for support, an unusual move for an organization less than two years old. The NMHF looked to celebrities to give them legitimacy as the organization faced the double stigma of pacifism and unpatriotic ideals and because of public unease around the subject of mental illness. The NMHF found an important ally in Supreme Court Justice Owen Roberts, a Pennsylvanian who in 1945 had retired from the

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64 National Mental Health Foundation, “For These We Speak,” 1946, fol. 3, box 2, Harold Barton Papers, SCPC.

65 Public Charities Association of Pennsylvania, “Mental Health in Pennsylvania,” February 1947, fol. 11, box 2, Harold Barton Papers, SCPC.
court and returned to his home state. The Republican Justice Roberts was best known as a swing-vote on New Deal economic policies on the Supreme Court, opposing economic regulation while upholding the National Labor Relations Act and the Social Security Act. Roberts took a more liberal stance on civil rights and civil liberties, advocating the rights of indigent people to counsel and the freedom of speech and religion. Most notably, Roberts vehemently opposed the internment of Japanese Americans during World War II. When the Byberry reports hit the newspapers, Justice Roberts championed the issue of mental health and became President of the NMHF. With his backing, former First Lady Eleanor Roosevelt, the soon-to-be chairwoman of the United Nations Commission on Human Rights, also joined the Board of Directors. Roosevelt had not only become a great supporter of welfare causes, but she had also opposed the internment of Japanese Americans, ultimately failing to convince her husband not to order it.

Civil libertarian Roger Baldwin became part of the Board of Directors, both because of his own conscientious-objector past and his commitment to civil rights. Human rights became a central reason for reform in U.S. mental hospitals.

The revelations about American mental hospitals also sparked a bipartisan effort to reform them in the name of American democracy and care for the weak. The postwar era was a time of economic prosperity and a peak of liberal governance in which state and federal governments expanded social and economic programs for U.S. citizens. In this context,

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Democratic luminaries, such as President of the United Auto Workers Walter Reuther and First Lady Bess Truman, signed the list of national sponsors, giving an important stamp of approval from the liberal establishment. Republicans joined as well, like the prominent Republican Henry Luce, owner of Life and a renowned anticommmunist. As Luce wrote in his landmark essay “The American Century,” he viewed America as the international Good Samaritan and a force of international democracy.\textsuperscript{70} Because of this international role, the United States had to eliminate the prison-like conditions of its “snake pits.” The presence of such high-level sponsors helped the NMHF change the public conceptions of people in mental hospitals to deserving care rather than just custody, and made the issue one of national concern. In turn, this bipartisan coalition did not call for the disbandment of these institutions. Instead, both Republicans and Democrats supported increased government spending to improve the treatments offered to people in state-funded mental hospitals.

An era of big government spending and a focus on making productive citizens bolstered the efforts to reform and expand mental hospitals. In Pennsylvania, the fiscally conservative politics of Governor Martin were replaced by a new Progressive Republican Governor James Duff. While Duff opposed economic regulations and organized labor, he differed from Martin in his support for social services for people in need. Another Republican-leaning organization that supported reforms was the Pennsylvania Economy League, a business-interest organization based in Pittsburgh. The league, incorporated in 1936 in order “to cut wasteful government spending,” was dominated by regional business interests.\textsuperscript{71} Because the mental-health legislation


had major implications for taxes and government budgeting, the Economy League became active on this issue as well. While the league initially opposed the mental-hospital appropriations projects, it ultimately 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,” it stated. The fiscally conservative league held that the prevention and cure of mental illness would be economically advantageous to society, and it announced its support for the governor’s construction program, while still emphasizing the importance of “a planned curative program,” rather than just construction projects. Thus, a bipartisan effort formed between the more politically liberal organizations such as the NMHF and the PCA and the more conservative Republican Party and Economy League. A bipartisan consensus on big government spending to reform and expand mental hospitals was afoot.

While advocates had invoked the language of the Holocaust to convey what they viewed as an immediate crisis within mental hospitals, at that point the comparison ended and the critiques of Mary Jane Ward appeared almost irrelevant to the discussion. Even in the face of “Bedlam 1946” and The Snake Pit, mental-health advocacy organizations, conservative business leagues, the Department of Welfare, and the Governor’s Office responded to the crisis not with a rejection of mental-health institutions, but instead with more beds and more treatment.

The impetus to reform rather than to dismantle mental hospitals came in part from the optimism in science and medicine in the years after World War II, when rehabilitation was the watchword. In Replaceable You, David Serlin defined the decade after the war as a time when

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72 Harold Barton, “Notes of Harold Barton,” February 13, 1947, fol. 10, box 2, Harold Barton Papers, SCPC.

73 Pennsylvania Economy League, “Mental Health Program in Pennsylvania,” 1947, fol. 8, box 25, Subject Files, Governor James H. Duff Papers, PSA.

74 Ibid.
the medical profession and the public celebrated procedures that would rehabilitate and alter the human body. Disabled veterans touted their new prosthetic devices and plastic surgeries, while hormone treatments and sex reassignment became national news. According to Serlin, “physical rehabilitation became an allegory of national rehabilitation and the capacity for medical procedures to make such rehabilitation not only visible but also literal on the human body.” These medical procedures dovetailed with new federal policies that focused on rehabilitating the physically disabled. Vocational rehabilitation programs emerged in the 1920s to help disabled people return to industry or occupational work, and the federal government greatly expanded employment opportunities for people with disabilities in the 1940s and 1950s. For people with intellectual disabilities, professionals in the postwar period charted their productive possibilities and made arguments about the possible costs and benefits of rehabilitation, leaning away from racial-danger language of earlier decades. According to Allison Carey, professionals of the day espoused that “professional intervention would save the nation from undue economic and social burdens.” In the field of psychiatry, the tide also shifted to cure rather than custody, part of the renewed rehabilitation program for people with both mental and physical disabilities.

The political cures continued to happen within the custodial framework, rather than in the community, and they centered on places that did not hold people with criminal histories. In Pennsylvania, the Legislature passed a bill for construction of mental hospitals in 1947 with $70 million and unexpended funds that brought the total to $82 million for mental institutions, “greater than the total of all previous appropriations combined in the history of the

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76 Audra Jennings, “With Minds Fixed on the Horrors of War: Liberalism and Disability Activism, 1940–1960” (PhD Diss., The Ohio State University, 2008).

77 Carey, 83–104, quotation from 104.
Department. At Byberry, the funds enabled the Department to modernize the kitchen and toilet facilities, build new garage and storage facilities, and fully renovate nine buildings. The changes to hospitals proved a double-edged sword. On the one hand, parents and friends of people in mental hospitals thanked the governor profusely for the improvements the state made. For instance, one woman wrote that she had a friend in a state hospital who was cleaner and better dressed than before the reforms. A true appreciation of the governmental efforts to take better care of loved ones came through. At the same time, though, the building programs led to a rise in the number of people that the hospitals could safely hold. The number of people in Pennsylvania’s mental hospitals and state training schools increased by five thousand people between 1944 and 1951. This surge reflected a national trend as the rates of people committed to mental hospitals reached its highest point ever in U.S. history. The critiques of mental hospitals did not lead to their closure, but instead their expansion.

The reform efforts also fueled an expansion of the number of treatment initiatives for people in mental hospitals, including many of the same treatments that Mary Jane Ward opposed as coercive. In 1947, Pennsylvania Secretary of Welfare Charlie Barber optimistically estimated that with better treatment programs, the best state mental hospitals could return seventy percent of people to their communities within a year, excluding the elderly. As a result, state money also

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

79 [Description of Construction Projects at Philadelphia State Hospital], box 4, Philadelphia State Hospital Unprocessed Collection, PSA; [Description of Buildings at Philadelphia State Hospital], box 9, Maps Folder, Philadelphia State Hospital Unprocessed Collection, PSA.

80 Lorna Huffman, Letter to Governor Duff, December 28, 1948, fol. 7, box 25, Subject Files, Governor Duff Papers, PSA. Also see Jane D. MacDonald, Letter to Governor Duff, August 10, 1948, fol. 7, box 25, Subject Files, Governor Duff Papers, PSA.

went to hiring more psychiatric staff and increasing treatments.\textsuperscript{82} After 1945, the number of psychosurgeries conducted in mental hospitals also spiked, a development that psychiatrists considered positive as more individuals could benefit from breakthrough technologies.\textsuperscript{83} Because of the consensus from policymakers, Department of Welfare officials, and the NMHF, the state responded to the crisis with more treatment programs, rather than fewer. The expansion of these rehabilitative programs happened largely without the input of the people who were treated, and without any discussion of the involuntary nature of treatment that Ward had brought to light in \textit{The Snake Pit}.

When the dust settled in 1951, Albert Maisel again picked up his pen and wrote about the changes in mental health since “Bedlam 1946.” In preparation for his retrospective article, Maisel visited thirty hospitals across the country and found that many of them, from Pennsylvania to California, Kansas to Minnesota, had increased their appropriations for mental hospitals and initiated reforms in mental-health laws because of the national outcry and bipartisan legislative actions.\textsuperscript{84} According to Maisel, government spending and improved staffing had made all the difference, truly transforming the places from asylums to hospitals.\textsuperscript{85} To bring the changes to life, Maisel told the story of a woman committed for fourteen years to a state hospital, who came back to sanity through regular talk therapy and daily attention. Finally, at the age of seventy-two, she found work as a companion to an elderly person and left the institution. Maisel concluded his uplifting essay with a photograph of the Ohio governor on Halloween in

\textsuperscript{82} Barber to Governor Duff, December 1, 1947.
\textsuperscript{83} Grob, \textit{Mad Among Us}, 183.
\textsuperscript{84} Albert Q. Maisel, “Scandal Results,” \textit{Life}, November 12, 1951.
\textsuperscript{85} Ibid.
1949 showing the governor setting fire to a pile of strait jackets, cuffs, and mittens at the Minnesota Anoka State Hospital, representing a break with the mental hospital’s prison-like past.

Yet, the treatments in the late 1940s and 1950s in mental hospitals remained largely involuntary. Letters from people in institutions and their supporters offer a glimpse into an alternative view of the progressive reforms of the late 1940s. One woman wrote to Governor Duff about her concerns over the rush to build. She had lived at Danville State Hospital for one year, from 1944 to 1945, where her husband committed her without her consent. The conditions there 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.”

Another 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.”

These voices of opposition, along with Mary Jane Ward’s, remained marginal to policy debates in the late 1940s. However, they foreshadowed a larger movement for patients’ rights that would develop within about a decade through the writings of Erving Goffman, Thomas Szasz, and Ken Kesey.

While psychiatric professionals, politicians, advocates and bureaucrats expanded the treatments, people in the late 1940s did not gain the right to choose or refuse treatment, nor did they gain the right to their freedom if they wanted to leave the institution. In this era of human

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

87 J. C. Heinz to Governor Duff, February 28, 1949, fol. 7, box 25, 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.
rights and care for people with mental illness, the perspective of people in mental hospitals, the
people most affected by state policies, remained largely irrelevant to policy making. The \textit{parens}
patriae model of commitment and custody in institutions overrode these voices of opposition.
The references to Bergen-Belsen and the analogy of the snake pit had not led to the closure of
these hospitals; instead, at a time when American politicians and the public had created a hybrid
of custody and cure, mental hospital institutionalism reached its height.

In the shadow of this focus on mental hospitals lay prisons. Even though the Ashe
committee on prisons had in 1944 found that the state prisons had fallen into terrible disrepair,
the legislature did little to nothing to correct the problems. Instead, most of the state’s money for
improving institutions went to the mental hospitals and the Ashe plan to improve prisons was
effectively “shelved in competition with other social welfare and health claims.”\footnote{88 PCA Penal Affairs Division, “A Statement to the Governor’s Committee Investigating Pennsylvania’s Prison System,” \textit{Currents in Pennsylvania’s Health and Welfare} 4, no. 4 (Summer 1953), 26–27.} As the mental
health reformers focused on disassociating mental health from criminality, so too did the state
neglect the institutions that held people convicted of crimes. The state’s prisons continued to
deteriorate into the early 1950s, and in 1952, a riot broke out at Western State Penitentiary in
which the inmates 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 institution once a month and talk with the people there. Here, Pennsylvania was not
alone, as over two dozen other prisons across the country rioted in 1952 and 1953.\footnote{89 James V. Bennett, “The Significance of the Prison Riots,” \textit{Currents in Pennsylvania’s Health and Welfare} 4, no. 4 (Summer 1953), 2–5; Clement T. Woutersz, “Demands Made by Inmates at Time of the Riot at W.S.P.,” January 18, 1953, fol. 1, box 2, Department of Justice, Bureau of Corrections Special Investigations, PSA.} The
expenditures to the mental health systems nation-wide had led to dilapidating prisons and the
unrest of the people living inside them.
The state responded to the riots by attempting similar reforms in the correctional system that it had in the mental health system. As the following chapter will discuss, the state embarked on a program to build new classification centers and psychiatrically-oriented treatment and classification programs for people in prison. Another main response in 1953 to the prison uprisings was that the state removed prisons from the supervision of the Department of Welfare. Instead, the Department of Justice became responsible for prisons, under a new Bureau of Corrections.90 The removal of the corrections system from the Department of Welfare reflected the broader trend occurring through the late 1940s. In response to accusations that the Department of Welfare mental hospitals resembled prisons, policymakers worked to make distinctions between the two categories of people and two types of institutions. Finally, by 1953, they no longer even ran under the same branch of government. Instead, one now fell under welfare and the other under justice.

In the years between 1945 and 1955, mental hospitals in particular came under public scrutiny as prison-like and confining settings. However, despite critiques such as Ward’s that called the entire system into question, a culture of institutionalism and a focus on paternalist custodialism remained strong in mental health. Meanwhile, institutions for people with criminal histories did not receive the same widespread attention, reflecting a divide between policies towards people deemed dangerous or law breaking and people considered victims of physical or mental disability. But the total focus on innocent victims in mental hospital at the expense of people in penal or security-focused institutions cuts to the heart of postwar social policies and civil rights. The framework of providing more social supports and the emergence of community

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alternatives for people deemed innocent, or victims, would play a large role in the debates over the role of government over the next few decades.

Rights also play a large role here as well. Individuals with mental illnesses were given the right to receive treatment from the state in the late 1940s and 1950s, although it came primarily in the context of involuntary incarceration. The claims to the liberty that Ward clearly articulated were not taken seriously in this period. Instead, improving and expanding coercive treatment became a human rights movement in the post-war period, and it came at the expense of civil liberties. This tension between state treatment and civil rights became a central issue of the debates over deinstitutionalization in the 1960s, 1970s, and even still today.
CHAPTER III
STATE PSYCHIATRY IN THE AGE OF ANXIETY

The years between 1955 and 1965 were a time when rehabilitation of the individual became a paramount theme in American society and politics. In 1966, sociologist Philip Rieff wrote in *The Triumph of the Therapeutic* that society had eschewed faith to focus on personal self-fulfillment and change.¹ Historians have also charted how rehabilitation of the individual also became a paramount theme in U.S. liberal governance. Jennifer Mittelstadt charted how welfare programs focused not only on providing welfare recipients with income assistance, but with social programs devised to make them financially independent.² A similar concept infused programs for people with disabilities, and Audra Jennings argued that in this era state governments introduced new vocational programs for individuals with physical disabilities in order to make them more productive in a capitalist society.³ In the case of intellectual disability, sociologist Allison Carey found that a movement of parents and family members of people with mental retardation advocated for better rehabilitative services in institutional settings, community vocational programs, and public schools.⁴ Taken as a whole, the late 1950s and early 1960s was a time when the rehabilitative ideal of fixing individuals to solve the social problems of the postwar capitalist system was central to liberal state programs.

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Central to these state programs were the mental health and corrections systems, and the years between 1955 and 1965 similarly brought an embrace of the rehabilitative ideal. During the Age of Anxiety in the 1950s, psychiatric understandings of human behavior proliferated throughout American culture. Pharmaceutical companies introduced major and minor tranquilizers and sedatives for the first time to the American public. The American Psychiatric Association (APA) worked with politicians to create public mental-health services in communities rather than in distant mental hospitals, culminating in the landmark Community Mental Health Centers Act which Congress passed in 1963. In particular, historians Edward Shorter and Gerald Grob have depicted the era as the beginning of the deinstitutionalization of mental hospitals with new ideologies of community mental health enabled in large part by the advent of psychiatric medications. These historians have depicted the late fifties and early sixties as the start of a long trend towards moving away from the archaic mental hospital and towards the modern system of community-based psychiatric treatments.\(^5\) If the decade after World War II brought the peak of custodial institutionalism, the following years brought new programs that sought alternatives to these places.

This progressive narrative in mental health to some extent mirrors accounts of the history of prisons at this time. Some scholars have described the decades after World War II as one in which prison officials moved away from pure imprisonment as a way to stop crime. In the 1950s and 1960s, American prisons experienced a revival of what sociologist David Garland called a “‘penal–welfare’ structure, combining the liberal legalism of due process and proportionate

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punishment with a correctionalist commitment to rehabilitation, welfare and criminological expertise." While the focus on rehabilitation had begun as early as World War II, policymakers placed more emphasis in the 1950s on seeking more curative alternatives and ancillaries to prisons. The number of people imprisoned between 1961 and 1965 in America declined annually, and the President’s Crime Commission advocated for the creation of resources in the community to rehabilitate people convicted of crimes in lieu of punishing them. As a result, these reforms brought new ideologies in mental health and corrections that turned away from the large, custodial institution and appeared to weaken the tradition of confinement.

While I agree that this period brought this anti-custodial institution turn, I argue in this chapter that the trope of anti-institutionalism does not do justice to the developments at the time. The actual numbers of people in prisons, mental hospitals and juvenile delinquency facilities did indeed fall in the early 1960s. However, the mental-health and corrections systems as a whole grew during this period with the proliferation of parole officers, foster homes, halfway houses, and outpatient facilities. The state created these smaller, community-based programs as ancillaries to mental hospitals, training schools, and prisons in order to rehabilitate individuals with mental illnesses and/or criminal histories. While the new methods were not based in large, custodial institutions, they still entailed the coercive placement of people into them by psychiatrists and the courts and a more dispersed form of institutionalism emerged. By studying this transformation, I complicate the progress narrative of this era as the beginning of deinstitutionalization. Instead, I cast it as a time when state psychiatric interventions proliferated in society, weakening the reliance on large custodial institutions. Yet, still, the reforms relied on

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a notion of the state’s power to intervene into individual behavior as a response to social disorder.

**Crises in Mental Health-Penal Institutions**

Pennsylvania became a leader of reforms in mental health with the election of the 36 year-old Democrat Governor George Leader in 1954. Leader grew up on a poultry farm in rural York County and was influenced by his father, who was active in the Democratic Party. After serving in World War II and attending graduate school at the University of Pennsylvania’s Fels Institute of State and Local Government, Leader successfully ran for his father’s former seat as state senator, and then set his sights on the Governor’s Office. Leader’s strong agrarian and labor support helped him win the seat, which had been held by only one other Democrat, George Earle (1935–1939) in the twentieth century. When Leader took over, he became one of the most progressive governors the state had elected. Even though Leader entered office as a young man, he took bold steps toward improving social services, modernizing the Civil Service system, and initiating the Pennsylvania Industrial Development Authority which created jobs and supported manufacturing. Leader also implemented the Fair Employment Practices Commission in 1956 and helped pass a law to expand the rights of women in regards to property ownership. To Leader, state government had the ability to create better housing for people, cure mental illness, and prevent juvenile delinquency – it was just a matter of creating the programs to do so. Leader’s platform echoed the postwar liberal ideals of strengthening the United States by

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supporting the economic and social well-being of the citizens through social programs and civil-rights policies.9

A central plank of Leader’s program focused on rehabilitating individuals with physical and intellectual disabilities. For instance, he oversaw the creation of a vocational training facility for people with physical disabilities in Johnstown, Pennsylvania, the largest and best-funded program of its kind nationally. He also appropriated educational funding for children with disabilities to study in public schools, and exempted individuals with visual disabilities from a number of fees and regulations.10 These new initiatives reflected statewide and national programs intended to rehabilitate individuals with disabilities in order that they become more productive citizens.11

As the administration placed a higher value on social welfare and rehabilitation, so to did it make mental health a more central issue. In the mid-1950s, the Keystone State ranked forty-fifth among the states for its rates of discharging people from mental hospitals, a statistic that made it known as one of the worst in the country for “warehousing” people in institutions.12

When a local historian interviewed Governor Leader in 2009 and asked him about the mental-health program in the 1950s, he recalled, “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.”13 The mental hospitals’ infrastructure at the mid-twentieth century conjured

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10 Wolensky, 56–58.

11 Jennings; Carey.


13 As quoted from Wolensky, 66.
up images of today’s prison industrial complex. The immensity of the mental-health system, coupled with the reformist zeal of the young Governor, led to a second wave of reforms that came less than ten years after the agitation of the conscientious objectors at Byberry.

A Democratic State Senator, Harry Shapiro, took over as the head of the state’s Department of Welfare, and in that position he sought to improve conditions at the institutions under his discretion. He worked closely with Governor Leader in a relationship so productive that decades later, Leader commissioned and co-authored a book about his friend and colleague titled Unlocking the Doors. His program of reform came in large part because of major scandals at three hybrid mental-health-penal facilities: Farview, Morganza and Laurelton. These were some of the only security facilities the Department of Welfare ran after the state had created a separate Bureau of Corrections in 1953, and they erupted in conflict in the mid-1950s.

The Farview State Hospital for the Criminally Insane came into national news first. The state had established Farview in 1905 and opened it in 1912 as the first and only mental hospital for the criminally insane in the state. The hospital sat in the northeast corner of the state on Moosic Mountain, where it overlooked Waymart, a borough twenty-five miles north of Scranton and 141 miles north of Philadelphia. Although the anthracite coal region around Farview did have some economic opportunities in the twentieth century, it held far fewer people than the dense metropolitan areas of Philadelphia and Pittsburgh. Still, it was not totally isolated. While the region held only a small portion of the state’s population, it held at least a quarter of its

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14 George Michael Leader and Elisabeth Myers, Unlocking the Doors: Harry Shapiro and the Reforms of the Pennsylvania Mental Health System (Hummelstown, Pa.: Leader Publishing, 2005).

institutional population. By the 1960s, the northeastern quarter of Pennsylvania held four state mental hospitals, one developmental center, and two prisons all within a 120-mile radius.\textsuperscript{16}

Section 404 of the Pennsylvania Mental Health/Mental Retardation Act allowed the Bureau of Corrections and the Department of Welfare to commit people with criminal charges or sentences to Farview without judicial review. The law also allowed two physician’s certificates as enough for an involuntary and indeterminate commitment. So, by the mid-1950s, most people at Farview did not live there by order of the courts, but instead came to the institution from prisons that had deemed them criminally insane or from other hospitals where they “had proved too violent or troublesome for the staff to handle.”\textsuperscript{17} The courts had very little involvement in the commitment decisions, and the staff of Farview only had to review the commitment at least once per year.\textsuperscript{18} As a result, the hospital held people convicted of crimes who were also diagnosed with mental illnesses or who had been in mental hospitals but whom the administration deemed too dangerous to stay there. While in many ways Farview operated like a prison, the individuals there did not have prison sentences, but instead had indefinite terms.\textsuperscript{19}

This hybrid mental-health–penal facility that the Department of Welfare ran came into the national spotlight when a judge released Louis Henry Ross, a.k.a. the Laughing Eel, who had acquired the nickname because he hysterically laughed at his victims after robbing them and had

\begin{footnotes}
\item[16] The facilities included Farview State Hospital for the Criminally Insane, Retreat State Hospital for the Mentally Ill, Clarks Summit State Hospital for the Mentally Ill, Danville State Hospital for the Mentally Ill, the White Haven Center, State Correctional Institution (SCI)-Muncy, and SCI-Dallas. SCI-Dallas had converted in 1966 from a prison for defective delinquents to a medium security prison.
\item[18] Ibid., 18.
\item[19] For example, Ralph Hoge had murdered his young son and later appealed the court’s ruling that he was insane so that he could transfer back to Western State Penitentiary. At Western State, he could become eligible for parole while at Farview he most likely would never have left because so few people left Farview under the commitment rules. This case reflected how Farview resembled a prison. However, people in fact often lived there for longer periods as the staff often did not want to release patients because of their criminal backgrounds. “Await Verdict in Sanity Hearing,” \textit{The Record-Argus}, Greenville, Pa., January 26, 1955, 3.
\end{footnotes}
the uncanny ability of eluding the police. Ross had committed a string of robberies in the 1920s, and the court had given him a six to ten year prison term. But, because the judge found him insane, he went to Farview rather than prison. Ross lived there for thirty years until he unsuccessfully escaped. When the police took him in front of the court after catching him, the judge reviewed his records and determined that Ross “must have been sane since 1943,” and released him to society.\(^{20}\) The case spread through the national media to places as far-flung as Long Beach California and Hagerstown, Maryland and Farview became known as “the road of no return.”\(^{21}\) The determination of the Laughing Eel’s sanity revealed serious cracks in the mental-health system in 1954, and showed that the lack of quality psychiatric services at the mental hospital amounted to lifelong imprisonment for people found insane one time and never properly reevaluated. The case of the Laughing Eel exposed the grave injustices when the mental-health system failed.\(^{22}\)

The eyes of the public then turned to the Morganza Training School, another mental-health–penal facility. The state had established Morganza in 1854 as a training school for delinquent boys twelve miles north of Pittsburgh. By the 1950s, Morganza held both boys and girls diagnosed with mental-health disorders in cottage-style dormitories with no bars on the windows or external walls.\(^{23}\) Morganza came to Shapiro’s attention after an incident in which


children were confined for only a small infraction. Soon after, the death of an 18-year-old boy in a machine shop accident prompted employee and inmate whistleblowers to come forward and report deeply troubling practices at the facility. The Legislature set up a committee in 1955 to hold hearings and investigate conditions there: In the hearings, four African American young women reported guard beatings and employees testified to physical reprimands and isolation cells. In the middle of the investigation, a number of youth took matters into their own hands, further throwing Morganza into crisis. Fifteen teenage girls, dressed in jeans and blue jackets with white stripes escaped by climbing through the cottage windows at night. It was the largest escape in some years and it reflected the teenagers’ unhappiness with their confinement and the disorganization of the institution. The hearings and the escapes of the youths exposed to the public an environment that was anything but therapeutic and rehabilitative, contrary to the stated intention of the Department of Welfare institution.

The third major crisis occurred at Laurelton State School and Hospital. The state had created Laurelton in 1913 as the Pennsylvania Village for Feebleminded Women, with the purpose of “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.” Because of this rule, the women stayed an average of twenty-nine years each, often leaving after they had reached menopause. The Department of Welfare considered Laurelton a “closed institution,” with locked cottages and a maximum-security cottage built on campus in 1953 because, by that time, the institution confined many women with delinquent

24 Leader and Myers, 50.
26 Ibid., 5.
backgrounds, not just diagnoses of mental defects.\textsuperscript{28} Shapiro looked into conditions at Laurelton and reported that the women only gained access to water once per day, and that staff restrained, beat and dragged some of them by their hair. These behaviors, along with the maximum-security cottage were “reminiscent of the Dark Ages,” Shapiro stated to the press.\textsuperscript{29} Even though critics accused Shapiro of political motivations, he still got the backing of Governor Leader and successfully pressed the Legislature to investigate conditions at Laurelton.\textsuperscript{30}

**Community Cures**

In the 1940s, conscientious objectors had called for reform at civil mental hospitals; in the mid-1950s, the spotlight fell on these hybrid mental-health–penal institutions that had more the explicit intention of security in their missions. There are three main reasons these facilities garnered this attention. First, the conditions in the civil facilities had improved more than in the more security-focused institutions: By the 1950s, the conditions at places like Farview, Morganza, and Laurelton were worse than at the others. Second, the 1950s was a decade of increased policing of deviant and delinquent behaviors. During the years of anticommunist witch hunts and police surveillance, Governor Leader enhanced the Commonwealth’s police forces, and the state built a new State Police Academy in Hershey. The Legislature also passed laws that prohibited adult pornographic literature and regulated illustrations of drugs, violence, and vulgarity in children’s comic books.\textsuperscript{31} In this environment of security interests, institutions like Laurelton, Farview, and Morganza particularly held the public and state government’s attention.

\textsuperscript{28} Ibid., 31.

\textsuperscript{29} “Mental Defectives in Laurelton Cottage,” *The Lock Haven Express*, Lock Haven, PA, February 16, 1955, 3.


\textsuperscript{31} Wolensky, 57–58.
Finally, the crises at these institutions, the most security-based sites the Department of Welfare oversaw, laid bare the question of the exact role of the mental health institution in society. By investigating these institutions and trying to make changes at them, the state exhibited how rehabilitation could be possible at any institution, even ones intended primarily to protect society.

The crises at these three institutions prompted the Department of Welfare to embark on a plan to again overhaul the mental-health system. Although this time, it would not just plan renovation and construction projects, but instead focus on rehabilitation. Embodying Leader’s “brain-trust” mentality, the Department contracted with the American Psychiatric Association, the most prestigious mental-health organization in the country at the time, to help survey the situation and make recommendations. Building on the National Mental Health Foundation’s work, a number of lay-led community groups also got involved, including the Pennsylvania Citizens’ Association with its offshoot, Pennsylvania Mental Health (PMH), and the Pennsylvania Association for Retarded Children. PMH became a particularly influential organization as it worked closely with the APA to study the state’s mental-health program. These organizations became an important voice for community interests, influencing the direction of professional psychiatrists in state policies.

In the late 1940s, the state had responded to the crisis at Byberry and The Snake Pit with a major building campaign, However, in 1955 the APA, PMH, and Department of Welfare envisioned community settings as the best places to provide mental health services. People would no longer have to be removed from society to receive services. They emphasized community alternatives in large part because of the proliferation of psychiatric interventions

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beyond the mental hospital in the 1950s. At that time, the vast 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 the domain of alienists in far off asylums, but instead doctors working in offices in local cities and towns.\textsuperscript{33} Freudian psychoanalysis also held great cultural and political influence. Even though many psychiatrists did not identify as psychoanalysts \textit{per se}, they identified with psychoanalytic approaches and emphasized the power of the unconscious and early childhood experiences as core causes of human dysfunction. Psychoanalysis in the fifties pervaded psychiatric and popular understandings of social disorders and human nature, including sex, family structures, conflicts, and neuroses. The United States itself became “the world center of psychoanalysis” in the fifties according to medical historian Nathan Hale.\textsuperscript{34} Reflecting the ascension of this field, \textit{Life} magazine published a series in 1957 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 college 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 bomb.”\textsuperscript{35} By the mid-1950s, psychiatric practices had broken free from the mental-health institution and permeated American culture. Psychiatric treatments were no longer relegated to individuals placed in mental hospitals, but could be deployed to varying degrees in doctor’s offices, community mental-health clinics, and with new psychotropic drugs.

\begin{itemize}
\item \textsuperscript{33} David L. Herzberg, \textit{Happy Pills in America: From Miltown to Prozac} (Baltimore: Johns Hopkins University Press, 2009), 15–46.
\item \textsuperscript{35} Ernest Havemann, “The Age of Psychology in the U.S.,” \textit{Life} (January 7, 1957), 68.
\end{itemize}
Just as psychoanalysis reigned in the 1950s, so too did psychopharmacology. Prior to the fifties, psychiatrists had used various drug treatments to alleviate mental illnesses. But, with the medical advances of World War II such as penicillin and the polio vaccine, researchers made rapid progress in identifying 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 antidepressive medications on a scale never seen before. Even general practitioners began prescribing new antianxiety medications such as Miltown and Equanil, introducing psychiatric medications to people outside of the mental hospital setting. The major tranquilizers reserpine and chlorpromazine (called Thorazine) most affected mental hospitals and the people who lived in them. These powerful medications alleviated delirium and sedated people, with side effects including jaundice, trembling, and cases of suicidal depression. In the first few years after Thorazine’s appearance, doctors prescribed it to large numbers of people living in institutions and in 1955 alone, its pharmaceutical company sold $75 million worth in America. Psychiatrists in mental hospitals prescribed these more potent drugs far more than psychiatrists in private practices, and in mental hospitals such as one at Rockland where Mary Jane Ward had lived, nearly eighty percent of the people there took the drugs.

The introduction of Thorazine dramatically altered the practice of psychiatry within mental hospitals as the possibility for calming large numbers of people with sedatives made psychiatrists far more optimistic about curing the people they treated. These drugs also opened up new visions of releasing people with mental illnesses back to their communities, with appropriate prescriptions. The widespread use of heavy tranquilizers in mental hospitals sowed

the seeds of protest against what many people considered “chemical straitjackets,” but the introduction of this new drug dramatically changed the policymaking imagination, creating a vision of the future in which mental hospitals could become obsolete.

Key to the reforms was a renewed emphasis on thinking about people with mental illnesses as innocents. Harry Shapiro stated that that the story of mental health in Pennsylvania was the story of fifty thousand people “…forgotten and neglected, subjected to cruelties and punishment; mechanically restrained; locked in cells and solitarily confined for horribly long periods of time.” To Shapiro, these individuals represented “the pawns of unscrupulous politicians and the victims of a myth that nothing could be done for this.”

The capstone report of the changes in the period written by the Department of Welfare reflected a highly racialized and gendered political imagery of innocent people and new forms of care. The Department argued in it that people 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.” No mention is made of the eugenic threat of people diagnosed with these social disorders, nor their direct danger to society. While the threat of people deemed feebleminded and mentally ill pervaded political discourse in the 1920s and 1930s, this language was largely absent from this 1950s literature.

Race and gender were also not mentioned in the report, purportedly hidden from the policy debates. But the photographs that the Department of Welfare used told a different story.

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38 Harry Shapiro, “Speech,” [1955–1958], Department of Public Welfare Collection, Secretary of Welfare Speeches fol. 1, box 1, PSA.

39 Shapiro, “Speech.”

The report opened with two images, one of the shoes and ankles of a young white girl and the other of a white boy looking forlornly downward while a white adult hand with a wedding ring patted his shoulder. Later, in the section on children and youth services, the report included a photograph of a nicely dressed white teenage girl and boy walking happily down a path together, embodying proper teenage behaviors. In depicting an elderly person, the Department’s report showed a white elderly woman’s hands on a table with an embroidered tablecloth and china plates, presumably at home rather than in an institution. Finally, the report’s section on reforms in mental health and welfare concluded with the photograph of a white, middle-class family in a convertible car, the father in the driver’s seat with the mother next to him, their two children waving to the camera.41 White middle-class women, children, and the elderly were prominently displayed as in need of mental-health and welfare services. Other than this image, men predominantly appeared in the delinquency or crime section. For instance, in the publications of the Public Charities Association men were not displayed in sections on mental health, but instead in the crime and delinquency sections. Absent from these publications were images of African American women and men.42 Individuals in mental hospitals are shown in publications as largely innocent white young men and women in need of assistance and in need of being returned to their middle-class families. The underlying message of these images was that the PMH and the Department of Welfare viewed these individuals as needing to return to the nuclear family rather than live separately from society. With this goal in mind, the state needed more rehabilitative mental hospitals and community mental-health services to help this reintegration.

41 Ibid.
In order to make this rehabilitative transformation possible, the massive building campaigns of previous decade no longer seemed appropriate. Instead, the Department of Welfare and the Governor focused on “brains not bricks,” its slogan of mental-health reform.\textsuperscript{43} In 1955, the state legislature passed House Bill 670 (Act 255), which created a Commissioner of Mental Health and stripped administrative power from the politically appointed boards of trustees at state hospitals.\textsuperscript{44} Staffing at mental hospitals posed a significant problem, particularly in Pennsylvania where patronage continued to determine these jobs. The APA wrote in its report: it described that, “The size of the payroll and the number of jobs have always made mental hospitals a good target for the spoils system.”\textsuperscript{45} As a result, “incompetent psychiatric workers” who “drifted” from one job to the other caused a high turnover rate because of the political cache of the work.\textsuperscript{46} In order to make mental hospitals more therapeutic, the PMH and the Department of Welfare worked with the “Mr. Clean” Governor Leader to pass legislation that put psychiatric workers on a merit system. The Department of Welfare banned partisan politics and dismissed people “who were making political use of state facilities.”\textsuperscript{47} The Department created two thousand civil service jobs and launched “Operation Opportunity,” a recruiting campaign to bring better-qualified staff into the mental-health system, concomitant with salary raises competitive with other states.\textsuperscript{48} By 1956, the Department proudly boasted that politicians no

\textsuperscript{43} For the “brains not bricks” reference, see Pennsylvania Mental Health, “Prerequisite for Progress: A Report on the State Mental Health Program,” October 1960, David L. Lawrence Papers, fol. 22, box 25, PSA.


\textsuperscript{45} Ibid., 2.

\textsuperscript{46} Ibid.

\textsuperscript{47} Pennsylvania Department of Welfare, The Quiet Revolution, 7.

\textsuperscript{48} Ibid.
longer controlled the appointments of psychiatric workers. The state had successfully created a new civil service branch, with a large workforce of mental-hospital employees.

The Department went further and took a number of additional steps to make mental hospitals more rehabilitative in response to the problems there. The state hospital at Embreeville became the model institution for the changes, as the Department improved staff there and increased “occupational, recreational and industrial therapy.” 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 were introduced to restore a sense of personal identity and dignity. A single menu was established for patients and employees.” The introduction of 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 its discomfort with publicly explaining the widespread effects of the drugs. The Department instead touted its “Open Door Policy,” instituted at two state mental hospitals. It removed locks from the doors of these facilities and allowed a number of individuals to return to their homes. Amidst these changes, Laurelton Village became an “open institution,” as by 1956 it did not have locks on the cottage doors and the Department converted the maximum-security cottage in an open one with individual rooms. Laurelton also returned many women to their communities, such that the average length of stay fell from twenty-nine years in 1955 to only four in 1965.

Because of these reforms within the institutional setting, the total number of people living in mental hospitals began a descent in Pennsylvania that lasted the rest of the century. These

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49 Ibid., 9.
50 Ibid.
51 Mertens, 31.
reforms and the decline in the population was heralded by the government as a triumphal beginning to a process that would eventually make the mental hospital obsolete. The Department of Welfare called this change a “quiet revolution” and 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. Since the new program was inaugurated, a steady flow of admissions has been maintained but discharge rates have continued to mount too.52

Not only did the number of people fall, but the vision of the mental hospital itself also changed dramatically. The APA and PMH wrote, “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.”53 In 1958, Harry Boyer, the President of the Pennsylvania Congress for Industrial Organizations reflected on the changes to the Pennsylvania Welfare Forum. 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

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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.54

Boyer’s optimism reflected the broader public discourse in which people viewed mental hospitals as moving away from institutionalizing people for long periods of time.

In the spirit of rehabilitative alternatives, the Department of Welfare created a number of new mental-health programs in community settings and the APA advocated the creation of more community mental-health services to Pennsylvania’s government in its Blueprint for Mental Health. In it, the APA suggested that the state help to create psychiatric wards in general hospitals, making treatment and less-intensive services more accessible for communities. Leader’s administration used federal funds allocated in the Hill–Burton legislation to build new psychiatric beds in thirty-one general hospitals between 1955 and 1958 in Philadelphia at the Pennsylvania Hospital, Jefferson Hospital, the Albert Einstein Medical Center, and the Southern Home for Children.55 The APA also recommended creating community mental-health centers, which Pennsylvania did in building its Commonwealth Mental Health Center in Philadelphia, which included a 24-hour reception center for diagnosis and referral services to other agencies, general hospitals or clinics, “in many cases eliminat[ing] the need for hospitalization.”56

54 Harry Boyer, “Text of Speech Given at Pennsylvania Welfare Forum,” March 28, 1958, Department of Public Welfare Collection, Secretary of Welfare Speeches, fol. 1, box 1, PSA.

55 Commonwealth of Pennsylvania Governor’s Office, “Press Release,” June 9, 1958, Governor George M. Leader Papers, fol. 10, box 34, PSA.

Reflecting the creative and optimistic spirit in psychiatry at the time, the APA recommended day hospitals where people could go for eight to ten hours during the day, and night hospitals where they could go in the evening and receive insulin/electric shock, drug treatment, or psychotherapy to help them recover before leaving in the morning. The APA also proposed new diagnostic and classification centers to make it easier to identify problems individuals were having. Finally, it recommended the creation of small-scale institutions that resembled new programs for people with physical disabilities: foster homes, halfway houses, sheltered workshops, and rehabilitation centers for people with emotional illnesses. The report acknowledged that these types of places were not usually used for people with mental illnesses, but it posited them as an exciting new avenue. The Department of Welfare implemented many of the APA’s suggestions which did not just focus on improving mental hospitals, as it had done in the late 1940s at the behest of the conscientious objectors. Instead, the Department embarked on a new program to make mental hospitals more overtly therapeutic and to create mental-health services and psychiatric beds in communities rather than at far off institutions.

Yet, these reforms did not bring about the shrinking of state mental-health programs and they continued to rely on a notion of state interventions with or without the consent of the people affected. Letters from people within mental hospitals to the Governor directly exposed this continued reliance on state power to treat people. One man at Norristown State Hospital wrote a letter to the Governor requesting that he stop the electroshock treatments that he was receiving. As the Department touted new psychiatric treatments such as electroshock treatments, individuals like this man wrote to oppose this new, modern approach. Another man wrote from the Philadelphia State Hospital against the treatments forced on him by the psychiatrist there,

again challenging the progressive changes at the time. The archives do not hold any more documents to show the outcomes of these requests for help. However, the existence of these letters reflects that the increasingly intensive treatment regimes in the mental hospitals came regardless of whether the people receiving them agreed to receive treatment or not.

People who did not live in the mental hospitals also took notice of this coercion at the time. In the 1950s, the sociologist Erving Goffman interviewed people in psychiatric hospitals for his book *Asylums*. He spoke to many people in the St. Elizabeth’s Hospital and found that many of the people there compared mental hospitals to jails. This carceral analogy that the people vocalized gave voice to their conception of these spaces as coercive institutions.

Meanwhile, at the same time, Ken Kesey worked at a mental hospital on the west coast. There, he witnessed many of the scenes of power and denial of liberty that he later described in *One Flew over the Cuckoo’s Nest*. At the same moment that the Department of Welfare celebrated these new rehabilitation regimes, people who lived and worked in mental hospitals articulated the loss of power embedded within a state interventions into individual behavior.

Conservatives also critiqued the issue of psychiatric authority during this peak of psychiatry in the 1950s, forming a more politically organized response to the profession. In particular, right-wing anticommunists argued that “head-shrinks” used their medical methods to advance a left-wing agenda. The issue came to a head nationally over Congress’s passage of the Alaska Mental Health Bill in 1956. The act gave land in Alaska over to create new psychiatric facilities in the territory as previously people would have to travel to mental hospitals in Portland, Oregon. The Alaska Bill became the national focus of the right-wing antipsychiatry movement, which challenged the act as a communist led attempt to create concentration-camps.

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58 David V. Randall, “Memo to Harry Shapiro,” August 5, 1957, Governor Leader Papers, General Files, fol. 6, box 81, PSA; David V. Randall, “Letter to Harry Shapiro,” May 21, 1958, Governor Leader Papers, General Files, fol. 8, box 81, PSA.
for people with mental illnesses. Led by Barry Goldwater, the bill also critiqued the involuntary commitment system which they said railroaded people into confinement at the loss of their liberty.59

This conservative antipsychiatry movement also sprouted on the local level. In Pennsylvania, the organization Montgomery County for America in Royersford came out against the mental health system in the state in 1959. It drafted a list of resolutions and sent them to the Governor, saying,

WHEREAS:

1) Psychiatrists admit the study of mental health is not a true science;

2) Definitions of mental health suggest that those who reject generally accepted political concepts demonstrate basic abnormalities;

3) Dictatorial power in the hands of mental health officials who decide cases prejudicially;

4) So-called experts have questionable loyalty;

Montgomery County requests a complete and thorough study of mental health and organizations and individuals promoting it which are “eroding our traditional American liberties …”60

This organization deemed mental-health officials as politically subversive, left-wing radicals out to take over the political system. Their critiques constituted a reaction to the expanding, rather


60 Montgomery County for America, “Letter to David L. Lawrence,” 1959, Governor Lawrence Papers, fol. 22, box 25, PSA.
than contracting, mental-health system in the fifties, and the questions of power and liberty embedded in involuntary commitments.\textsuperscript{61}

In the field of mental health, the fifties then represented a key turning point. On the one hand, the Department of Welfare sought to make mental hospitals more rehabilitative and to create new community-based mental-health services. As a result, while the number of people living in the mental hospitals began its decline, the total number of people entering the system rose. The state spent more money on people in mental health institutions, the civil service workforce expanded, and the Department hired more psychiatric workers. During this expansion, the state continued to maintain a significant amount of power over psychiatrist-guided treatments, reflected in the critiques people within institutions, and the nascent antipsychiatry movement. Even though the segregationist form of institutionalization for people diagnosed with mental illness weakened, the apparatus of the mental-health system grew.

**Psychiatric Crime-Fighting**

In the mid-1950s, as mental health reform became central, so too did juvenile delinquency take hold in both political and cultural discourses. In the years before, during, and after World War II, the rates of juvenile delinquency in the United States rose due to the social upheaval of the wars and the Great Depression. According to Michael Rembis, “the popular perception among most Americans living between 1917 and 1960 was one of a nation of young people run amok.”\textsuperscript{62} While the problem of delinquency dominated in urban areas, many people

\textsuperscript{61} For additional letters from conservatives, see Loyce Furman Cargile, “Letter to David L. Lawrence,” March 23, 1959, Governor Lawrence Papers, fol. 19, box 25, PSA; Anna M. Kelley, “Letter to David L. Lawrence,” March 9, 1959, Governor Lawrence Papers, fol. 19, box 25, PSA.

considered it a serious issue in rural regions, among both men and women. The problem became so critical that in 1953, the United States Senate created a subcommittee on juvenile delinquency that held hearings in a number of urban areas, including Philadelphia. The movie industry also made juvenile delinquency a public concern in American life. In 1955, James Dean played the rebellious outsider in *Rebel without a Cause* who got into knife fights and drag racing. That same year, *Blackboard Jungle* showed the struggle of a war veteran working as a teacher in a violent inner-city high school, who faced a new battle with both the black and white students he taught.\(^{63}\)

Sociologists and psychologists became key problem-solvers in response to the rise of juvenile delinquency as a public concern, reflecting the influence of the psychiatric profession and social sciences at the time.\(^{64}\) As a result, juvenile delinquency became a site where many of the ideas of rehabilitation in mental health transferred into the state corrections system. Youth crime became a central connector between the mental-health and corrections systems because of the involvement of psychiatrists and welfare officials in the policymaking.

In Pennsylvania, the issue of juvenile delinquency became particularly pronounced in Philadelphia’s urban black communities in the fifties. The Department of Welfare and social scientists turned their attention to law-breaking among youth in the City of Brotherly Love, and defined it along the lines of race and social class. The most central study occurred when a group of criminologists conducted a birth cohort study of all the delinquent behaviors of ten thousand boys residing in Philadelphia and born in 1945 (turning eight in 1953). They found that


delinquency was defined in part by socioeconomic status as youth of the working class were more likely to be determined delinquent than boys of higher socioeconomic status. However, race superseded class here. The authors wrote, “these differences are not, however, as pronounced as the differences between whites and nonwhites,” and found that half of the African American youth that the researchers studied were picked up by the police. In comparison, the police detained less than a third of the white youth that they studied. African American young people also made up far more of the recidivists, or chronically arrested individuals. The researchers also mapped intellectual disability onto criminality in evaluating their subjects. They assessed chronic offenders as having lower IQs, higher rates of mental retardation, and lower rates of achievement, and stated that these trends were more pronounced among the African American young people. In this way, they linked mental ability and race to the likelihood of committing crimes, a practice that dated to the Progressive Era. These findings would later help the construction of institutions specifically made for youth who had intellectual disabilities and criminal backgrounds.

Notably, the researchers also found that the courts treated the youth differently along the lines of race. African American juvenile delinquents in particular faced more serious actions against them by the courts. For instance, the criminologists found that white youths in the birth cohort were half as likely to be arrested for their offenses than black youth. Black youth also received harsher dispositions when they met their judges in court, with longer terms of probation and institutionalization. The higher rates of arrest of African American young people and the higher rates of state interventions reflects how, when it came to juvenile delinquency, the police

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66 Ibid., 89–90, 93.
67 Ibid., 222–24.
and the courts viewed young men of color as requiring more state interventions as juvenile delinquents. These decisions strongly mirrored the sociological studies that Khalil Gibran Muhammad’s charted in *The Condemnation of Blackness*. In the 1920s and 1930s, civil rights organizations had tracked how policymakers and the public responded disproportionately harshly to blacks who committed crimes.\(^68\) As a result, institutions for juvenile delinquents since at least the early twentieth century and through the 1950s disproportionately confined African American youth, similar to the trend in adult institutions.

The Department of Welfare responded to juvenile delinquency with treatment-focused interventions. However, before charting the state’s rehabilitative approaches, activism in Philadelphia at the time reveals an important alternative response to juvenile delinquency. Community organizing around juvenile crime reflected an alternative approach to rehabilitation – one that focused much more on the problems of racism in society than the problems of the individual. The Reverend Leon H. Sullivan, a young community activist in Northern Philadelphia who had worked with Adam Clayton Powell, Jr., and A. Philip Randolph, led the effort against juvenile crime. Sullivan later became well known for his organizing around economic self-sufficiency, but in his early years in Philadelphia he focused on curbing youth crime. After Sullivan moved to the City of Brotherly Love, he took over the post of the prestigious Zion Baptist Church and founded the Citizens Committee against Juvenile Delinquency and its Causes (CCAJD). The CCAJD was comprised many different neighborhood associations and peaked at 100,000 members. The organization worked to solve the problems it saw as specific to the black community itself: racial discrimination in employment and therefore lack of jobs, poor parental supports for youth, and moral decay due to taprooms and taverns. As a

result, the CCAJD led clean block campaigns, antitavern pickets, and programs to promote intraracial support for the community as a way to stop what they saw as the encroachment of crime into the African American community. In this way, activists such as Sullivan focused on what they thought of as systemic issues within the black community and conditions caused by a racist society. Their efforts did not rely on unleashing psychiatric authority on youth, and black youth’s psychological makeup, but instead with confronting the problem of racism and poverty in the African American community.

In stark contrast to the CCAJD’s understandings of juvenile delinquency, the state government responded to the problem by creating a host of new treatment-oriented programs. In the 1950s, the Department of Welfare oversaw problems related to juvenile delinquency; it was not an issue primarily handled by corrections officials. While liberal politicians and policymakers acknowledged housing and employment as core parts of the urban-juvenile-delinquency problem, they still relied heavily on state interventions and rehabilitation programs in attempts to change the individuals themselves.

Here, they were renewing a concept of rehabilitation that had become popular in the Progressive Era. From 1880 to 1930, psychiatry grew greatly involved in how to diagnose, prevent, and cure behaviors that crossed social and legal boundaries including juvenile delinquency, alcoholism, homosexuality, prostitution, and other forms of crime. In the 1950s, with the cultural and social ascendancy of psychiatry, efforts to rehabilitate deviants, delinquents, and criminals mushroomed. In her book Sex Fiends, Perverts and Pedophiles,

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historian Chrysanthi Leon charted how, during the 1930s and 1940s, state policies focused largely on committing pedophiles, homosexuals, and rapists, “with rehabilitation underneath more incapacitative intentions.” During these years, custody trumped rehabilitation. However, Leon found that the 1950s marked a turning point when rehabilitation again became a primary stated ideology of the correctional approach to treat people convicted of sex offenses. Michael Rembis, has similarly found that prior to World War II, psychiatrists used intelligence quotients and eugenic notions of deviance to diagnose and treat female delinquency. After the war, psychiatrists relied more on psychoanalytic theory, they looked more to social and environmental factors as the cause rather than hereditarianism. As a result, they sought plans that incorporated these ideas into new rehabilitative strategies. In male prisons, Eric Cummins argued that experts flooded the system and rehabilitation became the watchword of the 1950s at California’s San Quentin prison, even as their intentions lay in maintaining power. While the rehabilitation of people who convicted crimes has a long history in the United States, the late 1950s stands APArt as a time when the psychological treatment model rose to the fore of discourse, even if the institution still embodied custodialism.

Their reforms were put on display in response to the crisis at the Morganza training school in 1955. After the institution had come under scrutiny, Governor Leader called for the

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71 Chrysanthi S. Leon, Sex Fiends, Perverts, and Pedophiles: Understanding Sex Crime Policy in America (New York: New York University Press, 2011), 55. Also see Beth L. Bailey, Sex in the Heartland (Cambridge, MA: Harvard University Press, 1999), for a discussion of how homosexuality changed from being treated as a crime to a psychiatric disorder with rehabilitative treatments.

72 Leon, Sex Fiends, 54–76. For additional literature on the psychiatric treatment of sex offenders in the postwar years, see Jennifer Terry, An American Obsession: Science, Medicine, and Homosexuality in Modern Society (Chicago: University of Chicago Press, 1999), 353–57.

73 Rembis, 119–42.

state to take action and give leadership to local communities in meeting a problem “which cripples children, destroys family life and represents a cradle for future inmates of our mental hospitals and adult prisons.” 75 Twenty-five hundred children went to institutions because of the juvenile courts each year, and Leader believed and proclaimed, “These children can be saved for productive citizenship.” 76 The Department initiated new therapeutic programs at Morganza, with the intention of developing standard techniques in other juvenile institutions across the state, the majority of them county or privately owned. 77 The state legislature also responded in 1956 by appropriating money for the first new correctional institution in thirty years, an institution for defective delinquents at Dallas. It was a hybrid mental-health–penal facility that held people diagnosed as having both mental defects and criminal propensities. 78 By investing in this institution and focusing on defective delinquents, the state tried to curb youth crime by treating intellectual disabilities. The reforms at Morganza and the new institution for defective delinquents, the Department of Welfare displayed a commitment to using rehabilitative measures embedded within institutions to address youth crime.

However, similar to the reforms in mental hospitals, the Department of Welfare also sought community-based alternatives to respond to juvenile crime. As it stated in its report, The Quiet Revolution in Mental Health and Welfare, “Thousands of children were growing up in Pennsylvania without happy home experience. [sic] It was to be anticipated that many of them would be unable to create stable family life as adults. The institutions for delinquents were

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75 Commonwealth of Pennsylvania Governor’s Office, “Press Release,” January 17, 1956, Governor Leader Papers, fol. 6, box 31, PSA.
76 Commonwealth of Pennsylvania Governor’s Office, “Press Release,” January 17, 1956, Governor Leader Papers, fol. 6, box 31, PSA.
77 Governor’s Office. “Press Release,” October 18, 1956, Governor Leader Papers, fol. 6, box 31, PSA.
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.”⁷⁹ As a result, the department created new services in its Office of Children and Youth Services. Between 1936 and 1956, Pennsylvania did not receive Federal Child Welfare Service funds for local public childcare programs. But, in 1956, the Legislature passed Act 146-A, which provided money to reimburse counties for childcare services.⁸⁰ The Department also created a new Division of Youth Rehabilitation to implement new programs in communities and consult with local agencies about adoption, foster care, protective services, and childcare.⁸¹ As Governor Leader stated, “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.”⁸² If the state used its “case-finding and treatment methods early enough,” it could cure the problem of juvenile delinquency.⁸³ As in the field of mental health, the Department of Welfare sought new alternatives to institutions to address juvenile delinquency.

In the early 1960s, state also used millions of dollars to create new, smaller facilities for juvenile offenders. Its most popular idea was forestry camps for 15-to-18-year olds, in which the teenagers worked in a small setting rather than large institutions. The state went even further and increased its funding to county juvenile institutions, established a state delinquency control institute, and gave major subsidies and grants for probation officers and police specialists to work with youth and embark on gang issues. In creating these projects, the Department projected

⁸⁰ Ibid.
⁸¹ Ibid., 18–20.
growth rather than contraction of the juvenile system, stating, “By 1970 the system must provide for 1,700 additional children.” As a whole, between 1956 and 1963, the juvenile justice system grew dramatically, as it built new juvenile institutions while also beginning to create smaller facilities.

While the CCAJD had focused its efforts on addressing racism and unemployment as core factors in juvenile delinquency, the Department of Welfare’s major focus remained on changing individual youth using treatment focused institutional and non-institutional methods. These changes in Pennsylvania reflected a renewed embrace of the rehabilitative ideal as the intention of corrections in the 1950s.

The expansion of rehabilitative programs and the creation of new types of institutions in the juvenile justice system in Pennsylvania ushered in similar reforms in adult corrections. The community-based ideals of the 1950s seeped into the language of prison reform in the following decade. In 1960, Pennsylvania’s Attorney General Anne X. Alpern headed the Department of Justice, which oversaw the state’s prisons. In response to an attempted escape at Eastern State Penitentiary, Alpern argued for the closure of Eastern State, and proposed “out-prisoner programs” at the state’s other prisons. Newspaper accounts reported that: “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.” People in prison would receive counseling and out-prisoner training, “just as an out-patient hospital program” would do. While the Bureau of Corrections did not ultimately implement Alpern’s plans for out-prisoner programs, it did initiate similar work-release programs in the 1960s. In the work release model,

84 Governor’s Coordinating Committee for the 1960 White House Conference on Children and Youth, A Blueprint for Action: Pennsylvania’s Program for Children and Youth (Harrisburg, PA, March 1, 1961), 2–4.
86 Ibid.
people in prison could leave during the day to go to work and school and then sleep at the prison at night. Also, in the 1960s, prison officials and judges increasingly relied on probation and parole as alternatives to incarceration, using the motif of community rehabilitation to change the offender. In this way, probation and parole greatly expanded even as the number of people in prisons dropped. As Chapter 4 will explore, the Bureau had created new community-based corrections programs such as halfway houses, drug treatment centers, and smaller regional facilities as alternatives to the prison. These rehabilitative programs inside and outside of institutions, begun in juvenile justice in the 1950s, would become central to the prison reforms of the 1960s.

In the Age of Anxiety of the late 1950s and early 1960s, psychiatric responses to mental illness and criminal behaviors proliferated. These reforms served to begin undermining the practice of large, custodial institutions as the state relied more on making institutions parole and out-patient and out-prisoner programs. In an age of welfare-state liberalism, these changes constituted a reimagining of American governance in which the state attempted to rehabilitate individuals with mental illnesses and criminal backgrounds in more community-based settings rather than distant and secluded institutions. However, the reforms continued to rely on state-sponsored rehabilitative interventions, infused with psychiatric ideas, to change people's behaviors. As a result, from 1955 to 1965, the mental-health and corrections apparatus grew rapidly, even with the move away from large institutions. This expansion would have two major effects on the trajectory of mental hospitals and prisons over the next few decades. First, the continued reliance on state psychiatric power prompted an explosion of anti-psychiatry from counter-cultural sources like Allen Ginsberg, Ken Kesey and Thomas Szasz. Second, this reliance on the notion of state-interventionism would become an important issue as politicians
and policymakers debated the future of mental health and corrections in the face of anti-psychiatry and anti-prison activism.
CHAPTER IV

FLYING THE CUCKOO’S NEST

“Unscrew the locks from the doors!
Unscrew the doors themselves from their jambs!”

- Allen Ginsberg, Howl

After Ken Kesey had worked in a mental hospital in the 1950s, he wrote and published One Flew over the Cuckoo’s Nest in 1962, a bestselling novel that described a tragic and inspiring revolt of people in a mental hospital. In the book, Randle P. McMurphy, a prisoner and leader of the rebellion had depicted himself as insane in order to serve his time in a mental institution, which he considered an easy way out of his prison sentence. When McMurphy entered the institution, however, he encountered abusive bureaucratic controls including electroshock therapy, forced drugging, and a powerful therapeutic regime that disempowered the patients, personified by the infamous Nurse Ratched. McMurphy mutinied against this therapeutic prison by disrupting it, a resistance that cost him his life. The book did not end entirely tragically, though. In the final pages, the protagonist Chief breaks through the walls of the hospital and runs away in a deeply inspiring final scene. The novel came into print at the very moment that state mental-health programs began to undergo revolutionary changes. The book became a blockbuster text not only because of its critique of mental hospitals, but because

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1 Allen Ginsberg, Howl and Other Poems, 2nd ed. (San Francisco: City Lights, 1959), title page.
2 Ken Kesey, One Flew Over the Cuckoo’s Nest, 40th ed. (New York: Viking, 2002).
of its broader anti-institutionalism and attack on the power of socially conformist forces in America.

In the late 1950s, the state Department of Welfare sought to begin creating alternatives to the mental hospital, while maintaining governmental control over the rehabilitation of people. During the 1960s, however, new ideologies within psychiatry and a widespread anti-institutionalism ushered in a series of reforms that more aggressively challenged the mental hospital system. The transformation occurred so dramatically, in fact, that when One Flew over the Cuckoo’s Nest became a movie a decade after the book’s publication, many courts had overturned state commitment laws and mental hospitals had begun a large-scale deinstitutionalization. As a result, tens of thousands of people returned to community settings and the involuntary confinement of people with mental illnesses dropped precipitously. In Pennsylvania alone, the number of people living at mental hospitals dropped in half in less than seven years from thirty-four thousand in 1966 to a little more than eighteen thousand in 1973. In the era following the publication of Kesey’s novel, the image of Chief breaking through the walls of the asylum became reality as liberal psychiatric and legal reforms undermined the century-old parens patriae treatment of individuals with mental-health disorders, by which the state acted as a caretaker for them.

A number of historians and disability-studies scholars have identified the decade as a major turning point in the history of deinstitutionalization: In less than ten years, the foundation of an historic system of mental health crumbled. For the most part, these historians have examined the process of deinstitutionalization at the federal level, tracking national legal cases,

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Congressional acts, and changing professional ideologies.\textsuperscript{4} While these works are invaluable to understanding this history, they do not focus on the changes at the state level. Such a distinction is not just a matter of semantics. Because the federal government did not run any mental hospitals, except those in Washington, DC, the process of releasing people occurred almost entirely on the state level. Similarly, while federal lawsuits had an important impact on patients’ civil rights, state-based lawsuits led to the direct discharge of many individuals. I study the development of deinstitutionalization at this level, a lens that offers insight into the impact of local politics, activism, and advocacy on this process and the direct effects of these changes on people within mental-health institutions. The local level also reveals how the legal changes to the mental-health system often occurred at the fault line of mental health and corrections, as the definition of the legal rights of citizens hinged upon separating out people deemed innocent from those people found guilty of crimes.

At the state level, deinstitutionalization proceeded unevenly along two different tracks. On one track, psychiatric policymakers called for expanding the social welfare system of mental-health services by increasing community-based programs. An ideology of psychiatric rehabilitation in people’s own localities took center stage as part of a broader focus on community control and ownership in the social-welfare policies of Presidents Kennedy and Johnson in the 1960s. I track the embodiment of these ideals in the work of Dr. Daniel Blain, who held the post of president of the American Psychiatric Association (APA) during these years and then took over at the Philadelphia State Hospital at Byberry in 1966. At Byberry, Blain initiated one of the first major deinstitutionalization programs in the state and the country.

Blain’s story tracks the liberal developments within the psychiatric profession at the time and the efforts by hospital superintendents to decrease governmental reliance on custodial institutions.

Separately, patient-sponsored lawsuits in the 1960s prompted the courts to redefine the civil rights of people with mental illness. During this decade, civil-rights advocates such as the Philadelphia-based lawyer David Ferleger worked on behalf of the rights of people living in mental hospitals by filing lawsuits that called for their civil liberties protections in commitment laws, the use of involuntary servitude in mental hospitals and for the treatment of children in the mental health system. Some of the most important legislation around involuntary commitments to mental hospitals, however, came from mental-health institutions that held people deemed criminal or dangerous. Representatives from the American Civil Liberties Union and prisoners’ rights projects responded to the requests of institutionalized individuals and challenged the constitutionality of the parens patriae tradition of involuntary commitment for the protection of the person. As a result, while before the 1960s the state could involuntarily commit individuals to mental hospitals for his or her treatment, by the 1970s, the power of the state government to commit people against their will had greatly diminished.

The sixties and its public concern for freedom provided fertile ground for the flourishing of One Flew over the Cuckoo’s Nest and its themes of nonconformity and anti-institutionalism. In this milieu, deinstitutionalization moved forward, albeit unevenly and because of distinctly separate efforts by the state social-welfare system and by civil-rights advocates. State policymakers sought to expand the protectionist vision of offering governmental treatment services to people in need, while civil-rights advocates put forth an antiprotectionist vision intended to shield individuals from involuntary state treatment. Involuntary commitments

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5 Anne Parsons, Interview with David Ferleger, August 3, 2011.
decreased dramatically, and the criminal legal system began to absorb some of the functions of the mental health system.

**Unscrewing the Locks from the Doors**

As I discussed in Chapter II, during the 1950s and early 1960s the state released people from mental hospitals and prisons at higher rates and created new halfway houses, outpatient programs, and community mental-health centers as alternatives to custodial institutions. However, these changes occurred at what seemed like a glacial pace. In Pennsylvania, the number of people living in mental hospitals began to fall, but very slowly. Cold War concerns about public safety also led to the build-up of hybrid mental-health–correctional facilities, even though psychiatrists saw the community as the best place for care. State mental-health and correctional systems by 1960 were still massive structures, and appeared to be growing rather than shrinking.

As Chapter 2 charted, antipsychiatry and anti-institutionalism grew that would burst into popular culture between 1957 and 1964. During this short time, many books were published challenging the institution not just as ineffective, but as inhumane, and they permanently altered the stakes of psychiatric reform within mental hospitals. Allen Ginsberg ushered in this new wave of writing with his epic poem *Howl*, written and published in the late 1950s. Ginsberg himself had a deep familiarity with mental illness as his mother lived in a mental hospital for many years, and he himself was committed for a short time to the Rockland State Hospital, the same institution where Mary Jane Ward had stayed. His stint at Rockland seemed almost a rite of passage, as so many other artists had also gone through institutional doors, including Jack Kerouac, William Burroughs, Ezra Pound, and Anne Sexton. Literary scholar Jonah Raskin
observed that at that time, “The madhouse seemed a required station of the cross for the American poet.”

In *Howl*, Ginsberg recast people with mental illness as disabled by their diagnosis, but also as some of the creative geniuses of America. “I saw the best minds of my generation destroyed by madness, starving hysterical naked.” In the socially conformist late 1950s, in which mental-health programs sought to cure all social disorder, Ginsberg’s *Howl* raged against the programs by celebrating transients, the mad, homosexuals, pacifists, and everyone who lived lives 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.”

Ginsberg criticized the mental hospital as a restrictive coercive place, much as Mary Jane Ward had in *The Snake Pit* a decade earlier. However, Ginsberg also celebrated madness as a source of inspiration, the “madmen and artists” of Kerouac’s circle to him comprising the heartbeat of a new generation.

Censors quickly banned the poem because of words like “fucked” and “ass,” but ultimately a court overturned the obscenity charge. The censorship and the power of the work made *Howl* a national sensation, and Ginsberg’s conception of mad genius and restrictive mental hospitals became popular in the late 1950s, paving the way for a spate of anti-institutional texts in the following decade.

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7 Ginsberg, 9.

8 Ginsberg, 25.

9 Raskin, 51.

A striking number of books challenging psychiatric treatment and mental hospitals went to press in the early 1960s. In 1961, Thomas Szasz tracked the history of psychiatric diagnosis in his seminal work, *The Myth of Mental Illness*. In it, he used historic understandings of insanity to challenge contemporary notions of mental illness, arguing that it was a socially constructed disease. Across the Atlantic, historian Michel Foucault published his *Madness and Civilization: A History of Insanity in the Age of Reason* in French in which he challenged psychiatry and its institutions as instruments of social ordering rather than of benevolence, a concept that reverberated throughout many future studies of asylums and prisons. That same year, American sociologist Erving Goffman published his work *Asylums*, for which he conducted research in the fifties, and in which he argued that residential institutions, like prisons, mental hospitals, and army barracks, dehumanized their inhabitants with regimentation.\(^{11}\) While the works of Szasz, Foucault, and Goffman were a far cry from the poetry of *Howl*, and while these and other intellectuals often disagreed on many issues, their works as a whole comprised a major intellectual challenge to the conception of the institution and its place in modern society.

In addition to *One Flew over the Cuckoo’s Nest*, critiques of mental-health treatment proliferated in literature. The New Zealand novelist Janet Frame, in her bestselling book *Faces in the Water* in 1961, described a woman’s abusive treatment at a mental hospital, based largely on her own experiences. In 1963, Heinemann Press in London published *The Bell Jar*, Sylvia Plath’s semiautobiographical novel. The book tracked a woman’s descent into mental illness, describing in detail the psychotherapy, insulin, and shock treatments that the protagonist underwent. In part because Plath committed suicide one month after the book’s first publication,

it became one of the most famous works on mental illness. Even though Plath’s work was far less damning about the psychiatric profession, her death underscored the sentiment of discontent with its effectiveness.\textsuperscript{12} These academic and literary works troubled and complicated the practice of psychiatry and mental hospitalization in the early 1960s more than ever before.

In the midst of this cultural anti-institutionalism, the vision of psychiatric treatment was shifted away from the institution and toward community mental health. But, the pace of change remained slow and the onslaught of criticism made reform all the more necessary for the legitimacy of the psychiatric profession. The national American Psychiatric Association and other organizations had pressed for federal legislation over the course of the late 1950s and early 1960s. But it was not until 1963 that Congress passed the Community Mental Health Centers Act, a bill supported by President John F. Kennedy that appropriated hundreds of millions of dollars to underwrite the planning for and construction of community mental-health centers across the country. The passage of this landmark act marked not only the first time that the federal government took a major leadership role in the direction of mental health, but also a national shift away from the institutional response to psychiatric disorders.\textsuperscript{13}

While the Community Mental Health Centers Act marked an undoubtedly significant achievement, change within mental hospitals continued to crawl forward. In Pennsylvania, the federal legislation provided $150 million dollars to the state government, prompting it to embark on a comprehensive survey and plan of its mental-health system, the first of its kind. Pennsylvania created forty task forces and held countless public hearings and meetings across


the state. In this multiyear project, the Department of Welfare used these surveys to draft construction plans for new community mental-health centers. These facilities would contain inpatient and outpatient services, twenty-four-hour emergency care, partial hospitalization and education and would initially run with large grants from the federal government. But while this process dragged on, the mental hospitals of Pennsylvania continued largely unchanged. Thus, by 1966, the Community Mental Health Centers Act had for the most part not led to the release of individuals from mental hospitals in Pennsylvania.14

The effort to release people from mental hospitals in the beginning stages of deinstitutionalization in the mid-1960s came in large part from the mental hospital directors and Department of Welfare officials themselves. It also came from collaboration between national leaders in psychiatry and state officials. The enactments of these reforms at the state level are well represented in the efforts of Dr. Daniel Blain, a major force in the American Psychiatric Association who in the sixties became a leader of deinstitutionalization in Philadelphia. Blain grew up in China, the son of missionaries. As a young adult, he trained as a psychiatrist in the United States and headed the Merchant Marine psychiatry program during World War II. After the war, Blain worked at the Veterans Administration and then in 1948, he took the post of Medical Director of the APA. While at the APA Blain encouraged the creation of community mental-health programs, and even after he left in 1958, he continued this work by implementing deinstitutionalization programs in Colorado and California. Chronic illness caused him to move to Philadelphia, his wife’s family’s home, where he joined the staff at the historic Pennsylvania

Hospital. However, his illness did not prevent his continued involvement in national affairs; in 1964, he took over as President of the APA for a one-year term.\textsuperscript{15}

Blain came to leadership in the years immediately following the publication of the works of Szasz, Kesey, and Goffman. Yet, when he made speeches as the President-Elect and then President of the APA in 1963 and 1964, he made no mention of any of these books.\textsuperscript{16} But his silence did not represent ignorance. Among the hundreds of pages of speech materials in his archives, one speech sits quietly at the back, undated and apparently never given to a public audience. This speech, titled “The Crisis in Psychiatric Legitimacy: Reflections on Psychiatry, Medicine and Public Policy” took on the general issue of challenges to psychiatric care. In it, 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 inability to tolerate deviance than in expressing the data of empirical observation.”\textsuperscript{17} In this piece, most likely composed in the early 1960s, he 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.”\textsuperscript{18} Instead, he envisioned a revitalized psychiatric


\textsuperscript{16} This assessment is based on a review of Daniel Blain’s speeches in the APA Archives, fols. 38 to 41. See, Daniel Blain, “Potentials for Help of the Psychiatric Patient” February 1963 and “Planning for comprehensive mental health services” September 25, 1963, in fol. 38, and “Psychiatry and the National Scene,” June 2, 1964, in fol. 41, box 100657 of Daniel Blain Papers, APA Archives.


\textsuperscript{18} Ibid., 5.
profession embodying a “New Look” that would continue to offer medical services, although in a vastly different form.

Blain opened his presidential speech to the APA by telling of the accomplishments of Benjamin Rush, the Revolutionary Era Father of Psychiatry. By harkening back to the origins of psychiatry, Blain legitimized the field as part of a longstanding tradition of medical care for people with mental illness. Yet, that did not mean 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.”

To Blain, medical psychiatry represented a historically specific response intended to protect individuals from suffering and from the stigma of a society that rejected many people who had mental illness. He responded to the challenges of Szasz and others not by directly engaging with them, but by relying on the profession’s historic legitimacy and by calling for a new era of psychiatric treatment.

After completing his term as President of the APA in 1965, Blain sought again to implement the novalescence he called for in his speeches. At age seventy, he became a psychiatric hospital superintendent, something he had never done before. But he did not choose just any psychiatric hospital. He chose the Philadelphia State Hospital at Byberry, one of the country’s most infamous institutions in a city struggling with racial violence and poverty. Byberry had thirty-four buildings where sixty-two hundred people lived, two thousand people over capacity. Needless to say, over-crowding still plagued the hospital, just as it had when the conscientious objectors exposed conditions there in the 1940s. Even as the population had slowly

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declined at many mental-health institutions in the state, Byberry had instead seen an increase.\textsuperscript{20} In a document titled, “Building Public Support for the Bedlam of Philadelphia,” Blain and a staff member described the layout as in a “style of architecture midway between Neo-Prison and Bureaucratic Bold.”\textsuperscript{21} To Blain, Byberry represented the ultimate custodial institution marked by a troubled past. By taking it over, he attempted to end the practice of large custodial institutions once and for all.

Blain’s intention to stop the practice of over-institutionalization reflected a rejection of custodial mental hospitals. He stated to the press that, “‘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.’”\textsuperscript{22} With these words, Blain represented psychiatry’s own rejection of the large custodial institution which had grown over the past decade. He emphasized to reporters that “professionals around the country have held for a long time that Byberry is terrible – it needs help.”\textsuperscript{23} While he did not specifically refer to the anti-institutional literature of Szasz and Kesey, he instead posited his own psychiatric anti-institutionalism that insisted that the old asylum form had become outdated and that psychiatric professionals and administrators like him wanted to make the change happen.

\textsuperscript{21} Daniel Blain and Dorothy Zuckerkandel, “Building Public Support for the Bedlam of Philadelphia,” [1968], box 5, RG 23 Philadelphia State Hospital Unprocessed Collection, Pennsylvania State Archives (PSA).
\textsuperscript{23} Ibid.
As he did in California, Blain worked with government officials to help advance
deinstitutionalization. On October 4, 1967, he led Pennsylvania Governor Raymond Shafer on a
tour of Byberry. Photographs of the meeting show the Governor touring the cramped dormitories and talking with administrators and people at the hospital, and after visiting the facility, Governor Shafer ordered that Blain close two fifty-year-old buildings at the hospital, which would greatly reduce the number of people there and relieve the over-crowding. Shafer’s suggestion reflected Blain’s own anti-institutional viewpoint. After the visit, Blain immediately embarked on what he called a “superhuman effort” to prepare to return people to their communities. While in the 1940s the conscientious objector mental-health reformers had sought to improve and expand mental hospitals so that they could cure people, in the 1960s the vision revolved around releasing people whom the hospitals had “warehoused” for too long. This new spate of protectionist reforms intended to help individuals by ending the practice of custodial institutions and providing people with treatment in their communities.

Here, the efforts to change the mental-health system in the mid-1960s reflected the broader Great Society programs that emphasized social welfare programs in communities. Medicare and Medicaid in particular made this move to community mental health possible, as they provided funds to the states for new mental-health treatments of people in their communities. The courts also began to take up the issue of the treatment of people in mental hospitals. In 1966, federal Judge David Bazelon in Washington, DC, ruled in *Rouse v. Cameron* that people in mental hospitals have the right to treatment while confined in mental-health

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institutions. In this landmark decision, Bazelon created the legal foundation for the right-to-treatment claim, which mandated that, if the government could take away the liberty of someone with a mental-health disorder, then it in turn had an obligation to provide adequate treatment at the institution. In the mid-1960s, the liberal concern for the care and welfare of citizens influenced the effort to either provide treatment in institutions, or move people out of them.

Blain put into practice these ideals of addressing social issues with community solutions in overhauling Byberry. In 1967, he formed a task force of at least two dozen people who reviewed case files and released all of the people who could be better served in other settings. The task force transferred hundreds of people to their families or to outpatient care at community mental-health centers, geriatric centers, and private nursing homes. To help the adjustment from Byberry, Blain set up a federally funded Socialization Unit where twenty social workers worked with people who had been at Byberry to help them find housing and live independently with the aid of one of the seven community health centers built in Philadelphia. Finally, in a process staff called the “Great Migration,” Blain reorganized the Byberry hospital so that people did not live according to their classifications, but instead by where they lived in the city. For instance, instead of dividing them based on their mental-health disorders such as depressive or psychotic, he instead reorganized the wards based on whether they lived in North, South or West Philadelphia. In this way, Blain rearranged the hospital so that it no longer had an insular quality, but instead emphasized connections between the people at Byberry and the outside community.

The reforms Blain initiated led to the rapid release of hundreds of individuals. In October 1968, only one year after Governor Shafer’s visit to Byberry, Blain reported to the Governor that

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27 “Byberry to Cut Patient Total by One-Fifth,” The Evening Bulletin.
he had closed buildings S-1 and S-2 in the summer, and that the population had fallen by one thousand in only a year. Since 1966, the in-patient population had dropped by two thousand people.29 A 1968 Evening Bulletin article reported that one half of people who had been at Byberry had gone to live in foster homes in the cities, with a comparable number living in their own homes, the homes of their relatives or in nursing homes. Medicare covered the care for individuals with senility at the Philadelphia Psychiatric Center, the Friends Hospital, and the Northeast Mental Health Center. According to Flora M. Gross of 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.”30 While Gross insisted that they did not just “push out” people, the statement reflects a defensiveness about the unusual speed with which people left the institution. The release of two thousand people from Byberry represented one of the largest such reductions in the country at the time, a dramatic change conducted at the level of the individual institution, with the support of federal funds and the leadership of the former APA president.

Blain did not just move people out of Byberry, he also welcomed community members into the affairs of Byberry. He set up a publicity office that touted the reforms, the first such effort at the institution and brought numerous community groups to the facility. In a progress report published during Blain’s tenure, the hospital emphasized its efforts in “bringing the community in,” showing a photograph of a Boy Scout troupe volunteering there.31 Blain took his community initiative even further when in 1968 he led a fundraising effort to preserve the

29 Daniel Blain, “Letter to Governor Shafer,” October 4, 1968, fol. 18, box 114, General Files, Governor Raymond P. Shafer Papers, PSA.


31 Philadelphia State Hospital at Byberry, “Progress Report,” n.d., Loose Photographs, Philadelphia State Hospital Unprocessed Collection, PSA.
seventeenth-century farmhouse where Benjamin Rush had been born, only four miles from Byberry. Blain hoped to move the house to the hospital land and to restore it there for the general public, where it could become a museum where the public learned about the Revolutionary era Father of Psychiatry as well as the reforms at the mental hospital. In this way, he hoped to bring people to visit the institution’s grounds. \(^{32}\) Unfortunately, the effort to save the Rush house failed. In 1969, a city worker accidentally bulldozed it, mistaking it for a condemned dwelling. Sam Nicholson, an employee who worked at Byberry, recalled that the hospital abandoned the project and pieces of the Rush house rubble sat for years after the accident in the institution’s basement. \(^{33}\) Nicholson’s recollection reflects the overall failure of this restoration project, regardless of the final resting place of the house. Blain’s effort to restore the Rush house represented a moment of incredible optimism in which the former president of the APA not only worked to overhaul one of the most troubled mental hospitals in the country, but also worked to foster public appreciation for medicine and psychiatry.

The newspapers generally celebrated Blain’s reforms as they occurred. The *Evening Bulletin*, one of Philadelphia’s leading newspapers, reported that seventeen hundred 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.” \(^{34}\) A few months later, the paper ran a story titled “Foster Homes Shelter 1,000 from Byberry” (emphasis added), reflecting the newspapers’ accounts of protecting from the hospital as a major


\(^{33}\) Anne Parsons, Interview with Sam Nicholson, August 2, 2011.

\(^{34}\) Donald C. Drake, “Byberry Releases 1700 to Ease Overcrowding.”
advancement. The failure of repeated reform campaigns over the years to improve these institutions, coupled with the anti-institutionalism of the time, coalesced to create this public support to remove people *en masse* from these facilities.

In the face of this rapid deinstitutionalization, however, the state government had few resources and social services for people leaving the hospitals. The Socialization Unit consisted of only a small group of social workers, in comparison to the hundreds of people who had left Byberry. Sam Nicholson remembered that many people who left Byberry often had a hard time accessing their social security checks once they left the facility. They often left the hospital only to face poor housing options and few sources of income in the community. The fast, reformist wave of releases had the serious consequence of sending people out of Byberry without enough resources to sustain themselves. Still, Blain’s program at Byberry modeled how other institutions in Pennsylvania and around the country could reduce their reliance on custodialism. The federal Community Mental Health Centers Act did not directly cause transfer of people out of hospitals because it had approved the building of new centers, many of which took in a different clientele than people in state mental hospitals. The legislation did not, then, order the release of people from hospitals. As a result, the release of individuals to their communities often happened in the 1960s at the mental hospital level, guided by administrators and Department of Welfare officials. Although people had trouble accessing social services, the spirit of anti-institutionalism and reform dominated the public discourse.

The deinstitutionalization efforts of Blain and other mental-health administrators did not dramatically alter the power structure of the mental-health system, however. Kesey’s *One Flew over the Cuckoo’s Nest* had depicted the mental hospital as a combine, with the psychiatric

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35 Gary Brooten, “Foster Homes Shelter 1,000 from Byberry.”

36 Anne Parsons, Interview with Sam Nicholson.
leadership holding the most power. In Blain’s reforms, mental hospital administrators addressed some of the worst abuses of the system while holding discretionary power over who could return to the community and when, a continuation of the *parens patriae* model. The people in the institution themselves still held little power in this phase of deinstitutionalization. It was not until the years between 1969 and 1973 that the issue of power, liberty, and the rights of patients became a major legal issue.

**Unscrewing the Doors from Their Jambs**

At the same time that Blain and other psychiatric professionals made efforts to decrease the reliance on custodial institutions, civil libertarians began a legal battle to dramatically alter the terms and conditions of mental-health commitments. As previous chapters have noted, individuals had resisted the psychiatric profession before: Mary Jane Ward published *The Snake Pit*, many people wrote to the Governor for their release, and right-wing conservatives challenged the left-leaning mental-health establishment. But, in the second half of the 1960s, activism by and for people within mental-health institutions coalesced, particularly in the legal system. In the midst of an era of legal civil rights, the courts took up the question of the rights of people living in mental hospitals, an issue that had remained largely untouched since Reconstruction.

The legal definition of patients’ civil rights in mental hospitals was not a wholly new problem in American politics. In the 1860s and 1870s, patient-activists, the courts, and the medical profession fought viciously over the legality of the involuntary confinement, a period called the “Packard era.” The nickname came from a case in Illinois in which a man falsely committed his wife Elizabeth P. W. Packard to a mental asylum. After legal action had secured
her release, Elizabeth Packard toured the country in the 1860s lobbying for better protection laws for people diagnosed as insane. She successfully advocated for a “personal liberty” bill in Illinois and Iowa that placed the discretion of commitments in the hand of juries.\textsuperscript{37} Her activism fanned the flames of other agitation, and people at the Pennsylvania Hospital applied for writs of \textit{habeas corpus} to gain their freedom in 1868. Because of these writs, the Pennsylvania courts debated the question of the human liberty of these individuals. Ultimately, the informal commitment structure remained intact in this state and in others, largely through the advocacy of medical professionals.\textsuperscript{38} In an era of the emancipation from slavery, people in mental hospitals made great strides in arguing that mental hospitals denied liberty to citizens because of the discourse and debates over freedom and citizenship at the time, but the commitment system did not change dramatically.

Not until a century later in the 1960s did the civil liberties of people in mental hospitals again become a major legal issue. In particular, the issue emerged at hybrid mental-health-penal institutions where deinstitutionalization was not occurring due to administrators’ concerns about public safety. At facilities such as the Farview Hospital for the Criminally Insane and the newly built Institution for Defective Delinquents at Dallas, the superintendents did not easily release people back to their communities. Even at a time when the psychiatric profession considered community settings the best place to treat mental illness, this model did not extend to people


\textsuperscript{38} In 1875, in the face of the legal challenges, the Supreme Court of Pennsylvania decided that commitments were not just confined to people who were considered dangerous, but that it also extended to people who needed “proper care and treatment.” Nancy Tomes, \textit{A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum-Keeping, 1840–1883} (Cambridge: Cambridge University Press, 1984), 252; H. J. J., “Civil Commitment of the Mentally Ill,” \textit{University of Pennsylvania Law Review} 107 (March 1959): 672–73; Paul S. Appelbaum and Kathleen N. Kemp, “The Evolution of Commitment Law in the Nineteenth Century: A Reinterpretation,” \textit{Law and Human Behavior} 6, no. 3/4 (1982): 348, 353.
with criminal or dangerous histories. In this way, the state continued to rely on the custodial model in the name of public safety even during a time of deinstitutionalization.

These tensions led to people at these facilities calling for their release. The first major legal action came at Pennsylvania’s Institution for Defective Delinquents at Dallas. Since 1937, Pennsylvania had implemented its Defective Delinquent Statute, which allowed the Department of Welfare to institutionalize people defined as mental defectives with a history of or predilection for delinquency. While many of the people diagnosed as defective delinquent had committed a crime in the past, they often had already completed their criminal sentence and yet continued to live indefinitely in an institution because of their diagnosis. The numbers of people held in this manner had risen so much that in 1960, Pennsylvania’s Welfare Department acted to build a multimillion dollar institution in the town of Dallas, only the second of its kind in the country. While the Dallas institution greatly resembled a prison, its commitment structure was that of a mental-health facility.

In the mid-1960s, people at Dallas put their pens to paper and wrote letters to civil rights organizations for help in their release. At that time, the federal court system was taking up the issue of the rights of institutionalized people, particularly people in prisons. In 1964, the U.S. Supreme Court had ruled that black Muslims had the right to worship in prison, and in the wake of this decision, the federal courts increasingly ruled in favor of prisoners. This tidal change in the courts inspired inmates across the country to file lawsuits on their own behalf and to seek assistance from lawyers on the outside. According to legal historian James Jacobs, prisoners “besieged” the federal court system with Fourteenth Amendment claims, as if “the courts had become a battlefield where prisoners and prison administrators, led by their respective legal

39 ; Nicole Hahn Rafter, Creating Born Criminals (Urbana-Champaign: University of Illinois Press, 1998), 227; Letter to Clare Cooper for Civil Liberties, 1966; “CLU Challenges Commitments of 500 ‘Defective Delinquents,’” unmarked news clipping, fol. 28, Spencer Coxe Papers, Temple University Urban Archives.
champions, engaged in mortal combat.”⁴⁰ Prisoners’ rights activism in the United States was closely tied to racial justice in the 1960s because of the immense racial disparities in the treatment of black men. The movement grew quickly and gained not only a national following, but also international recognition, as political scientist Marie Gottschalk discussed in The Prison and the Gallows.⁴¹ The men at Dallas were no different, and they wrote to many public interest attorneys, particularly in Philadelphia, about helping them leave the facility.

As a result of the men at Dallas writing letters, the Philadelphia-based American Civil Liberties Union (ACLU) of Pennsylvania took up the cases of hundreds of inmates at Dallas between 1966 and 1968. In particular, the agency challenged the constitutionality of the Defective Delinquent statute, calling it a violation of due process protections.⁴² The legal atmosphere was ripe for such a challenge. Just a few years earlier, in 1964, a civil-liberties attorney in Pittsburgh had successfully challenged the constitutionality of the state’s Barr-Walker Act, which gave indeterminate sentences to sexual offenders.⁴³ 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 because they were deemed wards of the state. But Gault challenged the parens patriae relationship of the state and juveniles, giving them rights and rejecting the claim that they would lose those protections because of the state’s protectionism.⁴⁴ When the ACLU took up this issue of the rights of people

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⁴² “CLU Challenges Commitments of 500 ‘Defective Delinquents.’”

⁴³ Gerchman v. Maroney, 355 F.2d 302 (1966) 302 3 Cir.

deemed defective delinquents, it wielded not only the legal precedent of prisoners’ rights cases, but also the precedent of the challenges to the sex offender and juvenile delinquent laws.

Freeing people from Dallas did not come without a fight, however. The Department of Welfare criticized the ACLU as “irresponsible” for trying to release these men. To the department, Dallas provided the people there with much-needed social services in the institutional environment. The department continued to defend the *parens patriae* structure for determining what treatment would be best for the people under its care, with the loss of their liberty in the matter. Even in the face of this criticism, the ACLU continued to challenge the law by citing due process violations and arguing that the state was imprisoning people who had never committed a criminal act. Because of the organization’s efforts, the state legislature repealed the act. In all, at least 800 men left Dallas. ACLU Executive Director Spencer Coxe termed the effort a “legal ‘jail break’ campaign,” and later commented that it was one of the most important victories of his long career.45

While legal changes undermined the commitment practices of people diagnosed as defective delinquents, sex offenders and juvenile delinquents, challenges to the commitments of people deemed criminally insane also began in New York. In 1959, the court system there 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 head of the hospital filed a petition to have him civilly committed, arguing that he had a mental illness and needed care. As a result, Baxstrom remained at the hospital after the end of his sentence. He did not go quietly, though, fighting his commitment by filing a *habeas corpus* petition in the state

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45CLU Challenges Commitments of 500 ‘Defective Delinquents;” Also, see Finding Aid for Spencer Coxe Papers, Temple University Urban Archives.
and federal courts alleging that his commitment was unconstitutional. The case made its way to
to review by the U.S. Supreme Court. In the opinion from February 1966, Chief Justice Warren
found the statute by which Baxstrom and other inmates were committed unconstitutional because
they “denied him equal protection of the laws guaranteed by the Fourteenth Amendment.”46 As a
result of the Baxstrom ruling, the state sent him and 966 other inmates from Dannemora and the
other New York State maximum-security prison, Mattawean State Hospital, to civil hospitals for
reassessment, eventually freeing the majority of them.47 But the U.S. Supreme Court’s ruling
about this commitment law only led to the release of people at New York State institutions. It did
not directly apply to similar institutions nationwide.

The success of the Baxstrom case still had an impact, however, as it made similar cases at
the state-level far easier to litigate. In 1969, for instance, a case emerged in Pennsylvania
centering on the Farview State Hospital for the Criminally Insane. As discussed in Chapter 2, it
was relatively easy for people to enter Farview, but it was hard to leave. Two criminologists –
Terence P. Thornberry with the Center for Studies in Criminology and Criminal Law at
University of Pennsylvania and Joseph E. Jacoby, Assistant Professor of Criminal Justice at
University of South Carolina – conducted research on Farview in the 1970s, leaving us
invaluable information about the institution. In their review of case files, Thornberry and Jacoby
found that about two-fifths of their subjects died while at Farview, making death the most
common mode of discharge in the 1960s. People with psychiatric disorders at Farview stayed far
longer in institutions than the average person imprisoned in Pennsylvania. This was not
necessarily due to the severity of their crimes. Instead, the unusually long stay was due to the

Thornberry and Joseph E. Jacoby, The Criminally Insane: A Community Follow-up of Mentally Ill Offenders,
fact that the employees at Farview were hesitant to release people because they might be held responsible for any crimes that happened after release. Bob Bechtel, a man who lived at Farview in the late 1940s, recalled going to Farview as a patient and realizing that the staff might never determine him rehabilitated, and he felt like he would live there for the rest of his life. In the criminal system, judges could give set sentences recommended for various crimes. But in the mental-hospital system, the staff did not have such a system and instead often decided to just hold the person longer. Individuals who displayed signs of mental illness and who had criminal histories became the most vilified in the system, and were the most quarantined from society. The *parens patriae* imperative intersected with the state’s responsibility for public safety, resulting in the overuse of confinement for individuals with dual diagnoses of criminality and insanity.

As a result, people at Farview wrote letters in the 1960s seeking their freedom as they had at Dallas. Because most did not have access to attorneys and because the staff largely did not release the people, letter writing to possible allies became a lifeline for freedom. One individual from Farview wrote a letter that made its way to 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, was at the University of Pennsylvania and was involved in the prisoners’ rights project. The younger Bazelon recognized the civil rights implications in the letter, and took on the case of the man at Farview. While the inmate at Farview sought his freedom, Bazelon and Curtis Reitz both recognized the issue of civil rights for a man who had served his criminal

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48 Thornberry and Jacoby, 3; Anne Parsons, Interview with Robert Bechtel, July 24, 2012.

49 Anne Parsons, Interview with Robert Bechtel.
sentence yet still remained confined in a mental-health institution for treatment.\textsuperscript{50} While mental-health law was wide open at the time, Judge Bazelon’s recent decision, the ruling at Dannemora and other challenges to mental-health laws proved a promising atmosphere for new litigation. On July 25, 1969, Reitz and Bazelon filed the lawsuit \textit{Dixon v. Attorney General} with Donald Dixon as the lead plaintiff in the District Court in the Middle District of Pennsylvania.

One of the first steps that they took was to create a class of individuals to represent. They created a class including all of the people committed, not by a family member, but by a member of the Farview staff.\textsuperscript{51} None of the class members were still serving time for their criminal sentences, if they had them, although a small group had had their sentences deferred pending a psychiatric exam. According to a demographic study, the \textit{Dixon} class’s average age was forty-seven, and twelve percent of them were over sixty-five. “Members of minority groups and the poorly educated [were] over-represented in the Dixon class,” and forty percent of the class was African American, far higher than the number of African Americans statewide, which stood at nine percent.\textsuperscript{52} Almost half of the \textit{Dixon} plaintiffs had not advanced beyond sixth grade, fifty-nine percent were listed as unskilled laborers, and only fourteen percent were professionals, managers, or farmers. Many had spent time in other mental hospitals.\textsuperscript{53} Because of the disproportionate representation of African American and white working-class men, the Farview case was not just about the injustice of mental-health laws, but it was itself a civil rights issue.

In the case of Dallas, the Department of Welfare had protested the ACLU’s efforts out of concern of protection for the people there. However, in the Farview case, the department of

\textsuperscript{50} Anne Parsons, Interview with Richard Bazelon, August 16, 2012.
\textsuperscript{51} \textit{Dixon v. Attorney General}.
\textsuperscript{52} Thornberry and Jacoby, 56–57.
\textsuperscript{53} Ibid., 57–58.
Welfare behind closed doors supported the effort to release people. Richard Bazelon recalled that the Department of Welfare recognized the deep problems at Farview, and encouraged legal action to change the practice of long-term confinement for these individuals. The department readily allowed the lawyers to access clients at Farview and documents to help create the class. In the past, the Farview staff had not wanted to take responsibility for releasing individuals from the institution, fearing retribution if a person from Farview committed more crimes. However, if the federal court decided to release the individuals, the institution would be relatively blameless for any future incidents, making it easier for the Department of Welfare to support the Dixon plaintiffs.

Public safety became the defining feature of the U.S. District Court judges’ deliberations. At the Dixon hearing on July 22 and 23, 1970, the plaintiffs put on witnesses involved in “Operation Baxstrom,” the nickname for the effort to transfer inmates from the maximum security mental hospitals in New York. These witnesses testified to the fact that only seven of the one thousand people released from Dannemora and Mattawean returned to maximum security institutions. Here, 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, for most, outside of institutional settings as a whole. In this way, the lawyers relied on the elision of any disabilities or differences of the people in this class in order to gain their civil rights. In his essay, “Disability and Inequality in American History,” Douglas Baynton charted how claims for civil rights of African Americans and women often came with the denial of any disability or difference in order to justify the people’s capacity for citizenship rights. Activists often unwittingly upheld the hierarchical structure that continued to exclude people

54 Anne Parsons, Interview with Richard Bazelon.
with various physical, mental, and intellectual disabilities from a host of rights.\textsuperscript{55} Similarly, here the \textit{Dixon} attorneys made their claim based on evidence that the people at Farview should have the right to due process protections just as any other citizen would have and argued that they did not have any major disabilities or criminal propensities. In doing so, the lawyers upheld the hierarchical structure that was emerging that continued to exclude people deemed a threat to society from the citizenry.

Regardless, the constitutional argument for civil rights protections overrode the concern for public safety. The court found the recommitment procedures no more than a “‘paper notation, without any formal hearing or process whatsoever’” and redefined the standard of commitment laws.\textsuperscript{56} In the court’s opinion, “The plaintiffs contend that Section 404 is unconstitutional on its face and also as applied to plaintiffs. We agree. Indeed, the defendant does not contend otherwise.”\textsuperscript{57} Again, the Department of Welfare did not pose a major barrier to this finding here, perhaps in large part because of the precedent of \textit{Baxstrom}. The court based its decision on recent U.S. Supreme Court decisions on the due process protections of sex offenders and the unconstitutionality of the Barr-Walker Act in Pennsylvania. It also cited the \textit{Gault} case that granted due process rights to juvenile delinquents. “We are unimpressed by the \textit{parens patriae} argument,” the Pennsylvania District Court wrote, “and strong courts have not been persuaded by it.”\textsuperscript{58}

But the District Court did not totally gut the state’s ability to commit people involuntarily to mental-health institutions. Instead, it offered a clear definition of the new terms by which the


\textsuperscript{56} \textit{Dixon v. Attorney General}.

\textsuperscript{57} Ibid.

\textsuperscript{58} Ibid.
Department of Welfare could commit a person to an institution. They placed law, order, and public safety at the center of the new reasons to institutionalize people.

The standard for commitment and the burden of proof shall be as follows: the evidence found to be reliable by the factfinder must establish clearly, unequivocally, and convincingly that the subject of the hearing requires commitment because of manifest indications that the subject poses a present threat of serious physical harm to other persons or to himself. (Emphasis added)\(^{59}\)

The court found that the commitment rules for the general rehabilitation of mental illness were not enough; instead, it ruled that involuntary confinement should occur only with the designation of danger. In the late 1960s, both liberals and conservatives had become deeply concerned about protecting society, because of a rising fear-based discourse around urban riots, civil disorder, and rising crime.\(^{60}\) The following chapter will look closely at this politics of law and order and how it affected imprisonment. However, it is important to note here that in the liberal re-creation of civil protections for people in state institutions, the court shifted the loss of liberty from the definition of mentally ill and in need of treatment, to mentally ill and presenting a threat to himself or others. A new paternalist model emerged that did not seek to provide the individual with involuntary treatment, but instead sought to protect society from harm.

\textit{Dixon v. Attorney General} had a major impact on the lives of hundreds of people who lived at Farview. 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, and the state transferred them to civil institutions near their homes and later to their home communities. In their study of people after Farview, Thornberry and Jacoby found that most of the Dixon plaintiffs did not commit violent assaults or have to be rehospitalized after their release, countering the prevailing political fear that they would create a crime wave upon their return. Overall, the releases adjusted to community living stably, with many people living with their families, and few living in boarding houses. The researchers then posited that a new commitment system for people deemed criminally mentally ill might be more based on “just deserts,” or “proportionality,” and called for more procedural protections for people diagnosed as criminally mentally ill to lessen the chances that they would spend an inordinate time in mental hospital commitment. While they argued against mental hospitalization for these individuals, criminal sentences and correctional institutions began to emerge as the accepted state response.

But the Dixon case did not just lead to the release of people from Farview. Its determination of the commitment law as unconstitutional affected the lives of thousands of other people in the mental-health system who did not have criminal histories. By eliminating the legal foundation of Section 404 of Pennsylvania’s mental-health law, the District Court eliminated the legal basis for thousands of involuntary commitments and ordered the release of people committed involuntarily without due process. Systemwide, the Department of Welfare contacted about fourteen thousand individuals and their families, notifying them of the court’s

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62 Thornberry and Jacoby, 202–3.
63 Ibid., 212.
decision. The legal redefinition of the rights of mental-hospital patients in Pennsylvania occurred at the intersection of the mental-health and correctional systems, in the definition of who should be removed from society, why, and in order to protect whom.

Three years after Blain’s major program of releasing people, the Philadelphia State Hospital at Byberry underwent a second major wave of releases because of the Dixon decision. Because Section 404 was found unconstitutional, the Byberry administration notified its staff that eighteen hundred of the twenty-four hundred individuals at Byberry were now informed they could either leave or stay at the facility – whatever they decided. The Philadelphia State Hospital Employee Bulletin announced to the employees that any of the patients were allowed to go if they chose and could remain if they wanted treatment. Many of the people did in fact choose to go, but this time, people left at their own discretion. Blain’s efforts to deinstitutionalize Byberry had initially reduced the number of people there, and then after the Dixon decision the numbers decreased significantly again because the commitment laws no longer permitted the involuntary confinement of people only because of their diagnosis of mental illness.

After the 1971 Dixon ruling overturned the mental-health-commitment laws in Pennsylvania, lawyers and policymakers over the next five years drafted new commitment proposals. Two Philadelphia lawyers, Richard Bazelon and Alan Davis, worked on drafting the new reforms. Specifically, they, along with the Mental Health Association of Southeastern Pennsylvania, sought to write 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

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65 Ibid.
66 Philadelphia State Hospital, “Care and Court Decisions,” Staff Bulletin 4, no. 24 (June 1971); Also see, “1,800 Byberry Patients Told They Can Leave,” The Evening Bulletin, July 3, 1971.
67 In the early 1970s, two smaller lawsuits challenged the constitutionality of Sections 412 and 424 and further weakened the Mental Health and Mental Retardation Act.
treatment, voluntarily or involuntarily; or were released from treatment.” Between 1972 and 1976, the drafting group held numerous public hearings, and worked with the Department of Public Welfare and the Pennsylvania Psychiatric Society. The process of revising the rules proved to be long and arduous, but it resulted in the Mental Health Procedures Act, signed into law only a few days after the bicentennial on July 9, 1976.

The committee that drafted the new legislation argued that the historic commitment laws arose for a benevolent purpose, but had gone deeply awry over time. To make this point, in a report on the legislation, the authors quoted Judge David Bazelon, “It sometimes happens that a system designed to protect the disadvantaged ends up oppressing them.” They 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, led 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.

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

This movement to offer more rights to people with mental illness coincided with drastic cuts to federal and state mental-health budgets in 1973. In February of that year, President Richard Nixon’s administration recommended a scaling back of federal grants to the states to build new community mental-health centers, a program initiated under Kennedy in 1963. Federal funding would only support the operations expenses for already existing centers.71 In the fall of that year, there were state-level cuts to mental hospitals, as Republicans argued that state institutions were costing more and had become a waste of state money. Both Democrats and Republicans also supported cutting mental-hospital budgets to fund community mental-health services.

But these cuts did not come without protest. Union workers went on strike at institutions across the state, including the state hospital at Byberry. The American Federation of Labor – Congress of Industrial Organizations even opposed a bill that supported patients’ rights, citing it as an example that the state was using rights 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 for civil rights.72 This labor perspective of opposing cuts on behalf of people in the hospitals would become a central challenge to the neoliberal deinstitutionalization efforts of the 1980s.


Intersecting with these changes was the fact that the early 1970s was also a time when many people called for protection of the streets, including protection from people with mental illness. In 1974, Governor Milton Shapp spoke about the process of deinstitutionalization, which he described as “controversial.” He said that many people had criticized the state for the movement of people out of mental hospitals, claiming that the community program was “not yet ready for ex-hospital patients.” In Philadelphia, the Department of Welfare reported that many releases were not wanted by their communities.

But the historic segregation of people with mental illnesses and the fear-based politics of the early 1970s did not prove conducive to a major societal shift away from fearing people with mental illnesses. Public concern with the danger and threat posed by people who had left mental health institutions shaped the new laws concerning mental-health disabilities. In their report, the drafters of the 1976 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.” The authors acknowledged a need for treatment, but stated that that need “must be weighed against untoward intrusions on his privacy. Medical judgments are integral to the process, but discretionary power must be limited in order to prevent an improper exercise of parens patriae.” They criticized involuntary commitments as being over-reliant 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 compromised in their commitment both to assist people with mental illness and to maintain order.

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73 Milton J. Shapp, [Speech], March 20, 1974, fol. 10, box 8, Series on Special Assistant for Human Services, Shapp Papers, PSA.

74 Pennsylvania Department of Public Welfare, “Legal Issues in Mental Health Procedures,” 1973, 11fol. 89, box 186, Subject Files, Governor Shapp Papers, PSA.

75 Ibid, 12.
in the institution.\textsuperscript{76} To counter this conflict of interest, they drafted this legislation to place the power of commitment more centrally in the hands of the courts. The courts would then decide whether the person posed “a clear and present danger of physical harm, either to himself or others,” a standard put forth in \textit{Dixon} and by the Supreme Court in \textit{Jackson v. Indiana}.\textsuperscript{77} While people with mental illness on the whole could no longer be committed solely because of their diagnosis, commitments for people found dangerous were an entirely different story. “The mentally ill, however, may be detained on a broader standard – the threat of posing a danger, or even merely a conflict, to society.”\textsuperscript{78}

In the late 1960s, a breathless sense of liberation pervaded the challenge to medical authority and the release of thousands of people from mental-health institutions. Even though postrelease services were minimal, the public discourse focused on the changes as bringing freedom to the people warehoused inside the wards. The challenge to custodial practices greatly undermined the mental-health system’s commitment laws, and the tradition of placing people in mental-health institutions to rehabilitate them changed dramatically in only ten years.

Historically, mental-health institutions had served both to provide treatment for people with psychiatric disabilities and to protect the public from potentially dangerous behavior. In the late 1960s, as the courts sought to provide civil protections for individuals with disabilities, they redefined the purpose of institutionalization. In cases like the ones at Dallas and Farview, the courts stripped the Department of Welfare of its paternalist protectionism. But this agency still retained the authority to involuntarily confine people deemed dangerous. In an era of

\textsuperscript{76} Ibid., 16.
\textsuperscript{78} Ibid., 7.
deinstitutionalization and civil rights, the courts did not totally reject state institutions; instead, it redefined them as places intended for public safety, not involuntary treatment.

But these changes occurred at breakneck speeds in the late 1960s and early 1970s, and there were serious consequences to such rapid change. This complicated liberation came through in the news coverage of a person at Byberry named George Elder. In 1971, the *Evening Bulletin* published a major article about Elder a Cherokee and African American man in his twenties, who during the Great Depression took to the road as a hobo. He travelled to at least twenty-five states across the U.S., and in 1942, at age 35, the police picked him up for hitchhiking and found that he had an improper draft card. When Elder appeared in front of the court, he bluntly refused to fight in World War II because of the way the government had treated the Indians. Instead, he demanded that the U.S. government reimburse him $342 for the injustices done to them. The judge did not send him to jail, nor did he release him. Instead, a psychiatrist certified Elder as legally insane, and the court committed him to the Philadelphia State Hospital at Byberry (known as Byberry for short). Later researchers found that Elder’s hospital file did not show that he had any hallucinations or bizarre behaviors. Yet, even when he petitioned for his release from the hospital, the staff refused because he did not have any relatives in the area. The news article reported that Elder then remained at Byberry for twenty-nine years until 1971 when at age sixty-four: In the midst of de-institutionalization, Byberry leadership informed him that he could finally leave.\(^79\) While the article carefully charted how Elder felt conflicted about leaving the hospital after living there so long, the overarching spirit of it focused on how mental hospitals had overly confined people, depicting a system that was both outmoded and in which people could no longer be confined like that.

While many people returned to their communities and families with no further problems, many others left the institution for poor housing and limited access to services. The *Philadelphia Inquirer* 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, but she never found him. Furious at the mental-health system, she claimed that the mental-health system took action to “protect their rights, but not the patients. They’re just opening the doors and sweeping them out.”\(^80\) The experience of this woman was not a total anomaly. Advocates argued that the Philadelphia State Hospital was “dumping patients,” without concern for their welfare. Franklyn Clarke, Blain’s successor and the first African American superintendent of Byberry, disputed the claims. Years later, he said, “We were wardens instead of therapists. Patients got worse, but you [the community] slept nights.”\(^81\)

Within only a few years, the people who had left Byberry without any support were nicknamed “Byberry people.” According to the *Evening Bulletin* in 1974, 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.”\(^82\) The dramatic changes in the mental-health system had come in large part out of an interest in protecting people. Dr. Blain and other mental hospital administrators sought to protect them from warehousing in the mental hospital, and the plaintiffs of Farview and their lawyers sought freedom from involuntary commitment. However, the new problems of poor social supports in community settings arose in the 1970s. In the criminal legal system, similar problems emerged when corrections officials tried to create community-based programs for people convicted of crimes.

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\(^81\) “Hearing,” *Philadelphia State Hospital Staff Bulletin* 4 no. 8 (February 26, 1971).

CHAPTER V

REHABILITATING THE PRISON

In 1972, historian David Rothman made what seemed a well-founded prediction about the future of correctional institutions in America based on the changes of the past two decades. “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 people 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.”¹ 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.”² The search for alternatives and the challenge to the asylum had led to an optimism that society would fully reject the large, custodial institution.

Liberal policies that rejected the segregation of people with mental-health disorders or criminal histories caused the fall in institution populations. During the fifties and sixties, many liberal policymakers and politicians worked to make the mental-health and criminal legal

¹ David J. Rothman, “On Prisons, Asylums, and Other Decaying Institutions,” The Public Interest (Winter 1972): 3–4. Rothman does not argue that the number of people in institutions for people with mental retardation fell, but he does point out that many physicians at the time were seeking out community alternatives to these facilities. Two decades later, in 1991, Rothman wrote a retrospective article acknowledging the failure of the anti-institutional movement he described in the 1972 essay.

systems more rehabilitative with treatment-oriented programs and the creation of community-based alternatives to institutions such as furloughs, halfway houses, work-release programs and community mental-health centers. They looked to localities as crucial resources in alleviating the social problems of poverty, poor mental health, and crime and found inspiration in new community-based ideologies within psychiatry and the anti-institutionalism of the time. As a result, by the early 1970s as Rothman described, the number of individuals living in institutions had reached its lowest point in decades, even in the face of rising crime rates, urban riots and expanding police forces. Prisons, mental-health institutions and juvenile facilities all seemed relics of a soon-to-be-bygone era.

Yet something happened in the early 1970s. At the very moment state governments released hundreds of thousands of people with mental illness from hospitals, the rehabilitative ideal in corrections and community alternatives to the prison came under fire. Spurred on by the anti-institutional sentiment of the sixties, activists in the seventies continued to challenge the authority of the medical and psychiatric professions in myriad ways: organizing against forced sterilization and 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 Mental Disorders: Diagnostic and Statistical Manual-II.³ But it was not only medical and psychiatric authority that were problematic to many activists. During the 1970s, American governance experienced a “crisis of competence” as many people on both the left and right challenged social

welfare policies as too interventionist, ineffectual, or wasteful. As faith in the power of medical and state authority weakened, the search for alternatives to the prison particularly came under assault. Francis Allen charted this shift in his 1981 book *The Decline of the Rehabilitative Ideal* in which he identified the early 1970s as the moment when the public lost faith in the ability of the American prison system to rehabilitate people and create law-abiding citizens. Liberal politicians and policymakers failed to change their tactics in response to the crumbling confidence in state-sponsored rehabilitation programs. Instead, liberals held onto their beliefs that social-welfare correctional programs based on the medical model would solve the problem of crime.

Concurrent with the waning faith in government came the rise of a bipartisan law-and-order conservatism infused with concerns about racial integration. Historian Michael Flamm has argued that anxieties about safety and security hastened the shift of large portions of the white working and middle classes from the Democratic to the Republican Party. The politics of fear, to Flamm, played a central role in undermining postwar liberalism and ushering in the ascendancy of conservatism. Heather Ann Thompson has echoed Flamm’s sentiments, further arguing that racism and social control were central to law-and-order politics and the creation of a new American segregationist system. Thompson, however, held that both parties shared a concern for the high rates of violence in black urban areas and fears of young black men on the streets. To Thompson, law-and-order policies were the tactics of not just Republicans, but Democrats as

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well. The post-civil rights era brought bipartisan law-and-order politics that denied African American men the ability to hold jobs, vote, and have access to social services on a mass scale.\(^7\) In this chapter, I add to this work by arguing that the rise of law-and-order conservatism redefined the conceptions of the practice of institutionalization in America. Law-and-order conservatives fought against community-based alternatives to prisons, begun in the fifties. Instead, they became political hot-button issues that renewed cries for segregating people deemed threatening from the streets. Rather than furthering deinstitutionalization, race-based fears fostered a conservative political vision that reinvigorated America’s reliance on custodial institutions, saving them from extinction.

I also engage with the work of Marie Gottschalk, who argued that it is important to go beyond the mere law-and-order argument for the rise of prisons. In her book *The Prison and the Gallows*, Gottschalk looks at how social movements such as the women’s rights, prisoners’ rights, and victims’ rights movements influenced the trajectory of mass incarceration, even if that was not their explicit intent.\(^8\) I similarly incorporate the relatively small, although powerful, resistance to the state-based rehabilitative model that came from civil libertarians and prisoners’ rights activists in the 1970s. These groups, while calling for community services for people who broke the law, argued that the expansion of community services should not come with the expansion of state authority. As a result of these developments, prisons did not decay in the midst of deinstitutionalization as Rothman had hoped, but instead changed form and began to grow rapidly.

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The changes in mental health and corrections between 1965 and 1975 happened in conversation with each other, often steered by the same actors and interest groups who defined the meaning of confinement of people in mental hospitals and prisons in tandem. In this political battle stood three main camps that did not always hold to party lines. First were liberals, many of whom advocated the expansion of law enforcement while repudiating a purely punitive vision of the prison. Rather than merely incarcerate individuals and remove them from society if they committed crimes, these policymakers supported a graduated and more indeterminate form of sentencing, more rehabilitative programs and alternatives to the prison. Here, they reflected a broader liberal impulse from the 1960s, which sought to solve social problems through state intervention and also looked to communities as valuable resources for addressing these issues. Second, proponents of law-and-order conservatism did not oppose the shift towards community mental-health care for people with mental illnesses and no criminal background. However, they did seek punitive measures against people who committed crimes, including individuals with mental illnesses who broke the law. To these conservatives, the prison system should segregate dangerous people from society rather than provide them with community-based services. Finally, a small but vocal group of Leftists, made up of civil libertarians and prisoners’ rights activists, opposed conservatives’ harsh measures but also distrusted the liberal rehabilitative model.

In the 1970s, the deinstitutionalization of mental hospitals continued apace, while efforts at deinstitutionalizing prisons failed and the meteoric rise of mass incarceration began. The center of deinstitutionalization, then, lay in the rejection of confinement for people judged innocent and the rapid embrace of confinement for people considered dangerous. These notions and definitions were directly tied to race- and sex-based notions of criminality, disproportionately affecting African Americans in the immediate post-civil rights era.
The Peak of Community Corrections

In the 1960s, urban unrest and rising crime rates became central to the public discourse. Urban uprisings rocked many American cities in the middle of the decade, including Philadelphia, and peaked in 1967 when 163 cities erupted in violence, often due to incidents of police brutality and inordinate economic inequality. At the same time, violent crime increased as the number of rapes, serious assaults and robberies quadrupled. Nationally, the homicide rate nearly doubled from 5 murders per 100,000 people in 1960 to 9.8 per 100,000 in 1974. Criminologists have attributed the rising rate of reported crimes to urbanization and to the fact that in the 1960s the Baby Boomer generation reached young adulthood, an age associated with higher rates of crime. Additionally, police departments counted crimes more thoroughly during the 1960s because of new reporting methods which in turn bolstered the statistics of rising crime. Notably, although the number of crimes rose in this period, the statistics resembled those from earlier in the century. For instance, the homicide rate in 1933 was 9.7 per 100,000, roughly equivalent to the 1974 rate.

The rising crime rate, urban riots, and political protests fostered fears for personal safety, particularly among whites, even though rioting rarely directly affected white areas. Very few rioters attacked whites and most of the casualties happened at the hands of police rather than the rioters, the large majority of whom did not bear arms. Even though rioting did not directly

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11 Mauer, 28; Thompson, 727.
12 Thompson, 727.
threaten them, however, many feared the possibility of street crime. A Harris poll in 1964 showed that seventy-three percent of Americans sensed that crime had grown in their communities, and the National Opinion Research Center reported in 1967 that one-third of Americans feared walking alone in their neighborhoods. 13 In 1964, conservative Republican Barry Goldwater had made fear and law and order centerpieces of his political platform against President Johnson, using racialized language to charge the Democrats with allowing violence to flourish in the streets, “the license of the mob and of the jungle.” 14 Political tactics and public fears of crime and riots fueled white concerns about personal safety, even if they did not directly experience the violence. The discourse around crime rose just as fast, if not faster, than the crime rates themselves.

But the Democratic Party did not stand idly by in the face of these public fears. For instance, President Lyndon B. Johnson fought the law-and-order politics of Goldwater and Nixon not by rebuffing them, but by creating his own “tough on crime” stance. In 1967, Johnson published a report, “The Problem of Crime in a Free Society,” and the following year he passed the Omnibus Crime Control and Safe Streets Act that created major grants to expand and improve police departments across the country. Under Johnson, law enforcement forces expanded nationally as did the number of arrests, particularly in black communities. 15

This liberal cooption of law and order occurred not only at the federal level. In Philadelphia in 1967, Democratic Mayor James H. J. Tate placed the Democrat Frank Rizzo into the office of Police Commissioner to regain credibility on issues of crime in the face of

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14 The phrase comes from a Goldwater speech at the Republican National Convention in July 1964, as quoted in Flamm, 31.

15 Thompson, 730–31.
Republican successes among white Catholic and Jewish communities.\textsuperscript{16} Prior to his appointment, Rizzo had led raids on four houses where Student Nonviolent Coordinating Committee organizers allegedly stockpiled weapons, and he became known for saying “The way to treat criminals is ‘Spacco il capo’ (break their heads).”\textsuperscript{17} The Democratic Party also became greatly involved in making harsher policing laws.

However, while liberals supported increased law enforcement on the streets, they took a more anti-institutional approach in responding to crime. In corrections during the 1960s, liberal politicians and policymakers implemented a series of interventionist initiatives that aimed to change people convicted of crimes through treatment, job training, and education in order to prevent further crimes. The 1960s was a time of optimism toward the state’s ability to solve social disorders, building on the rehabilitative emphasis over the past years. Welfare programs such as the Aid to Dependent Children between 1945 and 1965, for instance, aimed not just to provide mothers with economic support. They sought to rehabilitate women through job and educational programs so that they could eventually become independent from state assistance.\textsuperscript{18}

Central to the liberal vision in the 1960s was a belief in the state’s ability to rehabilitate individuals, a holdover from the previous decade. The liberal impetus for rehabilitation also stemmed from new policies in mental health, which was a central program of state social welfare systems at the time.

The rehabilitative and community-based reforms also took off in corrections in Pennsylvania. In 1966, the most well-known African American politician in the state, K. Leroy

\textsuperscript{16} S. A. Paolantonio, \textit{Frank Rizzo: The Last Big Man in Big City America} (Philadelphia: Camino Books, 1993), 85–86.

\textsuperscript{17} Ibid., 53.

Irvis, became particularly involved in mental-health reform. Irvis came from a black working-class family and earned his law degree at the University of Pittsburgh. In 1958, he won a state House of Representatives seat as a Democrat and rose quickly through the ranks.\footnote{Paul B. Beers, \textit{Pennsylvania Politics Today and Yesterday: The Tolerable Accommodation} (University Park, PA: Pennsylvania State University Press, 1980), 427–29.} He became Speaker of the House of Representatives in 1977, the first African American Speaker in Pennsylvania and the country since Reconstruction. Irvis nurtured a passion for justice and sponsored hundreds of bills through which he fought for civil rights, fair housing, better education, and improved public-health and mental services.\footnote{“Former Pa. House Speaker K. Leroy Irvis Dies,” \textit{Pittsburgh Post-Gazette}, March 16, 2006.} Irvis revealed his liberal ideologies as he repeatedly supported government social welfare programs to solve the problems of racism, poverty, crime, and mental-health disorders. Notably, although Irvis left a large body of archival records, no one has written about him in the scholarly literature.\footnote{Historian Laurence Glasco is working to fill this gap with a biography of Irvis. Also see, \textit{K. Leroy Irvis: The Lion of Pennsylvania}, directed by Bill Medica (Pittsburgh, PA: University of Pittsburgh, 2004).}

Irvis’s experiences as a politician in mental-health reforms greatly informed his work around prison reform. In the 1960s, Irvis galvanized the Legislature to create a bipartisan investigative committee that would survey conditions at all state institutions. The Legislature agreed to this suggestion following a series of shocking articles about the plight of people at the Pennhurst State School. Irvis then led an investigation of the twenty-nine institutions, visiting a number of them himself and diligently collecting the results.\footnote{Report of Bipartisan Committee on Visiting State Institutions (Harrisburg: The Committee on Visiting State Institutions, 1967).} The report recommended a series of administrative reforms at the institutions, and it also recommended the allocation of funding with the intention of “successfully returning as many patients to society as possible.”\footnote{Ibid., 4.}
bipartisan committee also gave the legislators firsthand knowledge of mental-health institutions and deinstitutionalization.

The liberal community-based rehabilitation programs in mental health stood as forerunners to change in corrections, and Pennsylvania in the late 1960s stood as a national leader in prison reform. “Long-haired Utopians,” was the phrase an opponent used to describe the Pennsylvania Bureau of Corrections in the late 1960s and early 1970s. And Utopian it was. Building off of the reforms in juvenile justice, the Bureau of Corrections in the 1960s encouraged the use of probation over imprisonment. The ideas of using more community-based programs had been bubbling in policy circles for a number of years, particularly at the Philadelphia-based Pennsylvania Prison Society. The Prison Society in the early 1960s resolved to support small and dispersed “work colonies,” “minimum security satellite service units” and better probation standards to improve correctional services outside of the prison environment.

At the same time, many criminal judges used probation more than ever, to the extent that two-thirds of convicts lived in the community under supervision. The Bureau of Corrections continued the trend by introducing a series of community corrections programs that provided a transition between incarceration and release. Supported by moderate Republican leadership and influenced by forensic psychiatrists, Bureau officials embraced the notion that prisons should provide inmates with rehabilitative services to ensure that they did not commit more crimes. As a result of these reforms, Pennsylvania’s eight state prisons operated at seventy percent capacity by


1968 and held only fifty-three hundred women and men, down from eighty-three hundred in 1963.\textsuperscript{26}

The reforms peaked in 1970 with the appointment of a new Corrections Commissioner, Allyn Sielaff, who had background in social work. Sielaff refused to address inmates by number, let them grow their hair as long as they wanted, and worked to make prison conditions less institutional. According to Pennsylvania prison historian John McWilliams, Sielaff wanted “to better prepare inmates for life after prison. Sielaff described 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.’”\textsuperscript{27} In the early 1970s, the Bureau of Corrections issued “The Changing Concept of Corrections,” a public report illustrating the Bureau’s ideology. The front cover showed a white man standing alone by a tree, while the back cover pictured him walking towards a white woman and child, the rehabilitated heterosexual man returning to his family and society. Here, the publication recalled the literature produced by the Department of Welfare to depict the return of people from mental hospitals back to their communities. In the foreword of 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.”\textsuperscript{28} He continued 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.”\textsuperscript{29} To Sielaff, community leaders and organizations had the ability to support residents (his word) “in various and controlled situations

\textsuperscript{26} Burton A. Chardak, “Penna. to Close Prison Here This Summer,” \textit{The Evening Bulletin}, June 23, 1968. Pennsylvania also used county jails to house prisoners with short sentences, but even these numbers fell by 1968.

\textsuperscript{27} John C. McWilliams, \textit{Two Centuries of Corrections in Pennsylvania: A Commemorative History} (Harrisburg, PA: Pennsylvania Historical and Museum Commission for the Pennsylvania Department of Corrections, 2002), 41–42, quotation on 42.


\textsuperscript{29} Ibid.
in a gradual preparation for release.”\textsuperscript{30} This reformist language represented an integrationist model of corrections. While liberal politicians and policymakers appropriated funds to expand police forces, in corrections they worked to change people’s behavior in order to prevent future crimes. The liberal vision did not seek to separate people convicted of crimes from society, but instead to reintegrate them back into it, using more community-focused programs.

To facilitate this plan, the Bureau of Corrections instituted work and education release programs by which residents could leave the prison during the day to work or school and the Bureau also created home furloughs from one to seven days. Even before inmates reached their minimum sentences, corrections officials could let them return home for short stints to reconnect with family, find housing and attend job interviews.\textsuperscript{31} Between December and September 1970, people in Pennsylvania’s prisons left on furlough almost ten thousand times and ninety-eight percent of them returned to the prison.\textsuperscript{32} If inmates returned to prison smoothly, they became eligible for small regional correctional 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.”\textsuperscript{33} Regional prisons held no more than 150 to 250 people, and the Bureau described them as “non-prisons in design.”\textsuperscript{34} Community treatment centers held no more than twenty people. Staff supervised the residents twenty-four hours a day and when they determined that the people in prison had progressed through the

\textsuperscript{30} Ibid.


\textsuperscript{33} Bureau of Corrections, \textit{The Changing Concept: Corrections}, 11.

\textsuperscript{34} Ibid.
programs, they released them for home, the Young Men’s Christian Association, foster homes or drug treatment centers. In both the regional correction facilities and the community treatment centers, the Bureau of Corrections also let residents leave daily to go to work or school. The Bureau justified these programs by arguing that they helped make convicts upstanding citizens. It publicly stated that home furloughs lessened the destructive effects of incarceration on families in order to “preserve a husband-and-wife relationship.” Community treatment centers and regional correctional facilities kept people close to their families and to possible forms of employment. The community, rather than the prison, became the ideal place to rehabilitate convicted men into heterosexual heads of households. Again, the motifs echoed the language used in portraying the return of people with mental illnesses to the nuclear family.

Smaller facilities and community programs brought not only social benefits, but also financial ones. The Bureau of Corrections touted these reforms for saving taxpayers $9.00 a day per inmate, which translated into millions of dollars a year. While the state had to provide funds to set up the programs, in the long run the state saved money. A monitoring firm had found that these community programs reduced recidivism and provided a solution to the expense of imprisonment as the number of people in prison would fall over time. The Bureau of Corrections also contended that these programs reduced the number of people on welfare rolls, as vocational and educational training would help ex-convicts get much-needed jobs. Taxpayers in turn would gain from the rise in taxes that ex-offenders would pay when they found employment.

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35 Ibid., 11–12.
36 Ibid., 12.
39 Ibid., 13.
Because women in prison already lived under a more rehabilitative model than men, reformers faced less opposition in creating community-based alternatives for them. Female penologists in the late nineteenth century had established a tradition of separate treatment for women in prison, which often entailed more treatment-oriented services that prepared them for lives of domesticity. Although this model changed during the twentieth century, the basic concept of separate and more rehabilitative services for these women remained.\textsuperscript{40} Women in Pennsylvania’s prisons served time under a graduated sentence, with no minimum sentence but a maximum sentence, and lived at State Correctional Institution-Muncy, a prison which in many ways resembled a college campus with beautiful brick buildings without bars on the windows.\textsuperscript{41} In Philadelphia in 1968, the Pennsylvania Program for Women and Girl Offenders (PPWGO) formed in Philadelphia because of the neglect of women in prison and because they “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.”\textsuperscript{42} With case workers 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 PPWGO.\textsuperscript{43} The search for alternatives to prison permeated new correctional reforms for both men and women.


\textsuperscript{43} Ibid.
In the midst of the deinstitutionalization of mental hospitals, prison reform had become a popular liberal reform as well. While law-and-order conservatives called for getting people convicted of crimes off the streets, liberal legislators and prison officials called for putting them back on them with counseling, education, and job training. Liberals did not ignore the issue of rising crime and urban riots. Instead, they took an interventionist position and sought to make communities safe by expanding law enforcement and then by placing people in corrections programs intended to rehabilitate them with a variety of community-based services.

**Conflict over Rehabilitation**

But, as these liberal reforms reached their zenith, they also began plummeting to their nadir. The debates came to a head around one piece of legislation, the Good Time Bill, which proposed to abolish minimum sentences for men in prison altogether. The legislation was sponsored by K. Leroy Irvis, who had led the investigation into mental-health institutions a few years earlier. By 1970, Irvis had become deeply concerned with the rise of police brutality and riots in the cities. For instance, in 1968, he appeared as guest on a major television series, “The Urban Battleground,” which documented the riots and civil rights protests in Pittsburgh during the 1960s. In response to the crisis in Pennsylvania’s cities, Irvis fought for fair housing and civil rights and then turned his attention to the criminal legal system.

Irvis decided that the central way to change corrections was to reform the sentencing system. At the time, men in prison had to wait until they reached their minimum sentence to go before the Board of Probation and Parole which would determine their release. If the Board did not release them, they would leave when they reached their maximum sentence, set by law. After

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44 Fritz Kleibacker et al., *The Urban Battleground, Tell It – Like It Is. Part Two* (Pittsburgh, Pa: WIIC-TV, 1968).
a long period of negotiations, Irvis, the Bureau of Corrections, the Board of Probation and Parole, and the Attorney General’s office developed an alternative vision. They proposed the Good Time Bill which abolished minimum sentences for most men in prison. Their proposed legislation did not erase maximum limits, just minimums, making them significantly indeterminate while keeping the set release date. The intention here was that if people in prison became ready to return to society any time before their maximum limit, they could do so. Here, Irvis was advocating for what he considered to be shorter and more rehabilitative sentences. The legislation required that the Bureau of Correction establish treatment plans with educational and therapeutic components, “to be best suited to effect the rehabilitation of such prisoners.” Irvis introduced the legislation in September of 1970, and used the occasion to introduce it as “the beginning of hope and the end of despair for many men.” He continued that the bill would permit prisoners to be rehabilitated and released when, in the judgment of the Board of Parole, they are ready to function in society. This bill is 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.

Irvis supported abolishing the minimum sentence as a way to make penal institutions more therapeutic than punitive. The Bureau of Corrections supported the bill because the agency

45 The exception was that people with sentences of less than two years or life sentences would not lose their minimums.
48 Ibid.
already administered such a program in its juvenile and women’s facilities, and the agency favored that model. Ultimately, the more indeterminate graduated sentence gave more bureaucratic discretion to the Bureau of Corrections, which governed the treatment programs and influenced when inmates left the institution.\(^4^9\) The Bureau here reflected that while it had vested interests in the rehabilitation model, it wanted to do so without losing discretionary power. These liberal policymakers advocated the abolition of the minimum sentence in order to make corrections more humane, yet they did so in a way that kept authority in the hands of the state.

By calling for the abolition of minimum limits, Irvis and the Bureau of Corrections tried to make men’s criminal sentences more similar to the indeterminate commitment laws governing people in mental hospitals and state schools. The people in mental hospitals and state schools did not have any set time limits, and the institutional staff at these places determined whether and when people would leave. Penologists were not searching for a fully indeterminate sentence like that used in mental hospitals. Instead, they worked to introduce a more graduated indeterminate system that resembled the sentences used for women and children in prison, no set minimum but a set maximum.

But the graduated sentence led to longer, not shorter, times in institutions. In the 1960s, when adult men in prison reached their minimum prison term, the Parole Board reviewed their cases and, in many instances, released them. The people in Pennsylvania men’s prisons in the 1960s stayed an average of one and a half years in state institutions (an average that was longer

than most states).\textsuperscript{50} While women in prison could theoretically gain release as early as the day they arrived in prison, they often stayed longer than the men. This discrepancy occurred because institutional staff created their own schedule of when women could come up for parole. Often the staff would not want to take the blame for releasing people too soon, and so the schedule made women eligible for release later than the men’s minimum terms set by law.\textsuperscript{51}

A similar problem of indeterminate confinement affected people in mental hospitals. Because the institutional staff decided when they went home, many individuals often lived in hospitals for many years. At Farview State Hospital for the Criminally Mentally Ill, the people there stayed an average of over six years.\textsuperscript{52} While the individuals at these institutions could theoretically leave after the first day, they often stayed longer than if they had had a minimum sentence because administrators feared releasing them too early. With the minimum and maximum time limits, men in prison had more protections in regards to length of time than these other classes of institutionalized people. The indeterminate sentence gave state officials the authority over rehabilitative programs and the power to decide when to release individuals from institutions.

As discussed in Chapter 3, the use of bureaucratic discretion in the confinement of people had become deeply controversial in the 1960s, particularly at hybrid mental-health-penal facilities. The most active opponent of the Good Time Bill was Victor Taylor, recently released from State Correctional Institution-Graterford who had worked at the Barbwire Society as


\textsuperscript{52} Terence P. Thornberry and Joseph E. Jacoby, \textit{The Criminally Insane: A Community Follow-up of Mentally Ill Offenders}, \textit{Studies in Crime and Justice} (Chicago: The University of Chicago Press, 1979), 3. This average is based on the years 1945 to 1960.
program manager, and then as executive director of the Prisoners Rights Council (PRC).\textsuperscript{53} Taylor himself had first-hand experience with rehabilitative services, as he struggled with addiction issues, and also in his capacity as program director worked on providing counseling services for inmates and ex-inmates.\textsuperscript{54} Having lived in prison himself, Taylor had a deep commitment to the ideals of shorter sentences and prison reform, but he still considered House Bill 680 “the so-called Good Time Bill,” and declared it downright “horrible.”\textsuperscript{55}

> 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!!\textsuperscript{56}

Taylor did not keep his views to himself, but communicated his views to the Philadelphia Yearly Meeting of Quakers and the Pennsylvania Health and Welfare Council. While both the Yearly Meeting and the Council supported the movement for prison reform, they ultimately came out against the Good Time Bill because of the issues that Taylor raised.\textsuperscript{57} Here, the Prisoners’ Rights


\textsuperscript{54} Committee to Improve the Administration of Justice, “Committee to Improve the Administration of Justice Monthly Report,” December 22, 1970, Prisoners’ Rights Council Collection, fol. 4, box 1, Temple University Urban Archives.


Council was the main black radical group speaking on the issue. A review of radical literature from Philadelphia at this time shows that many black radical groups in the late 1960s and 1970s focused more on police brutality under Rizzo than on prison reform at the state level. While black radicals supported political prisoners, few groups except the PRC engaged in the legislative process to change prisons.\(^{58}\)

The major sources of support for PRC’s position, then, came from civil liberties and legal organizations such as the American Civil Liberties Union, which had been greatly involved in questions of mental-health confinements. As discussed in the previous chapter, in the 1960s, the ACLU had opposed the indeterminate confinement of defective delinquents, a class of people in prison classified as dangerous and as having a mental disability. When faced with the passage of the Good Time Bill through the House, then, the ACLU mobilized against the legislation. Spencer Coxe, the executive director of the ACLU, argued that giving the Parole Board too much discretion would lead to more arbitrariness in a prison system already 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.”\(^{59}\) His second, more damning charge

\(^{58}\) The Thelma McDaniel Collection at the Historical Society of Pennsylvania is a major collection of black power and socialist literature from Philadelphia. I found only five references to prison conditions in the collection of this literature, while I found close to 100 articles, flyers and pamphlets devoted to the Rizzo regime.

was that “[R]ehabilitation is impossible in a prison setting, the sooner we disabuse ourselves of the notion that programs accomplish anything, the better off we will be.”

Here, the ACLU did not just reflect its own civil liberties interests, but also a broader shift within the legal profession. Attorney Alan Davis, familiar with the Farview case, became the face of the Philadelphia Bar Association’s opposition to the bill. Davis was also the lawyer involved in the case against the indeterminate sentence for women in 1968, and he relied on the legal challenges in that case make the Bar Association’s case. Representing the Bar, Davis bluntly wrote that "Indeterminate sentencing systems traditionally have been failures." The Pennsylvania Supreme Court had declared the 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... 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." His other major claim, in addition to these legal challenges, was that “The proposed bill overemphasises [sic] institutional rehabilitation." In an argument repeated by others throughout the debates, Davis wrote that the bill relied on the concept of rehabilitating people inside the prison. But he challenged that

…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

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60 Ibid.
62 Ibid.
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.\textsuperscript{63}

The final major organization to come out against the Good Time Bill was the Pennsylvania Prison Society, an internationally known organization founded in eighteenth century Philadelphia by such luminaries as Benjamin Rush and Benjamin Franklin. The Prison Society also stood as a central advocate of rehabilitative reform in the early 1960s, but it became wary of the rehabilitative model because of a recent study of California’s failed indeterminate sentence system. Because of the abuses of the system 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.”\textsuperscript{64} This antiauthoritarian positions by the Left challenged government authority in the realm of mental health and corrections.

But the liberal reformers in the Bureau of Corrections, along with Representative Irvis, failed to grasp the Leftist challenges. They also did not see that graduated sentences led to longer commitments. Instead, Irvis and the other liberal policymakers who supported the Good Time Bill maintained their faith that the government could reform the lives of its citizens through the criminal legal system. While Irvis and Bureau officials attempted to make the system more humane, they did not ally themselves with prisoners’ rights advocates who often described a racially discriminatory parole system and who had little faith in the rehabilitative sentence. Irvis

\textsuperscript{63} Ibid.

intended to fight racist penal policies with the graduated sentence, which he thought would shorten prison sentences. However, because he did not work with people in prison and their advocates on this issue, he failed to consider their lived experiences, which was that the graduated sentence could lengthen their stay rather than shorten it. This stance reflected a broader divide in which leftists opposed liberal policies, without much compromise between the ideologies.\textsuperscript{65} Irvis and other liberal legislators, both black and white, sought to maintain state rehabilitation rather than scale it back.

In 1970, the Good Time Bill did not make it out of committee. Irvis reintroduced it in the fall of 1971, and the issue of prison reforms suddenly took center stage as the Attica prison riot reverberated nationally. On September 9, 1971, following months of activism to improve conditions at the prison, a riot broke out and the inmates took full control of the facility. Notably, they did not demand their release, but instead called for more rights and basic humanitarian conditions. The prisoner activists, many of whom were black, broadcast their calls for justice with megaphones to reporters and people on the outside. They did not fully realize, however, the powerful armed forces gathering outside the prison walls. On September 13, 1971, Governor Rockefeller sent five hundred armed state troopers into the prison, where they killed forty-one people in the prison including guards, and injured almost 100 others in the process of taking back the institution.\textsuperscript{66} The mainstream media initially circulated myths that the men who were imprisoned had slit hostages’ throats before state troopers invaded. Even though the medical examiner found no truth in any of these stories, the media did little to rescind the falsehoods.


which caused many whites to blame the imprisoned people themselves for the terrible violence at Attica. The myths enabled many people to distance themselves from the prisoners’ rights activists’ charges of injustice and fostered a language of dehumanization that permeated public and political debates.67 The televised footage of the war zone at Attica fed the discourse of fear among many whites that had grown during the 1960s.

In October 1971, only one month after Attica, the Good Time Bill came up for debate in the Pennsylvania Legislature. Frank Lynch, a white Republican lawyer from white suburban Delaware County, spoke out against the bill.68 He compared the Board of Parole to the Leftists that supported the men at Attica, saying:

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.69

Lynch charged that liberals were not harsh enough on crime, and could in fact cause more danger on the streets with their policies.70 Other law-and-order conservatives agreed with Lynch and vilified state officials as radical liberals who let people convicted of crimes run rampant in society. These conservatives supported the power of criminal court judges to determine

70 Ibid.
sentences rather than state officials whom they viewed as liberal and dangerous with their experiments.

The other main opponent was State Representative Harry Comer, a white Democrat from Philadelphia who took a staunchly conservative law-and-order position. In 1969, Comer had supported rehabilitative reforms at the Pennhurst State School. After visiting Pennhurst, he helped pass a $1.6 million state grant to make improvements and to increase the number of staff in order to make the facility better for the individuals living there.71 Here, he reflected the continued reliance on institutions as a response to the problem of mental retardation (as opposed to mental illness). Comer did not believe, however, that Pennhurst should merely warehouse people; instead, it should help them gain skills to return to society.

When it came to crime and punishment, though, the “flinty” legislator rejected the rehabilitative approach. Comer championed capital punishment and even called for the reinstatement of the death penalty for people convicted of rape. He was so outspoken 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.”72 When the Good Time Bill came into the Legislature, Comer railed against the proposed reforms. At one hearing on the Good Time Bill, 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

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72 Ibid.
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.\textsuperscript{73}

Comer played on fears of sexual violence and physical harm by deploying the phrase “murderers and rapists,” even though they made up only a small number of people in prison. To Comer and his supporters, prisons should not support people with job training, education, or addiction counseling, but instead provide punishment and segregation from society. Notably, however, he did not oppose rehabilitation-based reforms that the PPWGO, along with Irvis, proposed for women in prison. Comer argued vociferously that men convicted of crimes particularly threatened their communities and 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 a vein of political discourse that used racially coded language to describe most people convicted of crimes as African American men. At no point did Comer, Lynch or other opponents to the Good Time Bill explicitly use racial terms, and in this way the language was seemingly color blind. However, Comer’s use of the word “rapists” indicated men, as few women were charged with rape at the time. Comer also used racially inscribed language to target African Americans. At the time, fifty-three percent of people arrested for murder, rape, robbery and assault in the country were black, even though they made up only twelve percent of the population, a national statistic that infused urban discourse around crime.\textsuperscript{74} In their work on teenage pregnancy, Kristen Luker and Jessica Fields have both critically engaged policy debates that are “color blind” on the surface. Luker and Fields have shown how in policy debates, the

\textsuperscript{73} Legislative Journal, October 6, 1971, 1509.

phrase “teen pregnancy” also often did not use explicitly racial language. However, the assumption was that “children having children” were largely young black women victims.75 Similarly, in her essay, “The Career Girls,” Marilynn Johnson found that public debates over rape and murder in the 1960s relied on notions of black perpetrators and white women, even though the crimes of rape and murder were most often intraracial rather than interracial. Law-and-order conservatives were more interested in the protection of young white women (often career girls working in big cities) than in protecting women of color.76 In the debates over the Good Time Bill, Comer and Lynch did not say that the inmates were black. However, the words “murderers and rapists,” along with “animals” and “jungle,” referenced African Americans without using explicitly racial terms. The debates over crime and how the state should respond to crime became a discussion over fears about African American men in the post-civil rights era.

The racially divisive conservative responses to the Good Time Bill did not go unchallenged, and a number of black legislators rallied to Irvis’s defense.77 Hardy Williams, a freshman legislator from Philadelphia, read aloud a letter from the Brotherhood Jaycees at Graterford Prison to counter the stereotypical images of people in prison and to argue for the return of reformed people to the community. Hardy’s sentiments were echoed by Sarah Anderson, a black legislator with a background in mental-health reform. Anderson spoke from the perspective of the victim and recounted to the Legislature how years before an assailant had hit her on the head with a pipe, seriously injuring her. Even still, she humanized her attacker and


people in prison. 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.” As a whole, Irvis, Williams, Anderson, and others did not directly invoke race or racism in their speeches. However, they crafted their positions in direct opposition to the law-and-order position and called for the continued integration of people convicted of crimes into, not segregation from, their community.

The final speech of the day came from K. Leroy Irvis, who much more directly fought the notion of people in prison as animals in a jungle. Irvis pressed the Legislature to look at the dangerous use of dehumanizing language and linked 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, Mr. Alexander, 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 anywhere else. Then we have other decisions to make.79

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79 Legislative Journal, October 6, 1971, 1509.
Compassion and forgiveness towards people convicted of crimes was the stance the Legislature should take, according to Irvis. If it did not, then Pennsylvania would take the path of racism and genocide. To prove his point, he specifically said that by not taking action, the legislators would follow in the footsteps of Adolph Hitler. Hitler had “got rid of people who displeased him,” using the technique of dehumanization to do so.\textsuperscript{80} Here, Irvis spoke as part of a broader black response against a purportedly colorblind system. To him, the language of “animals” provoked a discourse of fear that led to the continued segregation of black men rather than their integration into society.

Irvis fought to make “rehabilitation of the criminal the prime purpose of imprisonment” not only because he was interested in crime.\textsuperscript{81} He took the notion of state-sponsored rehabilitation, supported in mental health, and offered it as a solution to address the crisis of violence in cities, the rising tide of white law-and-order conservatism, and the segregation of blacks in prisons. But in the early 1970s, in the face of civil liberties challenges to state authority, the loss of faith in government competence and law-and-order conservatism, Irvis fought an uphill battle. The Good Time Bill stalled in the Senate for much of 1972. In comparison, Irvis’s second prison bill, which called for women’s treatment centers, passed the House of Representatives and Senate smoothly, and it did not inspire nearly the opposition experienced by the Good Time Bill.\textsuperscript{82} While Harry Comer had railed against such programs for men, he said little against the programs for women in prison. The segregation of men in particular was the


\textsuperscript{81} “Irvis Seeks Reform of Prison System in Penna.,” \textit{The Evening Bulletin}, April 1, 1971.

main thrust of the law-and-order opposition, which had its first major victory with the defeat of the Good Time Bill.

**Rehabilitating the Prison**

At the same time that the rehabilitative ideal in prisons came under attack, so too did the community corrections programs that the Bureau of Corrections had instituted. The fight over these community-based services became particularly controversial in the racially divided city of Philadelphia. Furloughs from Graterford, Philadelphia’s state prison, provoked particular public concern. At Graterford, ninety percent of the inmates were black.83 While politicians never blatantly used race to describe individuals on furlough from Graterford, to discuss a Graterford inmate was to imply a black inmate as they made up such a large portion of the inmate population. After the escape of one inmate (out of hundreds) from Graterford, furloughs came under intense fire from newly-elected 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.”84 Fears of sexual crimes particularly stoked public opposition to the community-based programs. In 1973, District Attorney Specter loudly decried the furlough of an inmate who had committed burglary, robbery, and assault with intent to ravish and rape.85 To conservatives, liberal prison officials were directly responsible for making the streets less safe with community corrections programs.

Judges also came out against the prisoner release program, including judges who had opposed the graduated sentence. A Washington County Judge mobilized his colleagues by

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sending out a survey to other state judges. He found that of the people who replied, eighty percent were dissatisfied with the new reforms. One Northern county judge even wrote, “The present attitude of the Bureau of Corrections administering the program is such that ‘they’ need the mental treatment.” A small mountain county judge concurred, and wrote that the judges were being “emasculated … by the long-haired Utopians of the Bureau of Corrections.” 86 These judges believed that the prisoner release program threatened their judicial power, leading to the release of people in prison deemed potentially dangerous. 87 The judiciary thus became a powerful force against the community corrections programs. Notably, neither the judges nor the district attorney’s office distinguished between violent and nonviolent offenders. To them, all people convicted of crimes posed the same level of danger to the public. There was no attempt to create a more nuanced program that took into account actual threat to communities.

As with the Good Time Bill, liberals and the Left were divided over community corrections programs. The Quaker Philadelphia Yearly Meeting, the black Philadelphia Urban Coalition, and the Philadelphia Bulletin all publicly supported the early release programs. To these liberal advocates, the community programs fit with other efforts to improve the inner city and to provide welfare, employment and health services to impoverished communities. But left-leaning prisoners’ rights activists and civil libertarians remained silent. The Prisoners’ Rights Council chose not to defend the furlough and community-treatment programs because they saw them as an extension of the already abusive Bureau of Corrections. The Prisoners’ Rights Council had received numerous letters from inmates complaining of the arbitrary denial of furloughs and entry into work release programs, and state officials’ power over who to let out of


the prison and when.\textsuperscript{88} State officials making the decisions could discriminate based on race, class or even whether or not they liked the person. Thus, while the organization supported efforts to give social support to convicts in the community, they did not support it happening under the total discretion of the Bureau of Corrections. Spencer Coxe, a Prisoners’ Rights Council member and Director of the ACLU stated that the community corrections efforts gave “the authorities more ways to coerce prisoners.”\textsuperscript{89} While in principle the ACLU and prisoners’ rights activists supported the creation of alternatives to the prison, they found the Bureau of Corrections’ power discriminatory. Liberals and Leftists were thus divided over the community alternatives to prisons as a larger whole.

In an era of economic crisis and broader social services cuts, then, community corrections went on the chopping block too. By 1973, the Pennsylvania state government was experiencing financial hardship, and it was forced to make cuts to various government services. In this time of economic crisis, the community corrections programs came under attack as social welfare programs, even though they saved the state government money. That year, the liberal Commissioner Allyn Sielaff left the post for a better paying job in Illinois. But, instead of appointing a successor as liberal as Sielaff, the Governor appointed Stewart Werner as Commissioner, a man who had far less enthusiasm for community-based reforms. Werner expressed doubts about placing people convicted of crimes in communities, arguing that the state’s diagnostic and treatment techniques could not handle such a move. After 1973, then, the Bureau gradually cut back the new community programs. The percentage of people in prison released on parole dropped significantly, commutations became rare, and eligibility for

\textsuperscript{88} Spencer Coxe, “Letter to James Robinson, Sr.,” May 9, 1974, fol. 5, box 17, Prisoners’ Rights Council Collection, Temple University Urban Archives.

\textsuperscript{89} Prisoners’ Rights Council, “Prisoners’ Rights Council Executive Committee Meeting Minutes,” April 11, 1972, fol. 4, box 1, Prisoners’ Rights Council Collection, Temple University Urban Archives.
community services was greatly restricted. At first, many people had to have served at least half of their minimum sentence to leave on furlough. Then, in 1975, the Bureau of Corrections tightened even these requirements.\textsuperscript{90} Even though the Legislature had just recently passed a bill appropriating money for regional treatment centers for women, the fiscal crisis put those programs on the chopping block as well.\textsuperscript{91} Just as the Legislature cut welfare programs seen as serving black women, they also cut these more treatment-oriented corrections programs.

Notably, these rollbacks did not occur evenly across the country. Instead, community-based corrections were particularly reviled in states with large black urban communities such as Pennsylvania, New York, and California. In 1973, New York passed its Rockefeller laws, which instituted harsh penalties for drugs, an issue which had historically fallen under the purview of mental health. A few years later in 1976, the Democratic Governor of California, Jerry Brown, signed into law a provision that ended graduated sentences in the state. The new penal code read “that the ultimate goal of imprisonment was no longer ‘rehabilitation’ but ‘punishment.’”\textsuperscript{92} Reporter Robert Kotzbauer wrote in 1974 that “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.”\textsuperscript{93} 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, had taken up the more punitive practice of using prisons primarily for removing people from society.

\textsuperscript{91} Ibid.
\textsuperscript{92} Gottschalk, 267, fn 24.
In comparison, many states without large black urban centers did not repeal their community corrections programs. Minnesota, which had few African Americans in its main city of Minneapolis, successfully passed a Community Corrections Act in 1973. This bill encouraged the counties in the state to rely on local rather than state services. In turn, many of these localities created alternatives to prisons as they were not using the large state prisons. As a result of this law, the state reduced the number of people sent to prison and the rate of incarceration fell while it rose in other states like New York and California. This Community Corrections Act was not unique to only Minnesota, however. The law became a model for similar laws in states such as Colorado and Oregon, which also did not have large black urban centers like Philadelphia, New York City, or Los Angeles. The divergent trajectories of prison reform between states with large black communities and those without underscore the centrality of racial reactionary politics in the demise of the rehabilitative ideal.

The end of community corrections led to new prison construction in Pennsylvania. By the mid-1970s, the Pennsylvania Bureau of Corrections initiated plans to build new prisons. The Bureau argued that although it had recently opened its fourteenth community treatment center, it had become “more difficult to find a place to put them,” because of public resistance.94 Commissioner Werner proposed a new maximum-security prison in 1974 to replace the century-old Western State Penitentiary and a replacement for Eastern State Penitentiary, which had closed a few years prior. The new prisons would not be “huge walled prisons in the old sense, but rather treatment-oriented institutions which meet national penology standards.”95 Regardless, the experiment with funding prerelease programs, furloughs, and community treatment centers was coming to a close. Even though Pennsylvania, like the rest of the country, experienced

94 Ibid.
95 Ibid.
financial turmoil in the early 1970s, the state continued on with a $60 million program of new prison construction.

In the first part of his six-part series, Kotzbauer wrote that in the late 1960s and 1970s, the Bureau of Corrections had dismantled the electric chair, made prisons less dehumanizing, and laid the groundwork “for a daring foray into community-based treatment programs.”

The decline of liberal ideologies and the rise of law-and-order conservatism led to the revival of the institutional form.

In 1979, the American Correctional Association (ACA), a national prison organization, met in Philadelphia. At the conference, one speaker lamented to the crowd, “The dreams of prison reform that ushered in the 1970s are as dusty if not as dead as Pennsylvania General Hospital today. Where there was idealism ten years ago, there is now a sense of futility about the chances of making real improvements in the system.”

In 1969, the number of federal and state individuals in prison in the United States had dropped to fifteen percent fewer than in 1961. But by 1979, the number had doubled, reaching over 300,000. In Pennsylvania, legislators in 1981 passed a mandatory minimum bill that required a minimum sentence of at least five years imprisonment for many violent crimes. As the rehabilitative ideal legally and politically faltered, the move to create community alternatives to the prison also weakened. The state’s prison population grew by fifty-three percent in the 1970s, mirroring the national trends. A new interventionist model arose in which corrections put people away in segregated institutions.

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98 Ibid.


100 Kotzbauer, “Prisons: A Haunting Fear.”
One speaker at the ACA offered an explanation for this end of reform. “Correctional officials, inspired by sociologists and a seemingly endless stream of money from Washington, were turning to community treatment programs, early release, and halfway houses in a rush to ‘deinstitutionalize,’ while providing group counseling, education and training to rehabilitate prisoners who remained inside …. 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 desserts.’”\textsuperscript{101} The end of rehabilitation provided the basis for the rollback of efforts to reduce the reliance on the institutional form in the criminal legal system.

Irvis and the Bureau of Corrections represented the unique role of politicians in deinstitutionalization and criminal justice in the 1960s and 1970s. Liberal lawmakers enacted legislation that made institutions for people with mental illness more rehabilitative and also funded community alternatives to long-term hospital commitments. Concurrently, these same politicians decided issues of crime and punishment at a time when law and order had become a major political issue in America. Law-and-order politics split politicians into two camps: more liberal politicians took the lessons of mental hospitals and applied them to prison reform. Politicians more committed to law and order took the opposite tack. They argued that people convicted of crimes deserved punishment and did not deserve any of the reforms that people in mental hospitals received. While deinstitutionalization continued in mental health, it largely ended in corrections. Prisons are not static institutions, but instead ever-changing places with shifting priorities. The rising popularity of law-and-order responses in the 1960s and 1970s led politicians and policymakers to redefine the meaning of confinement and the logic of prisons. This change brought not only an embrace of prisons, it brought their redefinition.

\textsuperscript{101} Ibid.
As a result, the separation of classes of people from society lived on in American governance. In an era following the supposed end of legalized and social segregation in America, the practice of segregation in state custodial institutions took on a new form. In his 1991 essay called, “Rehabilitation of the Asylum,” Rothman acknowledged the failings of his 1972 piece, and wrote that the trajectories of prisons and mental-health institutions broke apart in the 1970s and 1980s. The new institutional form disproportionately removed black men from society in the immediate aftermath of the civil rights movement. The racially charged politics of segregation had spilled over into the debates over prisons, and a new form of segregation emerged and began to grow rapidly.

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102 Rothman, “Rehabilitation of the Asylum.”
CHAPTER VI

RE-INSTITUTIONALIZATION

On December 8, 1981, a Philadelphia Evening Bulletin headline read “Legislators Approve 1% Budget Cut, 500 New Cells for Graterford.”1 These ten words in many ways captured state-level domestic policies in the 1980s. At the very moment that the state reduced its overall social commitments, including mental health institutions, it expanded its prisons. Soon, the legislature would appropriate support a capital spending bill for $87 million to build 2,510 new prison cells. These included new beds at Graterford, a prison outside of Philadelphia.2 This short news clip captured a key policy paradox of the 1980s; in the midst of major state and federal budget cuts, mental health institutions de-industrialized while prisons grew. As an inevitable by-product of the growing prison system and diminishing mental health services, the rates of people with psychiatric disorders in prisons began rising by the mid-1980s. At the state level, Republican Governor Richard Thornburgh led the legislature in the budget reallocations, mirroring similar shifts on the national stage under President Reagan.

The changes in mental health and corrections reflected how in key ways, politicians eschewed big government in the eighties except regarding the military and state security institutions. Legal scholar Jonathan Simon called this development a move towards “governing through crime,” as the crime victim became the ideal citizen and the criminal legal system the most effective way to respond to social issues in the 1970s and 1980s. In his Punishing the Poor,


sociologist Loic Wacquant argued that the rise of neo-liberalism did not bring the shrinking of the government but instead in the midst of social insecurity, an expansive and interventionist penal system flourished.³

Throughout the dissertation, I have charted how an interventionist institutional structure had existed prior to the rise of mass incarceration. Since the 1960s, this infrastructure had grown smaller in the midst of deinstitutionalization and in the 1980s politicians like Governor Thornburgh began closing these facilities in the name of community mental health and economic austerity. The emptying of these mental hospitals galvanized mental hospital employee unions in rural areas against the closures, as they represented both a loss of social services and a loss of public sector jobs. These unions then organized to bring prisons to the towns where mental hospitals had closed. In this way, mental hospital unions and communities played a major role in deinstitutionalization and the rise of mass incarceration. Geography scholar Ruth Wilson Gilmore laid out how local communities benefitted economically from the building of prisons in their areas. The turn towards imprisonment literally built a new industry out of prisons in late twentieth century America, a selective Keynesianism that fostered mass incarceration in the midst of cuts to social services.⁴ In this chapter, I build upon this work and argue that a selective neoliberal Keynesianism similarly shaped the domestic policies and economic measures involved in the closure of mental hospitals and the rise of prisons in the 1980s.

Because the state executive branch oversaw the mental health and correctional systems, the governor’s office and welfare policymakers wielded immense power in these areas. From


1960 to 1975, individuals such as Dr. Daniel Blain, Governor Milton Shapp, K. Leroy Irvis and Allyn Sielaff had worked to bring about more community-based programs for individuals in the mental health and correctional systems. However, a backlash against these programs formed, particularly against people with criminal histories and anti-institutional efforts receded in prison reform in the late 1960s and 1970s. The weakening of anti-institutional ideals laid the foundation for more aggressive carceral policies in the following decade, embodied in the efforts to close the Farview State Hospital and the administration of the Republican Governor Thornburgh.

**Centering Mental Illness and Criminality**

In 1976, the Farview State Hospital for the Criminally Insane became front page news when two *Philadelphia Inquirer* reporters published a series of articles exposing conditions there. Acel Moore, a young African American reporter, had picked up on the story while on his beat covering issues such as juvenile delinquency and gangs in the city. One day, he received a letter from an African American woman whose son had died at Farview, reportedly of a heart attack. She found the death suspicious, but when she looked into it, she was unable to find any other answers. An *Inquirer* editor assigned Moore and Wendell Rawls, Jr., a white reporter from Tennessee, to investigate the hospital. They took up the story tenaciously, reaching out to places as far as Denver and Los Angeles to locate witnesses and gather evidence. Notably, of their best sources of information came from individuals who had recently left the hospital because of the *Dixon* decision in 1971. To Moore, the issue was centrally one of racial justice, as a large
proportion of the men at Farview were black, and had been cast away with few people showing concern for their well-being.  

In their series, republished as The Farview Findings, Moore and Rawls reported broadly on the less than human treatment of the people with the dual diagnoses of mentally ill and criminal. The central piece of their work was the violence that permeated the facility. They found that the guards sponsored fights among the people at Farview, comparable to cock fights that everyone would gamble on. They also ultimately were able to uncover the fact that the man had died not from a heart attack, but from an assault, bringing closure to the mother’s story. The news series caused a firestorm of public discussion, and ultimately won Moore and Rawls a Pulitzer prize. Governor Milton Shapp responded to the allegations by creating a task force of seventeen people to study the treatment of people classified as criminally mentally ill in Pennsylvania.

The legal changes to the state commitment laws in the early 1970s had made it much harder to place people involuntarily in psychiatric hospitals. This issue became one of the greatest problems that the Task Force faced: how and where to transfer people with mental illnesses in the prison system. This issue particularly affected men with mental illnesses, as they made up the vast proportion of people in the criminal legal system. Because there were so few women considered criminally mentally ill, the state did not operate a large facility equivalent to

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Farview. Instead, the relatively small number of women deemed criminally mentally ill went to state mental hospitals or correctional segregation units.\footnote{A Plan for Forensic Mental Health Services in Pennsylvania: Report of the Governor’s Task Force on Maximum Security Psychiatric Care. (Harrisburg, Pa.: The Governor’s Task Force on Maximum Security Psychiatric Care, 1977).}

But the Governor was not the only person to take action on \textit{The Farview Findings}. The publication galvanized prisoners’ rights activists to organize around closing the hospital. The Philadelphia-based Community Assistance for Prisoners and the Prisoners’ Defense Coalition had already in the 1970s been organizing against abusive practices within psychiatry and particularly behavior modification programs in prisons. They used images of black men being lobotomized to criticize mental health programs used to “make Black People totally submissive to white rule and authority through coercive psychiatry in prisons and mental institutions.”\footnote{Prisoners Defense Coalition, “Appeal to the Black Masses,” n.d., fol. 3, box 11, Prisoners Rights Council Collection, Temple University Urban Archives.}

These groups then became vocal against the continued operation of Farview, a place where their activism around prison conditions and coercive psychiatry converged.

They gained support from the newly organized Alliance for the Liberation of Mental Patients, the first such organization by and for self-described mental patients in the state. The Alliance had organized in Philadelphia in the spring of 1976 when a small group of self-described former mental patients created the organization “to combat the abuses of which we had been subjected in the name of ‘mental health.’”\footnote{The Alliance for the Liberation of Mental Patients Newsletter, October 25, 1977, fol. 2, box 17, Prisoners Rights Council, Temple University Urban Archives.} Funded by small grants and private donations, the group set up an office and phone to “provide free factual information about psychiatric treatments and the legal rights of mental patients.”\footnote{The Alliance for the Liberation of Mental Patients Newsletter, October 25, 1977.} As the state ordered numerous investigations of the facility, the Alliance held demonstrations hearings at meetings of the task
force that Governor Shapp had formed. The group’s demonstration received good coverage, and it kept up the publicity by releasing a report about Farview, titled *The Farview Papers*. The publication kept Moore and Rawls’s findings alive and continued to embolden a number of self-described former-mental-patient activists to work to close the facility.\(^{11}\) The Alliance also reached out to people doing prisoners’ rights work. In the archives of the Prisoners’ Rights Council, at Temple University, researchers can find newsletters and flyers from the Alliance, one of the few places where such materials still exist.

Ultimately, the news coverage and political activism led the task force to decide that Farview should close by 1980. Task force members realized, though, that the decision would ignite criticism from members of rural Wayne County where Farview sat. To head off the opposition, it recommended that the state work to create economic alternatives in that area and explore ways to reuse the Farview facility for economic benefit.\(^{12}\)

At the same time, the task force faced the question of how the state should respond to the rising number of people in the criminal system with mental health disorders. They first looked to other states and found that a number of them were creating new facilities run by corrections rather than welfare agencies. This shift did not just reflect a more punitive response. It also reflected a more institutional response as these settings were “structured around behavioral change for the individual rather than a medical setting oriented toward facilitating swift return to the community.”\(^{13}\) After the research phase, the task force recommended that Pennsylvania also build new mental-health institutions within the criminal legal system. For instance, it

\(^{11}\) *The Alliance for the Liberation of Mental Patients Newsletter*, October 25, 1977.


\(^{13}\) Ibid., 17, 18.
recommended that the state formalize its psychiatric ward in Holmesburg Prison, which had been created as a temporary response in 1966.\footnote{Ibid.}

The shift of mental health services to the criminal legal system reflected a rising fear discourse in relation to both crime and mental illness in black urban areas, which was shared by both white liberals and conservatives alike.\footnote{Thompson, Heather Ann. “Why Mass Incarceration Matters: Rethinking Crisis, Decline and Transformation in Postwar American History.” \textit{Journal of American History} (December 2010): 703–734; Michael W. Flamm, \textit{Law and Order: Street Crime, Civil Unrest, and the Crisis of Liberalism in the 1960s} (New York: Columbia University Press, 2005), 51-82.} Between 1972 and 1979, the political discourse centered on people with mental illnesses who had committed crimes. A language of fear around releasees emerged particularly in the wake of deinstitutionalization measures. The redefinition of the rights of people with mental illness centered around how to protect society from possible danger or crime by people with mental illness. Yet, at the same time, activists and journalists resisted the treatment of people deemed criminally or dangerously mentally ill. There were conflicting concepts of these individuals: On one hand, many people argued that society should be protected from them; on the other hand, people argued that they should be protected from abusive government programs. Regardless of the stance, the political debates about mental illness in the 1970s centered around danger and criminality. Even people who thought that individuals with mental illness should be protected also called for the protection of society. This focus on crime and danger came in large part because the state was redefining the rights of people with mental illness while building up the criminal system, particularly in the African American communities of Philadelphia, and because of a new fear discourse around mental illness, particularly schizophrenia and its links to black urban violence.

Jonathan Metzl has charted how during the early 1970s, schizophrenia became a predominant diagnosis. The disease was inflected with fears of danger and threat after the
diagnosis-focused *masculine hostility* and *aggression*, terms that made their way into the revised 1968 second edition of the *Mental Disorders: Diagnostic and Statistical Manual II*, were disproportionately applied to African American men in particular. The racialized, fear-based discourse of the late 1960s and 1970s permeated the approach to mental health, making certain types of mental illness more threatening to the public. The state attempted to respond to this fear discourse around people with mental illnesses, waging a publicity campaign on behalf of people who had been in mental hospitals and asking Philadelphia comedian Bill Cosby to challenge the resistance of the public to the releasees.16

This discourse of fear coincided with political pressure from the predominantly white rural region of northeastern Pennsylvania to halt the deinstitutionalization of Farview. Local politicians and residents announced that over five hundred people would lose their jobs as a result of the closure of Farview. The controversy caused Governor Shapp himself to visit, where he was given a whitewashed tour of the facility, speaking to a number of people treated there, all of whom were on therapeutic medication when he spoke with them. One inmate said to the Governor that no one was trying to hurt him there, going so far as to say, “It’s a real swell environment.”17 In the face of the *Farview Findings* and his initial announcement to close Farview, Shapp changed his mind and, in December 1977, declared that the hospital should stay open, with the intention that it be slowly phased out. He also intended to construct two new regional facilities for people deemed criminally mentally ill near Philadelphia and Pittsburgh. The intention here was to create places to offer treatment that were smaller and closer to the

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communities where people lived, in the spirit of community mental health of the time.\textsuperscript{18} Shapp did not directly speak about the jobs he would save by keeping Farview open, and there was also a proposal to possibly phase it out slowly over time, but his glowing description of the hospital flew in the face of findings of Moore and Rawlings only a year earlier. Ultimately, the political economic interests of the region trumped the interests of the people held at Farview. Political opposition in largely white, rural northeastern Pennsylvania ultimately ended the anti-institutionalism at this hybrid mental health-penal facility. The community around Farview protested the closure of the institution and ultimately, the liberal anti-institutional effort to close it down died in the face of these protests. Community calls for keeping Farview open sheds light on this selective Keynesianism. Just as many towns called for the development of prisons as a local economic boon, so too did historic asylum towns have deep financial interests in mental hospitals.

\textbf{Closing Mental Hospitals}

The renewed expansion of the carceral state occurred at an even faster clip under the administration of Governor Thornburgh from 1979 to 1987. Thornburgh had began his career in law, but became interested in politics when he witnessed from afar the presidential campaign of Barry Goldwater in 1964. At the time, he identified with the conservative ideologies of limited government and free enterprise that the Republican Party espoused. But, he strongly opposed the elements of Goldwater’s platform which contained “strains of racism, McCarthyism and

jingoism.”19 While Goldwater’s principles galvanized many grassroots people in the New Right in the West in the 1960s, his ideals served to distance conservatives such as Thornburgh away from the anti-communism and overt racism of the party.20 Yet Thornburgh still believed strongly in 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.”21 To him, the importance of conservatism lay in protecting people from the “bigs,” including big government. As he later reflected, “…[S]ociety 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.”22 Herein lay a central tension. While Thornburgh and other conservatives opposed government interference, they focused on protecting people they considered law-abiding citizens, a distinction that later formed a major part of his statecraft. With these ideologies in mind, Thornburgh set out in the 1960s to “repair the party’s fortunes” by becoming politically active.23

In his early years as a lawyer, he espoused civil liberties causes. He served as a board member of the Neighborhood Legal Services Association of Pittsburgh, which advocated for improved legal services for the poor and in 1967, he cosponsored a constitutional provision with K. Leroy Irvis that mandated a public defender’s office in every county. The young attorney also joined Pittsburgh’s Urban League, which he remained active in for many years, and in the late 1960s, he even joined the American Civil Liberties Union (ACLU). He came to the ACLU out of

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21 Thornburgh, 20.

22 Thornburgh, 20.

23 Thornburgh, 22.
an interest in accessible legal services, and in 1968 he worked with the organization to advise protesters during the riots in Pittsburgh. Ultimately, however, Thornburgh left the ACLU in 1972 due to the organization’s defense of pornography and antiwar activism. But, his involvement reflected an interest in civil liberties in the Sixties, albeit limited.\(^\text{24}\)

In 1969, Richard Thornburgh took his first public service job as a federal prosecutor for Western Pennsylvania where he prosecuted members of the mob, and particularly labor leaders with ties to organized crime. While he often focused on political corruption and racketeering, he also gained exposure to the Drug Enforcement Agency and briefly oversaw Pennsylvania’s federal funds from the Omnibus Crime Control and Safe Streets Act of 1968.\(^\text{25}\) Recognizing a young talent, the Republican Party tapped him for a job as Assistant Attorney General in the criminal division of the Department of Justice under the Nixon Administration. In this role, Thornburgh continued to focus on political corruption, but he also worked on larger policy matters, including a project to re-codify the federal criminal codes. The Justice Department at the time reviewed the federal code and made a spate of conservative sentencing proposals, which included the abolition of parole, compensation for victims and taking sentencing out of the hands of judges, who were deemed too liberal.\(^\text{26}\) While none of these proposed reforms came to pass in the early 1970s, Thornburgh later brought these concepts with him back to Pennsylvania where in the 1980s as governor he became deeply involved in harsher penalties for drug crimes, violent crimes and corruption.

While Thornburgh conducted legal work in Washington, D.C., his second wife Ginny became involved in disability rights activism on a national level. Years earlier, his son Peter had

\(^{24}\) Thornburgh, 18, 32, 33.39.  
\(^{25}\) Thornburgh, 38-39, 41-45, 55.  
\(^{26}\) Thornburgh, 62-64, 67.
experienced severe brain damage in a car accident in which Thornburgh’s first wife had tragically died. As a result of the accident, doctors diagnosed Peter as mentally retarded and for years he lived at home and attended the Pittsburgh’s Crippled Children’s Home. In the late 1960s, Peter left the Crippled Children’s Home and Dick and Ginny Thornburgh faced the question of whether they would institutionalize him. The couple decided not to, and instead they placed him in the public school system which had limited resources for youth with disabilities at the time. As a result, Ginny became a disability rights advocate, and joined the Allegheny County Chapter of the Pennsylvania Association for Retarded Children (PARC). PARC had emerged as an advocacy group on behalf of individuals with mental retardation in 1949, as part of a broader movement housed in the national ARC. The Pennsylvania chapter in particular became a national leader in the 1970s, in large part because of its landmark court cases.\textsuperscript{27} Ginny worked as the president of the chapter and also became active at the national level while in Washington, D.C. Throughout her years doing this work she conducted unannounced tours of public and private institutions and reported on them to state officials and legislative committees, giving both her and her husband first-hand knowledge of the politics of institutions.\textsuperscript{28}

During these years, Ginny and Dick Thornburgh proved instrumental in some of the most important cases concerning people with intellectual disabilities in the twentieth century. In 1971, PARC filed \textit{PARC v. Commonwealth of Pennsylvania} to gain free and appropriate public education for children with mental retardation, an issue that the Thornburghs had faced with Peter. The organization quickly won the case and it became a watershed moment in the effort to integrate people with mental retardation into community settings. After this rapid victory, PARC


\textsuperscript{28} Thornburgh, 34, 60.
turned its attention to the Pennhurst State School, where a number of people, including Terri Lee Halderman, had died under questionable circumstances. At the time, the national Association for Retarded Children had resolved to oppose institutional living broadly, and the Pennhurst deaths opened up a chance to challenge the reliance on institutional living. Ginny Thornburgh became involved and urged PARC to file a federal lawsuit against Pennhurst, which it did in 1971. Dick Thornburgh also joined in the effort, and helped the U.S. Department of Justice intervene in the matter. After filing *Halderman v. Pennhurst*, the case quickly became nationally recognized for its claim to a right for individuals with mental retardation to live in the least restrictive environment possible.29

In 1978, Federal Judge Raymond Broderick ruled in PARC’s favor, holding that community-based services should replace institutions and that people had a right to live where they chose. To ensure that the people at Pennhurst would not be left for naught, Broderick also ordered that the state must provide, “suitable community living arrangements for retarded residents of Pennhurst.”30 Broderick’s decision became a powerful symbol of deinstitutionalization for people with mental disabilities. It reflected a broader focus in disability rights on community integration and the celebration of less restrictive environments in both legal and advocacy circles. An important first step in deinstitutionalizing state schools, the case would come back to haunt Thornburgh as Governor.

After the inauguration of President Carter, Thornburgh left the Department of Justice and returned to Pennsylvania. When he arrived home, he decided to join the race for governor and won out over the six other candidates in the primary election. He then set his sights on his

29 Ibid.
Democratic opponent, Pittsburgh mayor Peter Flaherty. In this race, Thornburgh capitalized on the widespread corruption within the Democratic Party at the time; indeed, no fewer than sixty members of the Democratic Governor Shapp’s administration faced criminal charges. In particular, Thornburgh brought his background as a prosecutor of political corruption and sold himself as the man who could clean up the state capitol of Harrisburg. He also knew that gaining support in Philadelphia would prove central to winning, and so he allied with factions that opposed Philadelphia’s Democratic Mayor Frank Rizzo. Thornburgh’s anti-Rizzo stance particularly appealed to black voters in the city, considering the mayor’s record of police brutality and neglect of the African American community and created an uncommon sympathy between the Republican candidate and the city’s black voters.\textsuperscript{31} His reputation for “political hygiene,” combined with his anti-Rizzo supporters helped put him in the governor’s seat, the first elective office he held.

Within months of becoming governor, Thornburgh faced a national crisis when one of the nuclear reactors at Three-Mile Island went through a partial meltdown. Thornburgh received praise for his handling of the crisis, including accolades from President Carter who visited the site.\textsuperscript{32} The Governor built upon this popularity to implement dramatic reforms in the state’s domestic policies and his primary target became the state’s deficit. For four consecutive years, Thornburgh balanced the state budget without raising taxes. Instead, he focused on reducing the state 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.”\textsuperscript{33} His


\textsuperscript{32} Lamis, 105–11.

particular target became the General Assistance program which provided money to any non-disabled people without children people who could not receive federal benefits. According to historian Michael Katz, “the policy assumed that most General Assistance recipients were healthy young adults who could not find work.”34 Because of this assumption, Thornburgh passed legislation nicknamed “Thornfare” which eliminated “any childless person considered able-bodied or employable,” from the General Assistance rolls.35 Here he reflected a broader national effort between 1975 and 1980 as a number of states including Massachusetts and New York removed people from welfare assistance based on their employability.36 The linchpin in Thornburgh’s welfare policies, similar to other state programs, hinged on cutting money for people deemed not in need of services. Instead, his legislation focused on proving that the General Assistance funds went to the “truly needy,” defined as the elderly, people with children and people with disabilities.37

With this focus on providing better resources for people with disabilities, Thornburgh became heavily involved in efforts to deinstitutionalize mental health facilities. As the parent of a son with mental retardation, Thornburgh faced the issue of community-based services. In the 1980s, Peter lived in a community group home in Harrisburg and worked in a sheltered workshop. Also, before he had become Governor, Thornburgh and his wife Ginny had actively supported non-institutional measures both personally and politically with the Halderman v. Pennhurst case. As Governor, Thornburgh set out to expand deinstitutionalization even further as


35 Ibid.


part of his reforms of the Department of Welfare. Here, his interest was not purely economical, as some have depicted the 1980s move towards deinstitutionalization. Instead, his approach was greatly informed by his experience with the mental health and mental retardation system. He particularly supported community-based services and during his tenure, the number of community beds for people with mental illness tripled. At the same time, the number of community residential beds for people with mental retardation grew by sixty percent. As a Department of Welfare Report boasted in 1986, “These Pennsylvanians found a strong supporter in this administration for efforts to enable them to live and grow as independent citizens in our communities.”

Thornburgh actively espoused a program of community-based programs for people with mental retardation and mental illness based on both his political ideologies and personal experiences.

As Governor Thornburgh increased the number of community-based programs, he worked to state mental hospitals and developmental centers. During the years he was in office, the Department of Welfare reduced the number of people in its state facilities by thirty-four percent and closed a total of ten facilities by 1986. By the time he left office in 1987, only about 8,000 people remained in state mental hospitals and 5,300 were in developmental centers. In this way, the Governor brought not just a platform of building up community mental health services, but he also sought to dismantle the reliance on large state institutions.

Retreat State Hospital was one such mental hospital to come under the knife. The story of this facility shows how the closure of a hospital played out on the ground and how the politics of institutions had a major significance to local communities. Retreat State Hospital lay outside the

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city of Wilkes-Barre, a mining town nicknamed the “Diamond City” for its anthracite coal reserves which sat in northeastern Pennsylvania. The hospital had opened in 1900 on the site of a former county poorhouse, and predominantly served people with mental illnesses. By 1980, the hospital held fewer than three hundred people who stayed for about thirty days on average. The majority of individuals by that time stayed there voluntarily and the institution ran a Community Preparedness Program, in which it returned people who had been institutionalized for long periods to their communities. Still, the hospital came under scrutiny by the Department of Welfare in the early 1980s. For one, it did not meet compliance requirements for Medicare, raising questions about the quality of its services. Second, Medicare no longer made payments for people at Retreat because it did not meet standards.\footnote{Retreat State Hospital Consultation Visit,” January 23–24, 1979, fol. 25, box 2, American Federation of State and County Municipal Employees Papers, Walter Reuther Library, Wayne State University.} In order to meet the Medicare requirements, the Department of Welfare would have had to increase the budget for the facility by sixteen percent, which ran in the face of the cost-cutting measures under Thornburgh. Finally, the hospital had far fewer individuals than other hospitals and it also sat near Danville and Clarks Summit, two larger institutions which could absorb the people from Retreat if necessary.\footnote{Richard G. Frank and W. P. Welch, “Contracting State Mental Hospital Systems,” Journal of Health Politics, Policy and Law 6, no. 4 (1982), 679; Eli Fleisher, Letter to the Editor, “O’Connell’s Effort to Save Retreat State Hospital Not Forgotten,” Wilkes-Barre Times Leader, February 19, 2004.} Because of these factors, the Governor in March 1980 announced that the state should close the hospital and transfer the people there to the other facilities.

Thornburgh and the Department of Welfare justified the closure as serving the interests of both the people at Retreat and the taxpayers. They claimed that the closure would generate a savings of $4.6 million along with $4.25 million in savings from a cancelled construction program there.\footnote{“Sides Forming in State Health Fight,” Beaver County Times, April 7, 1980.} The main emphasis on the Retreat closure lay on this cost efficiency, and he
touted it in his administration’s yearly report titled *Cost Cutting: Accomplishments and Actions*. This economic benefit dovetailed with his long-standing interest in reducing the reliance on institutional care for people with mental health disorders, a cause that he shared with his wife.

Thornburgh’s plan to shutter Retreat, however, met with immediate opposition from local interests in the Wilkes-Barre region. The area had suffered from deindustrialization in the coal industry since World War II when the economy shifted from manufacturing to the service economy. The coal region still had strengths in education, construction, textiles, and hospitals, but it was not the national powerhouse that it had been prior to the end of World War II. In this new economic landscape, the proposed closure of the hospital posed a significant threat in the region. The American Federation of State, County, and Municipal Employees (AFSCME) union representing the Retreat employees became the primary mouthpiece for the economic consequences of the closure. The union argued that the closure would cause unemployment for the workers and the region as a whole. In finding sources of support, it teamed with local politicians like State Senator Frank J. O’Connell, the Chairman of the Retreat State Hospital Retention Committee, who represented the economic interests of the region. O’Connell argued on behalf of his constituents when he said that the closure would dampen the economy there.

The Retreat union did not appeal to economic interests, alone. Rather, it also argued that the closure would hurt the people in the hospital themselves, and the union critiqued the broader

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45 Fleisher, “O’Connell’s Effort to Save Retreat State Hospital Not Forgotten.”
cuts to social services under Thornburgh. It even collaborated with some family members of people at the hospital to wage a “Stop Retreat” campaign to keep the hospital open. The first main tactic AFSCME took was to try to pass Senate Bill 581 that required the legislature rather than just the Department of Welfare to authorize the closures of state hospitals. Richard Kirschner, the father of a person at Retreat and an AFSCME attorney, became a particular spokesperson for the cause. He called the closure “insensitive,” and argued that “This case is being solely dictated by … economic expediency and nothing else.” The union hired an advertising firm and paid for newspaper advertisements and radio segments along with other employees’ organizations such as the Pennhurst Parents–Staff Association, the Pennsylvania Social Services Union, Pennsylvania American Federation of Labor–Congress of Industrial Organizations and the Pennsylvania Nurses Association. Their message focused on saving union jobs, helping the local economy, and continuing to provide for people with mental illnesses in need of their services. AFSCME thus aligned itself with the individuals at Retreat, arguing that it was acting both on behalf of the workers and the community, and also on behalf of the people who received services at the facility. This AFSCME-led coalition represented a broader national effort by state employees’ unions to resist the deinstitutionalization of public developmental centers and mental hospitals which happened across the country. In this way, the public sector workers challenged anti-institutional policies as a threat to their own jobs as well as the larger public welfare.

AFSCME also fought against the closure in the courts. Richard Kirschner, the father and AFSCME lawyer involved in “Stop Retreat,” filed a lawsuit on behalf of a small class of people

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46 “State Hospital Closing Opposed,” Reading Eagle, September 10, 1980.

at the hospital. In it, the union lawyers argued that the people had the right to choose which
institution they lived in, and therefore could choose to remain at Retreat. By placing the people at
the center of the suit, the union attempted to ally itself with their interests. They did not win,
however, as the Pennsylvania Supreme Court decided in favor of the state on appeal, holding that
no due process violations had been committed.48 AFSCME challenged the action of the court in a
separate case and argued that the Legislature had allocated the money to fund Retreat. They
posited that the executive branch had violated legislative authority. However, they lost that case
as well.49

The Retreat hospital workers’ union efforts highlighted two trends affecting public sector
workers in the 1980s. On the one hand, public sector unions proved a central antagonist of the
neoliberal paring back of social welfare government. The Retreat State Hospital Union’s
opposition to Thornburgh’s reforms of the mental health system reflected this broader public
sector employee union pushback against the starvation of the public sector and government de-
regulation.50 On the other hand, the “Stop Retreat” campaign also represented AFSCME’s newly
voiced commitment to institutional treatment of people with mental illnesses. Because hospital
towns and the hospital unions such as the AFSCME Retreat local and “hospital towns” relied on
the jobs and government money that they provided, they had a vested interest in maintaining an
more institutional rather than community-based service programs.

The “Stop Retreat” campaign prompted a number of mental health organizations to come
out more vocally in support of Thornburgh’s plan to close the hospital. One of the main
organizations was the Pennsylvania Association for Retarded Children which Ginny Thornburgh

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49 “Sides Forming in State Health Fight.”
50 Rebecca Hill, “‘The Common Enemy is the Boss and the Inmate’: Police and Prison Guard Unions in
had worked with over the years. Even though Retreat was a mental hospital and not a
developmental center, PARC supported its closure as part of their efforts to foster
deinstitutionalization broadly. In 1980, the organization was still embroiled in efforts to close
Pennhurst, among other institutions, and the Retreat case became another place where it worked
to reduce the state’s reliance on institutional care. PARC teamed with church groups and other
disability advocacy groups to fight Senate Bill 581, in large part because the requirement of
legislative authority threatened deinstitutionalization at many different institutions – including
ones that PARC was trying to close. PARC wrote letters to the editor and members went on TV
and radio to advocate for the closure of the hospital and more broadly against this restriction on
deinstitutionalization.51

The other major organization that came out in support of closing Retreat was the Mental
Health Association of Southeastern Pennsylvania (MHASP), based in Philadelphia. The MHASP
was a local branch of a national organization led by largely middle-class people that advocated
for state services for people with mental illness. The organization approached Thornburgh’s
proposal with more ambivalence than PARC hard, in large part because it was more connected to
the provision of services for people with mental illnesses as a whole, while PARC focused
primarily on people with mental retardation. Because of the MHASP’s focus on mental illness,
the group was deeply concerned at the quality of care provided in the early 1980s. In its annual
report of 1981, it reported that the main focus of the organization in recent years had been to
protect the progress towards community mental-health care that had occurred over the past two
decades. The Mental Health Association saw the reductions in state and federal budgets in the
1970s and early 1980s as a crisis to which they should respond with “sustained public pressure

51 Thaw and Cuvo, 198-199.
and documentation of needs to expand mental health services.”52 The association called for sustained pressure in part because the quality of care had declined. "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."53 In that light, the MHASP approached the closure of Retreat more cautiously than PARC, as it warily embraced Thornburgh’s mental health reforms as not fully addressing the needs of people with mental illnesses.

However, even though the MHASP did not support many of the cuts to the mental health budget that Thornburgh espoused, it did support his move to provide services in community-based settings. The organization had already shown a commitment to anti-institutional approaches in mental health. For instance, in 1980, it defeated House Bill 1824, which would have eliminated the preference for the least restrictive treatment setting as a factor in connecting people with mental illnesses to state services.54 Because of that imperative, the MHASP joined PARC, Thornburgh and the Department of Welfare to oppose the Stop Retreat campaign. An uneasy coalition of deinstitutionalization proponents formed that included the Department of Welfare and mental health organizations guided by contemporary psychiatric ideologies, the Governor’s office which espoused fiscal conservatism, and disability rights organizations. To the disability rights organizations, Thornburgh’s effort to close Retreat represented a positive step


54 Ibid.
forward towards insuring that mental-health services were not just provided in institutional settings, but also in community settings. Ultimately, the coalition of these groups successfully challenged the opposition led by AFSCME. The legislature passed Bill 581, but Thornburgh vetoed it and the legislature did not over-rule his veto. AFSCME also lost in the courts, and the plans to close Retreat moved forward.

In an unusual coda, PARC and Thornburgh’s administration found themselves on opposite aisles of the deinstitutionalization debates the following year. In the midst of the Halderman v. Pennhurst case, the Department of Welfare refused to proceed with the release of people from the Pennhurst State School. As a result, it incurred large fines from the court, while the state appealed the decision to the Supreme Court. The Attorney General’s office, which represented the state, argued that Judge Broderick and the federal courts did not have the authority to make the core decisions about Pennhurst and the people there. While Thornburgh himself supported deinstitutionalization, as governor he held that the states should determine the course of mental health, not the federal courts. The Department of Welfare went so far as to publicly portray the federal court system as causing the unethical release of people without proper services. In an interview, Welfare Secretary Helen O’Bannon stated to the press that the state government refused to comply with the federal order as it would "dump these people out into un-accepting, hostile environments where they can't get the services and where they will be shoved in the back rooms and attics that replace the back wards of these institutions of yesteryear."55 Here, the Department of Welfare used the language of “dumping” to fight the federal court’s decision, calling to mind the same language that AFSCME had used in its “Stop Retreat” campaign.

Eventually the case made its way to the United States Supreme Court, which ruled against PARC, and overturned Broderick’s decision. Past president of the national Association for Retarded Children, Elsie Schmidt, later recalled that, “They never disagreed that the place was awful, but they made it into a state’s rights issue… We couldn’t believe it, Dick Thornburgh of all people. I felt betrayed.” While Thornburgh had supported PARC in the Pennhurst case during the 1970s, as Governor he took a harsh stance against the federal courts authority. But, reflecting his own commitment to deinstitutionalization, when the Supreme Court overturned Broderick’s decision, he still sought the closure of Pennhurst. The Department of Welfare continued to move ahead with closure plans and it finally shut its doors in 1987, at the end of Thornburgh’s tenure. The rift between PARC and the Governor revealed in relief the core concept between his program of deinstitutionalization. Thornburgh supported the closure of places like Farview and Pennhurst when it was done under the supervision of the executive branch and its Department of Welfare. He did not, however, support the federal courts supervision of deinstitutionalization, nor did he support a constitutional right to the least restrictive environment. In turning his attention to the criminal legal system, he took a similarly strong state-based approach.

**From Asylum to Prison**

In the summer of 1980, as Retreat State Hospital was closing, the state faced a crisis in its prison system. It was four hundred people over capacity in its prisons and twelve hundred people in the penal system went on strike. They refused to work because of poor conditions, and continued the strike for nine days until it was resolved. During this time, three murderers escaped

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from prison, which led many people to question the effectiveness of the prison system.\textsuperscript{57} At the same time, fears around people released from the state’s mental hospitals rose in urban areas like Philadelphia. An \textit{Evening Bulletin} survey found that respondents listed “keeping maniacs off the streets” as the city’s most pressing problem.\textsuperscript{58} The Department of Corrections under Thornburgh faced the urgent question of how it would respond to the security breaches, prison unrest, and public fears about people with mental illnesses.

But the administration took a very different approach toward corrections than it did to mental health. Rather than talking about scaling back the corrections bureaucracy, Thornburgh made plans to build it up. Farview became one of these sites of expansion. In 1980, Thornburgh appointed a second task force to review the proposals for Farview under Governor Shapp. This time, the task force found Farview to be “clean, orderly and properly secured,” with few major problems.\textsuperscript{59} Because of the need for additional beds and the concern about people with mental illness who were considered dangerous, Thornburgh announced a new multi-million dollar plan to renovate the facility rather than phase it out slowly, as Shapp had initially proposed. In order to address the claims of abuse, Thornburgh proposed the creation of a review committee and patients’ rights advisor, but ultimately the facility would remain open. Thornburgh also rejected the phase-out plan because of financial concerns. As he said at a press conference announcing the appropriations, “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.”\textsuperscript{60} The money would be spent on both

\textsuperscript{57} McWilliams, 44–45.
\textsuperscript{58} “Keeping the Maniacs Off the Streets,” \textit{The Evening Bulletin}, December 5, 1980.
\textsuperscript{60} Ibid.; “State Will Invest in Renovations at Fairview State Hospital for Mentally Ill Criminal Offenders.”
renovating the facility and to make it more secure and prison-like. For example, the project
included the installation of bulletproof glass, doors with electric locks, better outside lighting and
a barrier at the front of the institution.61

At the same moment that the Governor and the Department of Welfare sought to close
mental health facilities such as Retreat, the Department of Corrections sought to build up
Farview. In deciding to build at the forensic mental health institution, the Governor rejected
ideas of building smaller facilities closer to people’s communities in the major urban centers of
Philadelphia and Pittsburgh. Instead, he decided to pour funds into the institution in the remote
region of northeastern Pennsylvania, a decision which flew in the face of his
deinstitutionalization and community mental health platform.

Thornburgh attributed the choice of keeping Farview to resistance from people living in
the areas where the state had planned to place smaller forensic facilities. “Additionally, there was
strong opposition from the two communities previously suggested as possible sites for the
proposed new institutions. In contrast, citizens of the communities surrounding Farview support
the facility and want to continue to see it in operation.”62 Here, the interests of former mental
hospital towns mirrored the interests of emerging prison towns. Gilmore and historian Rebecca
Hill have charted how prison guard unions in states such as New York and California supported
the construction of prisons and benefitted from policies that expanded the criminal legal
system.63 In the same way, towns where mental hospitals were de-industrializing benefitted from
the creation of state-run correctional facilities. In the large urban areas of Philadelphia and
Pittsburgh, community resistance to the institutions stood in stark comparison to the embrace of

61 Ibid.
62 “State Will Invest in Renovations at Fairview State Hospital for Mentally Ill Criminal Offenders.”
63 Hill, “‘The Common Enemy is the Boss and the Inmate’: Police and Prison Guard Unions in New York
Farview in rural Waymart County. With the justification of financial conservatism and community protection, the Farview State Hospital was injected with new funds to keep it open and running. The calls to close the facility for the protection of the people there, prompted by Moore and Rawls’ findings, were eclipsed four years later with a focus on institutionalism in order to protect people from the releasees.

The renovations at Farview were part of a broader appropriation of money into the prison system under Thornburgh. In November 1980, the Governor allocated $37 million to the Bureau of Corrections for renovations, including $20 million for the historic Western State Penitentiary, a facility targeted for closure by legislators and policymakers since the 1940s due to its age.64 Another building project he proposed was a new medium-security prison at Graterford, a prison farm that sat only miles away from the deinstitutionalizing Pennhurst State School. The choice of location was far from a coincidence. Sitting on the outskirts of the Philadelphia metropolitan area, the Pennhurst State School had been a major employer for the region. With the fate of Pennhurst at stake, the building of a prison was more amenable to the community. For the first time since 1960, a new adult prison would be built in Pennsylvania, and, notably, it occurred in an area where a state school was slowly downsizing.65

These building projects gave momentum in 1981 to what the Governor called his “War on Crime” in which he targeted “thugs and punks and pushers.” He announced publicly that the criminal justice budget was “designed to put fear to work for people … and to put punks and thugs and pushers firmly within the walls of a prison.”66 This war included a package of

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66 Stephan Salisbury, “Governor’s Prison Budget Draws Praise and Criticism.”
sentencing bills in 1982 intended to form the core of his crime-fighting effort. House Bill 1803 eliminated the probation and parole board. Instead, the state would release people from prison once they reached their minimum sentence. As the Bulletin reported, the concept was, “a sentence given is a sentence served.” With this shift towards determinate sentencing, Thornburgh drastically reduced the already weakened concept of correctional rehabilitation. At the same time, he encouraged longer prison sentences and proposed legislation that dramatically raised the minimum sentences for a host of crimes. He passed Act 54, which abolished the requirement that minimum sentences be less than half of the maximum sentence and that established mandatory minimum sentences of five years for individuals convicted of using firearms during crimes such as murder, rape, or robbery; five years for people convicted for the second time of rape, kidnapping, or robbery; and mandatory life sentences for people convicted of second- or third-degree murder. According to the Bulletin, Thornburgh “hailed the bills as ‘probably the toughest approach (to crime) that has been taken at the state level in the nation’s history.’”

Thornburgh’s focus on imprisoning people and trying to reduce the drug trade here is striking since he had reorganized the social services for drug and alcohol abuse. In 1972, Pennsylvania had become one of the first states to establish county authorities to develop mental-health-based plans of action around substance abuse and addiction in its Office of Mental Health. The office reported to the Governor’s Council on Drug and Alcohol Abuse and by 1980 it had become sizeable. However, in 1981, Thornburgh removed the Governor’s Council from the

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Office of Mental Health and placed it in the Department of Health. The shift fragmented substance abuse services, and reflected more of a commitment to tackling the problem of drugs with the criminal legal system rather than social services.\(^70\)

In order to accommodate the flood of people into prisons caused by his new legislation, the Governor took a number of measures to expand the corrections bureaucracy. He elevated the Bureau of Corrections to a full Department of Corrections. As a result, the Attorney General’s Office no longer oversaw the corrections system, and instead, it became a branch unto itself directly overseen by the Governor. Thornburgh continued to build even more prison cells in addition to the ones already created. He publicly stated that without money for new prison cells, “our war on crime will only be a war of words.”\(^71\) So, in order to fund this new construction, he created a $112 million government bond that would finance 2,705 new cells.\(^72\) Thornburgh sought to build up the state government, particularly its security forces and custodial institutions even at a time of deinstitutionalization.

Notably, a main way that the state sought to build new prisons was to use the infrastructure of closing mental hospitals. The state had already used the infrastructure of mental hospitals to build up the prison system. For instance, by renovating the Farview State Hospital, he kept a major institution running for the purpose of holding people convicted of crimes. Also, by building in Graterford near the Pennhurst State School, the state maintained a state institution in the region. Thornburgh also proposed that the state convert the Cresson State Center for people with mental retardation into a prison, along with Marcy State Hospital. And, finally, he


\(^{72}\) Ibid.
proposed converting the closing Retreat State Hospital into a regional prison.\textsuperscript{73} The plan to convert Retreat fell through as the state expected the local counties to assist in the costs of running it. Finally, the plans to build a prison at Retreat did not die, and eventually in 1988 it became a prison.\textsuperscript{74} Here, Pennsylvania reflected major national patterns of mental hospital to prison conversions, particularly in the Northeast and Midwest as dozens of such sites became correctional institutions.\textsuperscript{75} The emptying mental health infrastructure literally helped to build the rising correctional system.

The story of Governor Thornburgh’s diverging institutional approaches reflects a central contradiction within neoliberal policies. Rather than a scaling back of state infrastructure, there was a rise of correctional institutionalism in the place of mental health institutionalism. While a deinstitutionalization had occurred in the 1960s and 1970s, it was tied much more to a concept of growing state social services to serve the client population than a scaling back. The federal government and the court system also held far more power in this earlier stage of deinstitutionalization. In comparison, the deinstitutionalization under Thornburgh in the 1980s was conducted as part of Thornfare and the shrinking of state services to people deemed ineligible for them. Institutionalism in the criminal system, on the other hand, grew exponentially, flourishing in some of the very buildings which the mental health system had once inhabited.


\textsuperscript{74} “Plan to Convert Hospital into Prison is Scrapped,” \textit{Reading Eagle}, September 2, 1981, 21.

Conclusion

Between 1945 and 1985, the practice of institutionalizing people with mental illness declined while imprisonment for law-breaking rose. Four central changes occurred that dismantled the old system of confinement in mental hospitals and continued the reliance on the practice of institutionalization. First, in the 1940s and 1950s, psychiatrists and policymakers worked to decouple criminality from being attributed to people in civil mental hospitals. At the same time, they created a host of new community-based psychiatric interventions for people with mental illnesses that served to weaken the practice of custodial institutionalism in mental health. The publicity materials that conveyed these changes to the public focused on returning white middle-class men and women to nuclear families, reifying notions of race and class in who could reintegrate to society.

Second, in the 1960s and early 1970s, the courts and state government rewrote the laws governing confinement so that people could no longer be institutionalized against their will merely for being diagnosed as mentally ill. The new laws, however, allowed for the continued confinement of people with mental illness deemed dangerous to society. The laws also changed so that people previously held in mental hospitals were held in prisons. Thus, juvenile offenders, sex offenders, drug and alcohol abusers and people with mental illness who broke the law all had been held in mental hospitals through the mid-1960s. With the rewriting of the laws, prisons became the place to hold these classes of people by the mid-1970s.

Third, deinstitutionalization did not bring about a full rejection of state custodial institutions. Instead, it constituted a process by which the state government politicians and policymakers decided that large institutions were inappropriate for innocent and noncriminal people with mental illnesses. These people gained access to more community-based services,
although the amount was far more limited than initially imagined in the 1960s. At the same time, the politics of fear and conservatism led to the rejection of community-based ideals for people who broke the law, who were far more disproportionately African American. As a result, the punitive prison form revived and confinement grew rapidly in prisons and forensic mental hospital wards.

Finally, the decline of mental hospitals and the continued state reliance on incarceration with prisons occurred because of resource reallocations. During the 1970s and 1980s, the financial responsibility for people with mental illnesses shifted from state departments of welfare to private and public medical insurance companies, including Medicare and Medicaid. Particularly in the 1970s, social welfare programs for people with mental illness came under attack along with other liberal programs dating to the New Deal. However, the rise of conservative politics that valued public safety brought more allocations to prisons, enabled by the historic institutional infrastructure of asylums. The state ownership of land, buildings, and large mental-hospital workforces helped the state recycle many mental hospitals into prisons, effectively underwriting the first wave of prison building in the 1980s.

As a result of these changes, by 1985, many state governments faced a crisis in the provision of mental-health services for community-dwelling clients. The issue of the people with mental illnesses who were homeless became critical and often-struggling community mental-health centers could not keep up with the rising need for services. Yet, funding for the practice of institutionalizing people in prisons, far more expensive than community-based care, continued after the bulk of deinstitutionalization had occurred. The number of people with severe mental illness and drug/alcohol addictions in prisons also rose. While they made up a segment of the prison population, the growth reflected the changing priorities of state governments from welfare
to public safety. The point of entry for rehabilitation and treatment services shifted from mental health to the criminal legal system. While mental health and criminal justice are just two facets of American governance, their dramatic changes offer a new perspective on the changing politics of neoliberalism in the late twentieth century. The rise of neoliberal politics curtailed social services and ushered in a new mindset of scaling back government services rather than using them to solve social problems, as in the Great Depression and postwar era. The fall of state mental hospitals and the rise of prisons shows, the second half of the twentieth century was best described as a renegotiation of incarceration amidst shifting priorities from social-welfare services to public safety and punishment.
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