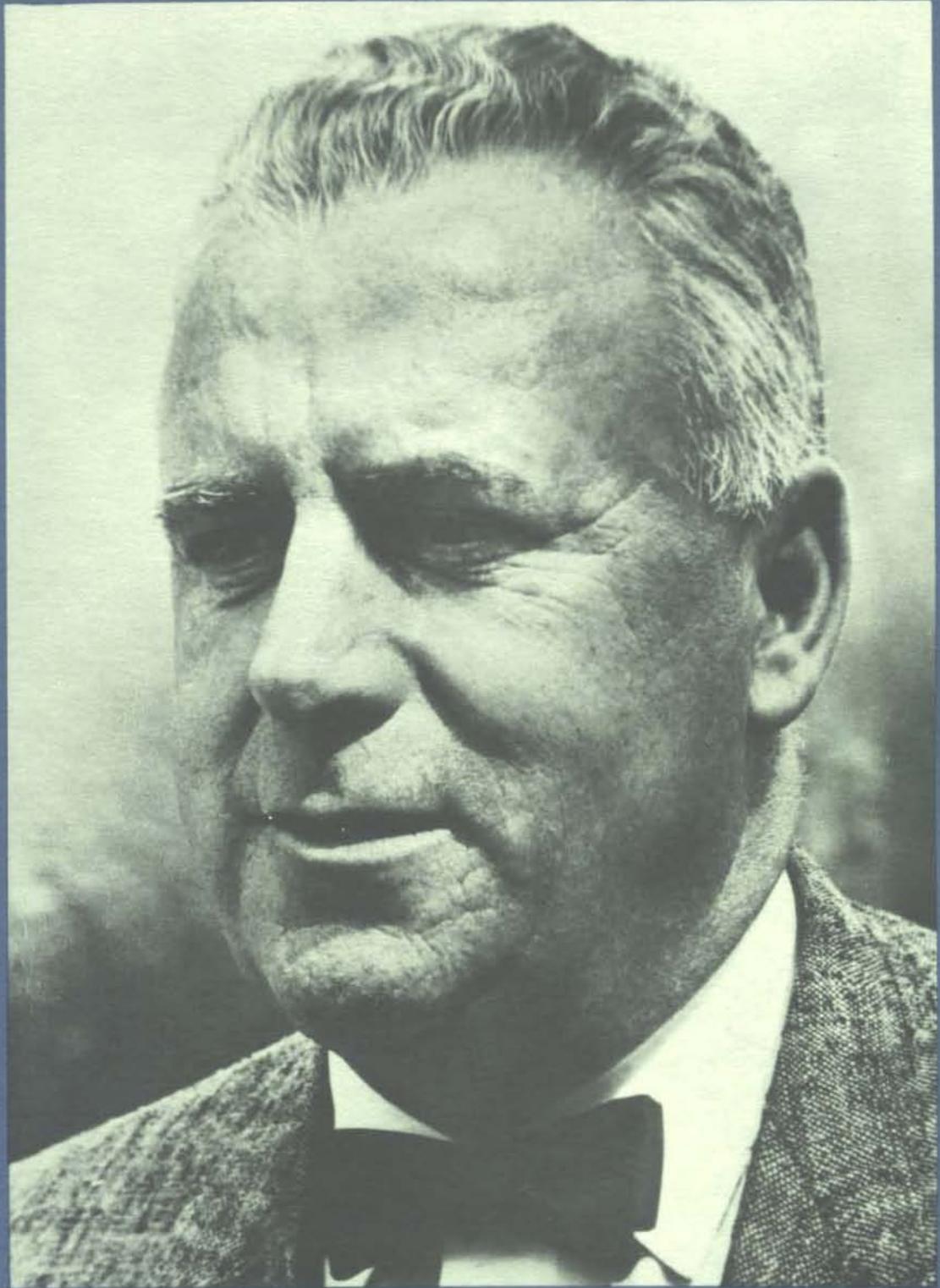




Rhode Island History

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Editor's Note

This issue of *Rhode Island History* is the second installment of two special issues devoted to the history of the care of mentally disabled people in Rhode Island. The first issue (*Rhode Island History*, XL [November 1981]) presented an overview of the care of the mentally disabled in Rhode Island since colonial times and focused on the care of the mentally retarded; this issue offers a closer look at the history of the care and treatment of the mentally ill in the nineteenth and twentieth centuries.

Both issues grew out of a major public education project entitled "Days of Darkness, Days of Hope," sponsored by the Rhode Island Department of Mental Health, Retardation and Hospitals. Our thanks go to the authors for making the fruits of their research available; to John T. Duffy, project director, who first suggested the idea of publishing these special issues; and to Salvatore Mancini, who provided a selection of his photographs taken for the "Days of Darkness, Days of Hope" project.

Besides the special issues of *Rhode Island History*, the project included an exhibition with ninety photographs and text commentary, lectures, and a series of public service announcements. The project was made possible by a grant from the Rhode Island Committee for the Humanities. Additional support was provided by:

Rhode Island Development Disabilities Council
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Introduction

There is no escaping the fact that a history of mental institutions and mental health programs in the United States presents a grim, almost unrelieved, record of disappointments. Pages of eyewitness accounts, state investigations, and photographs confirm the evidence of neglect, leaving very little to the imagination. Not only have reform-minded professionals and laymen been unable to secure a meaningful change. The difficulty goes even deeper, to the lack of obvious villains on whom to heap blame, to the absence of a single source of failure that might be easily corrected. Were the inadequacies of the system solely the fault of an incompetent group of medical superintendents or stingy legislators, then at least one could design a strategy to try to upgrade the quality of the staff or to improve lobbying campaigns. But although there are examples enough of these shortcomings, they do not reach to the core of the problem. Almost every generation has produced a number of would-be reformers whose good impulses and benevolent motives cannot be doubted. Starting with Dorothea Dix in the nineteenth century and through Clifford Beers and Adolf Meyer in the twentieth, interested citizens have done their best to upgrade the quality of care. Despite their efforts, however, the results have not been satisfying. It is doubtful whether we treat the mentally ill any better than our Jacksonian or Progressive predecessors did. In this field there is not much evidence of a march of progress.

Why have mental health policies proved so inadequate? Why have reformers so consistently been unable to realize their ambitions? Part of the answer lies in the domain of medical science. Psychiatrists do not understand many of the causes of mental illness, just as they do not understand the causes of other deviant forms of behavior, such as crime, and so efforts at amelioration confront chasms of ignorance. To circumvent the gap, some psychiatrists like Adolf Meyer compiled lengthy and detailed life histories of the patients, expecting that an abundance of information would somehow or other clarify the roots of the problem. Others anticipated that the application of one or another theory like Freud's might provide sufficient guidance for therapeutic efforts. And still others, despairing of the search for cause, experimented with a variety of interventions from electric shock to drugs, hoping to alleviate symptoms if not eradicate them. But none of these approaches proved particularly helpful. Cures were rare and solutions evasive.

Another part of the difficulty rests with political and administrative officials. Especially at times of shrinking resources and budgetary constraints, the impulse to take the most from the least, to penalize the

powerless, is too tempting to avoid. The mentally ill do not form a constituency able to exert influence in decision-making councils. Even compared to the mentally retarded they are a weak group, for the retarded do have powerful parent organizations determined to advance their claims. Moreover, public prejudices against the mentally ill are strong, probably even stronger than against the retarded. Neighborhoods remain loathe to accept the mentally ill into their midst, allowing images of the rare nightmarish case to define the entire group. Residents organize to keep them out of their communities and off their streets, with the result that in numerous states many of the mentally disabled are forced to remain invisible in institutions or run-down boarding homes.

Over the past ten years, one group that has never before concerned itself with the plight of this minority has taken up its cause, and that is civil libertarian attorneys. In many states, they have persuaded judges that the mentally ill have rights that must be respected. Building on precedents from the civil rights movement, they have advanced such novel doctrines as a patient's right to reside in the least restrictive setting (which would often be something else than an institution), a patient's right to refuse treatment (like shock therapy), and according to the United States Supreme Court, the patient's right to receive treatment, at least if he is involuntarily committed to a state hospital, without being dangerous to himself or to others. Many federal courts have accepted these principles, and as a result of their decisions, a number of state legislatures have been compelled to upgrade their institutions, hospital administrators to give greater weight to the wishes of their patients, and departments of mental hygiene to devote energy to establishing community services and group homes.

Despite these accomplishments, the future role of civil libertarian lawyers and courts in mental health reform is problematic. It is difficult to imagine judges continuing to take the time to oversee the practices of mental hospitals, particularly if the most glaring abuses subside. There are also distinct limits to the ability of outsiders to effect permanent change within a bureaucracy. The threat of court action may spur a state mental health department to undertake a crash program to improve institutional conditions or to start community placement. But it remains unclear whether the effort will go beyond crisis management to structural change, whether the needs of the mentally ill can continue to command necessary resources over time. So, too, evidence of a growing revolt against court intervention is mounting, both from within the judiciary and from outside critics. One wonders whether the decade of the 1980s will reveal as many examples of judicial activism in mental health as the 1970s did.

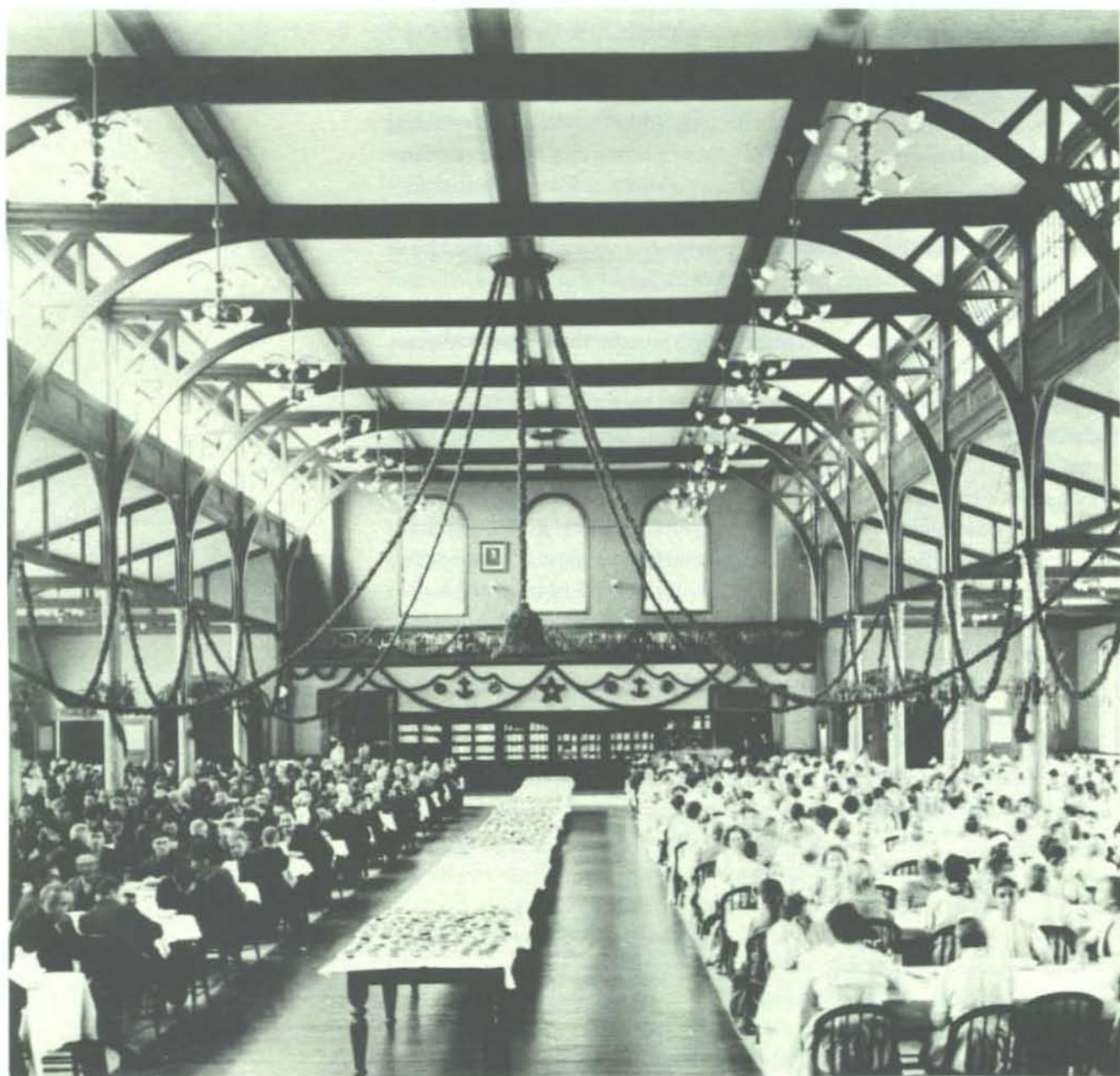
In this same spirit, one wonders whether the mental hospital will for the foreseeable future continue to dominate mental health programs. Will congregate care in large-size institutions remain, as it has since the 1820s, the core of the system? In the 1950s and 1960s, it seemed as

though alternatives might take hold. Rates of release from the facilities suddenly and dramatically climbed; for the first time, the institutional census dropped by thousands of patients. But recent developments make such a conclusion seem premature. For one, although the length of stay in a mental hospital has declined, many patients continue to move through it, creating something of a revolving-door syndrome. Still more important, it has proven much more difficult than imagined to create a network of services in the community. While there are shortages of personnel and barriers of community hostility to overcome, the most serious problem remains the inability to command the necessary dollars; and at least one major source of this inability goes to the institution's ongoing command of the bulk of state and federal appropriations. In effect, the dollars have not followed the clients into the community. Even in states where those seeking help in the community far outnumber those in the institution, the overwhelming amount of public funds goes to the institution.

Policy choices that are framed in an "either-or" style usually seem too rigid and ideological in character to be persuasive. But it may be that in the field of mental health we face just such a discomfiting polarization. At the moment, no one takes much pride in existing conditions. It is evident that the effort to establish alternatives to institutions has meant that some patients have moved from back wards to back alleys, left to make their own way in the worst sections of a city with few welfare or therapeutic services to protect them. But perhaps failures in deinstitutionalization reflect back on the power of the institutions, making it unlikely that community services will come into place without a firm commitment to moving away from an institutional system.

The record before us does not provide firm guidelines for future policy or much room for easy optimism. A spirit of reform in and of itself will not necessarily generate improvements. By the same token, a sensitivity to this history ought to encourage us to strike out in fresh directions; the traditions we inherit are not so successful as to compel conformity. Our predecessors did keep trying to devise new solutions and experiment with new approaches. Surely we can do no less.

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Custody and Control: The Rhode Island State Hospital for Mental Diseases, 1870–1970

by Janet Golden and Eric C. Schneider*

Patient care in the Rhode Island State Hospital for Mental Diseases slowly evolved from custody to the treatment of patients. In the nineteenth and early twentieth centuries, the institution was little more than a warehouse, erected by the state to hold the indigent mentally ill. Beginning in 1907, under the direction of Dr. Arthur H. Harrington, medical and social services at the facility were created and strengthened. The growing patient population stimulated an interest in discovering the social, hereditary, and biological causes of mental illness, and in finding the means for preventing them. An arsenal of drug and mechanical treatments was developed with a variety of results. In the second half of the twentieth century, a pharmaceutical "revolution," brought about by the use of newly developed tranquilizers, achieved control over many symptoms of mental illness.

Perhaps the most striking fact about the history of the State Hospital was its constant lack of funds and its neglect by state authorities. Almost every annual report published by the hospital or its overseers began with a plea for more money and a detailed explanation of why it was needed. Too often these pleas were ignored, and only periodic exposés by the press stimulated an interest in improving the quality of life at the institution. The parsimony of the state was responsible for the shortage and underpayment of workers, the poor conditions of buildings, the absence of needed materials and equipment, the overcrowding, and the general unwholesomeness of the environment that characterized the hospital from its earliest years until the 1970s.

I

The Rhode Island State Asylum for the Incurable Insane opened its doors in 1870, a late arrival in the national movement to establish state mental hospitals. As David Rothman has pointed out, "a cult of asylum swept the country" beginning in the 1850s, and by 1860 twenty-eight of thirty-three northeastern and midwestern states had constructed public institutions for the insane. The motive for their construction was a belief that the insane could be cured if properly cared for in an

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Christmas decorations grace the dining hall of the Rhode Island State Hospital for Mental Diseases, January 22, 1919. Photograph courtesy of the Rhode Island Department of Mental Health, Retardation and Hospitals.

1. David J. Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic* (Boston, 1971), 130.

2. Board of State Charities and Corrections, *Annual Report, 1870*, 27–30, hereafter cited as BSCC, AR.

3. Rothman discusses the removal of patients to rural areas. Rothman, *Discovery*, 137–138. A host of deviants in Rhode Island were removed from urban areas and quarantined together at the State Farm. BSCC, AR, 1870, 13; AR, 1876, 14.

environment providing the correct discipline. By 1870 there were few illusions, however, about the ability of mental institutions to offer a therapeutic setting for the insane. The institution for the “incurable insane” was clearly custodial, a point underscored by its construction on what would later become the site of the state’s poorhouse and prison in Cranston. The essential impetus for the building of the institution was a desire to save money.¹

Prior to the opening of the asylum, the state’s insane were kept in the Butler Hospital in Providence, a private facility, or were sent to asylums in Vermont and Massachusetts. By building a local facility, the state hoped to cut costs and to gain stricter control over eligibility for support. There was much distress over support of ineligible persons, such as one woman who had been maintained in asylums for twenty-three years and who “was a prospect for needed support for years to come,” but who had no legal standing as a Rhode Island resident.²

If frugality was to be the watchword of state policy, then the selection of a farm site proved to be ingenious. It allowed for the removal of the insane from the city, their isolation in more tranquil rural areas, and their occupation in simple manual labor, a combination that both state legislators and leading asylum superintendents found desirable. The asylum, which included the State Farm at Howard, was spread over 417.7 acres of land, and included pavilions for the insane, the state workhouse, a laundry, a chapel, and farm buildings. Over the next 100 years institutions and acreage were added. The size of the grounds made it possible for the patients to have more liberty than was available at other institutions. This freedom to roam seemed to make them “happier and more tractable than when under restraint.” More important, patients were able to participate in farming, which was both a crude form of occupational therapy and a way of keeping costs down.³

Patient life at the asylum revolved around the performance of simple tasks. The state attempted to provide “most of the comforts of life that can properly be asked for in an institution supported at public expense.” Patients did the institution’s day-to-day chores, but were not

Staff and attendants pose for a group photograph at the Rhode Island State Hospital for Mental Diseases, ca. 1920s. Photograph Courtesy of Cranston Historical Society.





An early photograph of the Rhode Island State Hospital for the Insane. Courtesy of Rhode Island Historical Society Library (RHi X3 4518).

very hard driven at their labor. The 1878 *Annual Report* noted: "Some have worked in the gardens; some, during their seasons of quiet, have done the repairs of the buildings, and have made and mended the bedding and clothing; others, so far demented or so feeble of body as to be incapable of labor have passed their time according to their bent, sitting under the trees or basking in the summer and enjoying warmth of the stoves in winter; and a small number have remained in confinement or under restraint."⁴ Nonetheless their labor was significant. The nineteenth *Annual Report* (1886) described their work for the previous year: "The women have done most of the house work, including a very large proportion of the washing (no ironing) sewing and mending, and some knitting." For the men there was heavy farm work; in addition to raising crops they were busy "cutting wood, clearing land from stumps and stones, grading, etc."⁵

The population of the institution increased annually (see Table I) and strained its resources. In 1884 the state assumed responsibility for all the indigent insane within its boundaries, and state-supported patients at the Butler Hospital were moved to the facility at Howard. The growing population increased the demand on the state treasury. In 1881 the state was willing to appropriate money for singing birds and cages to "contribute to the happiness of the patients"; by 1886 it relied on pri-

4. BSCC, AR, 1879, 16; AR, 1877, 20.

5. BSCC, AR, 1887, 13.

TABLE I
Hospital Population

<i>Year</i>	<i>Number of Patients</i>
1870	118
1880	243
1890	493
1900	723
1910	1101
1920	1688
1930	1895
1940	2752
1950	3206
1960	3236

Syphilis Treatment at the State Hospital

Effective medical treatment of syphilitic patients was a significant accomplishment at the State Hospital. A 1911 annual report contained the estimate that fully 10 percent of the patients were suffering from syphilis. In its late stages the disease causes general paresis (paralysis), delusions, loss of memory, convulsions, and numerous other forms of mental and physical deterioration. Only in the twentieth century did effective cures become available. These included Salvarsan, fever therapy, and ultimately, penicillin.¹

Salvarsan, first used at the hospital in 1917, was developed by Dr. Paul Erlich and his assistant Sahachiro Hata. The drug was a form of arsenic (an element which was medically useful but highly toxic) known as arsphenamine. Soon after its discovery less toxic compounds were developed and used in its place. In 1931 it was discovered that intramuscular injections of bismuth (a chemical with many medical uses) given with a course of arsphenamine treatments effected a surer and faster cure.²

The fever cure, another popular treatment for syphilis, began at the State Hospital in 1927. It involved giving the patient a disease that caused a high fever. Initially malaria was the treatment of choice; later special hot boxes were developed to raise the patient's temperature. Other fever treatments included the use of typhoid-paratyphoid vaccine. Rat bite fever and, more commonly, malaria were used, often in conjunction with drug treatments.³

Penicillin was first tested as a cure for syphilis in 1943, but it did not become widely available until after World War II. The State Hospital began using it in 1945 and found it so effective that fever and drug treatments were soon suspended. Penicillin had several advantages over the earlier treatments. It worked faster and was generally safer. Neoarsphenamine treatments, when first begun at the hospital, often took three years. Patients were given ten courses of ten treatments, and between each course there was a rest period lasting from six weeks to six months. Fever therapy was risky. The treatments might leave the patient with a new disease, and any form of fever could be dangerous.⁴

Today syphilis is rarely thought of in terms of the mental destruction it can wreak upon its victim. The development of effective medical treatments meant that one of the common causes for admission to a mental hospital was eliminated, and that relief was brought to the many who suffered the consequences of this disease.

1. State Hospital for the Insane, *Annual Report*, 1911, 8; Kenneth L. Jones *et al.*, *vd* (New York, 1974), 64-65.

2. Stephen Bender, *Venereal Disease* (Dubuque, Iowa, 1971), 8-9, 23; State Hospital for Mental Diseases, *Annual Report*, 1916, 8 [hereafter cited as SHMD, AR]; SHMD, AR, 1917, 12.

3. SHMD, AR, 1927, 5.

4. Samuel I. Kennison, "As to the State Hospital for Mental Diseases," *Rhode Island Medical Journal*, X (Apr. 1927), 53-56; Bender, *Venereal Disease*, 9; Theodor Roseburg, *Microbes and Morals* (New York, 1971), 214-218.



A graduating class of nurses at the State Hospital for the Insane. The original photograph is undated, but it was probably taken sometime before World War I. Courtesy of Cranston Historical Society.

vate philanthropy to provide amenities for the patients. For example, an appeal by a member of the State Board of Charities and Corrections for items to enhance the lives of the patients led to the donation of two pianos.⁶

For the first eleven years the institution was run by Mr. and Mrs. Frederick W. Perry, formerly attendants at the Butler Hospital in Providence. Eventually the institution's management became the province of physicians. Between 1881 and 1886 three different physicians directed the asylum. In 1886 Dr. George F. Keene took the position of superintendent, which he held until 1905. Keene was connected with the hospital for twenty-two years, beginning as a visiting physician, holding the office of deputy superintendent for over ten years, and serving as superintendent for nearly eight years. His former assistant, Dr. Fred B. Jewett, succeeded him. A scandal in 1907 led to Jewett's firing and the selection of a superintendent from outside the Rhode Island medical system. Jewett was removed when it was revealed that he had kept a patient in a straight-jacket for eight days as punishment for insulting an attendant, and had ordered the patient to remain confined until he apologized. In reviewing the case during Jewett's dismissal hearing, the State Board of Charities said that it "was going altogether too far to expect an insane person to apologize to an attendant."

Abuse of a patient, as in the case that led to Jewett's firing, was an all too common part of the institutional "care" given the insane. Exposés, such as Clifford Beers's *A Mind That Found Itself* (1907), helped to sensitize the public to the scandal of institutional life. But state authorities, rather than confront the deep-rooted problems of the institution, chose simply to hire a new superintendent. After Jewett's firing the board chose Dr. Arthur H. Harrington, a physician and a graduate of

6. BSCC, AR, 1883, 17-19, AR, 1880, 19; AR, 1885, xvii.

7. Fred Jacobs, "Private Care and Public Custody: Institutions for the Insane in Rhode Island, 1840-1900" (honors thesis, Brown University, 1978), 108-109; BSCC, AR, 1880, 19 (Dr. Leon C. Vinal); BSCC, AR, 1884, 6 (Dr. Edward P. Stimson); BSCC, AR, 1885, xvi (Dr. Herbert J. Pomroy); BSCC, AR, 1886, 5 (Dr. George F. Keene); see also Arthur Harrington, "State Hospital for the Insane," in *The Institutional Care of the Insane in the United States and Canada*, ed. Henry M. Hurd et al., 3 vols. (Baltimore, 1916), III, 563-570; *Providence Journal*, Jan. 16, 1907, *Providence Journal*, June 12, 1907.

8. In 1909 the *Report of the Superintendent of the State Hospital for the Insane* was issued for the first time. In it Harrington published statistical tables along with information about the institution. Each report included an article on some aspect of mental illness as it related to the State Hospital; Harrington was the author of most of the articles. In 1912 a nurse training school was opened at the hospital. See *State Hospital for Mental Diseases, School of Nursing* (n.p., n.d.), 9. In 1915 evening clinics began in Providence. See *State Hospital of the Insane, Annual Report, 1915*, 7, hereafter cited as SHI, AR. In 1916 a field worker was hired, and soon after there was a full-fledged Social Service Department. See SHI, AR, 1916, 11-12.

9. SHI, AR, 1913, 36-44; *Providence Journal*, June 25, 1922.

10. *Report of the Superintendent of the State Hospital for Mental Diseases, 1917*, 39, hereafter cited as SHMD, AR.

11. BSCC, AR, 1908, 27-28; SHMD, AR, 1920, 50-52. The National Committee for Mental Hygiene, "Rhode Island Mental Hygiene Survey," 1923, 17, called for a psychopathic hospital. The mental hygiene movement aimed to prevent mental illness, in part through action in the community. Criticism of the asylum, and its isolation from both the community and developments in modern medicine, was at its core. It endorsed the treatment of acute episodes of mental disorder in a clinic or psychopathic hospital, the use of boarding homes and family care for patients no longer needing hospitalization, and improved care for former patients who had been discharged into the community. For a discussion of the mental hygiene movement see David J. Rothman, *Conscience and Convenience: The Asylum and Its Alternatives in Progressive America* (Boston, 1980), 293-375.

Brown University, who had held positions at various mental hospitals in Massachusetts and at the New York Eye and Ear Infirmary.⁷

Under Harrington's direction the clinical capabilities of the institution were vastly increased. During his tenure, from 1907 to 1926, more doctors were hired, a nurse training school was begun at the hospital, patient statistics were collected, a medical out-patient clinic inaugurated, and social workers added to the staff. All of these were needed to aid a hospital population that had grown from 1,006 to 2,143.⁸

Harrington, like other practitioners, social scientists, and public leaders of the period, believed that heredity was among the major causes of mental illness. The collection of patient statistics was designed in part to test this theory. Similarly the collection of patient histories by the social workers was meant to uncover family members with mental illness. In 1922 Harrington exhibited a chart at the National Conference of Social Workers that showed the results of one of his studies. He found "twenty one insane, feeble-minded, epileptic, or neurotic individuals out of fifty-eight in three generations are due to an insane grandmother." He hoped his local studies would push Rhode Island to hire social service workers and to adopt eugenic measures that would prevent the transmission of pathology.⁹

Harrington saw social workers as not only investigating the background of the patients, but also preparing for their discharge by finding suitable placements. He appealed to the state to hire more social workers, pointing out that it would save money. The 1917 *Annual Report* discussed several cases in which the social service department made the discharge of patients possible. In one case a man remained hospitalized eight months past his recovery; only when the social worker found him work on a farm was he able to leave.¹⁰

Harrington endorsed two of the important goals of the mental hygiene movement: the placement of patients outside the hospital and the construction of psychopathic hospitals in urban areas. Harrington supported a parole system that let patients out of the hospital for up to six months, and he encouraged a family placement plan in which people were paid to board patients in their homes. Discharged patients had the opportunity to make weekly visits to an out-patient clinic in Providence. He also urged that a psychopathic hospital be established in Providence, which would be more accessible than the State Farm and would allow for out-patient care of acute cases.¹¹

Harrington's plans were grander than the state's budget, however, and many of his recommendations were not met. Particularly unfortunate was the state's unwillingness to build a separate building for the tubercular patients. Their inclusion in the general wards led to a high rate of infection among patients. Also disturbing was the failure of the state to increase the pay of the staff. Harrington urged that pay be increased in order to attract and keep good attendants; he also favored offering male and female staff members equal pay, stating that they worked equally hard.

Music Therapy at the State Hospital

From the earliest years of the State Hospital, music played an important therapeutic role in the lives of the patients. It was seen as a means of enhancing their environment, of soothing them, and of giving to some an opportunity for meaningful participation in the hospital society. Music therapy began in 1881 when the state legislature made a special appropriation of fifty dollars for the purchase of twelve canaries and six brass cages. The pairs of birds were placed in the six halls of the institution, where they proved to be "healthy and good singers" and where "their presence and song contributed to the happiness of the patients."¹

Canaries were not the only source of music; over the years the hospital acquired several pianos and eventually had its own brass band. When the newly renovated assembly hall opened in 1900, patients were entertained by a five piece hospital orchestra, which included one patient/musician. By 1904 another patient had joined the orchestra, which played for patients during their dinner and supper hours in the new congregate dining hall. This facility, which seated over a thousand patients, had a musicians balcony with room for a chorus and an organ.²

It took several years for the hospital to acquire an organ. In 1920 Dr. Arthur Harrington, the superintendent, brought to the Penal and Charitable Commission a plan for purchasing an organ. Funds were to come from several sources, including money raised through the sales of items made by patients, the profits from the sale of honey produced by the institution's bees, and the donations encouraged by radio and newspaper appeals. Harrington believed that music was "helpful in soothing disordered minds," and upon his arrival at the institution he began to work with the chapel choir. Eventually there were fifty singers, and a music director was hired to work with them. In 1925 this hospital choir and its accompanist gave a concert at a local radio station. After the concert ended, Harrington made an appeal for donations to the organ fund. Appeals such as this, together with the publicity given the drive by the *Providence Journal*, which collected the donations and published daily a list of new donors, enabled the hospital to purchase an organ later in 1925 without ever using funds from the state treasury.³ Upon installation, the organ was played during the meal by Harry Kenyon, a blind musician trained at the Perkins Institute. Shortly after the organ was in place Dr. Harrington resigned his position, although he remained associated with the hospital as a consulting psychiatrist and an "organist's assistant."

1. Board of State Charities and Corrections, *Annual Report*, 1880, 19, hereafter cited as BSCC, AR.

2. The brass band is first mentioned in BSCC, AR, 1898, 18. The assembly hall performance is noted in BSCC, AR, 1900, 7. The noontime concerts are described in BSCC, AR, 1904, 22.

3. See Arthur H. Harrington, *The Story of the State Hospital Pipe Organ* (Howard, R.I., 1926).

The State Hospital for Mental Diseases, ca. 1928. Photograph courtesy of the Rhode Island Department of Mental Health, Retardation and Hospitals.



12. SHI, AR, 1915, 39–40. See also State Department of Public Welfare, *Annual Report*, 1938, 10, hereafter cited as DPW, AR. Harrington's support for equal pay is in SHMD, AR, 1919, 10. On mental hygiene see Rothman, *Conscience and Convenience*, 363–364.

What made Harrington unusual among asylum superintendents was the extent of his support for the mental hygiene movement. Rothman has found that “neither the legislatures, nor the hospital boards, nor the trustees, nor the superintendents ever devoted major energies to concerns or activities that went beyond institutional boundaries.” Harrington, however, supported parole, after-care, out-patient clinics, the establishment of a psychopathic hospital, social work—in fact the entire panoply of Progressive measures. If the mental hygiene movement in Rhode Island failed and the asylum remained the centerpiece of state policy, the failure was Rhode Island's and not Harrington's.¹²

II

Patients in mental hospitals were victims of many illnesses. Prominent among these illnesses were somatic diseases, including syphilis, pellagra, epilepsy, and diseases of old age. Alcoholics and drug addicts as well as the feebleminded and insane criminals were kept in the mental institution. The hospital took in all these people in part because they manifested some form of mental disorganization, but also because there were no alternative places to send them. For example, sw was admitted at age fifty-three, her record noting that she was an imbecile. sw had gone to school until age ten or eleven, but had barely learned to read. First her parents and later her sister cared for her, but sw began to have delusions of persecution and became difficult to keep at home. She claimed to have visions; one Halloween she thought she saw a “big devil” with wings, red eyes, and a long tail. Finally sw threatened to kill the neighbors, and in 1898 she was sent to the state hospital where she remained until her death in 1914. But not all the patients in the State Hospital were like sw. dw, a plumber from Bristol, entered the State Hospital in 1905 at age thirty-eight. His mother informed the hospital that dw had contracted syphilis a number of years before and

that the disease had apparently entered its final stage. DW was paralyzed and remained at the hospital slightly longer than a year before he died. Lastly, JE, a laborer born in Ireland, was taken to the Silverhook jail after the police found him running about in the fields near his home. While in jail he tore his clothes to shreds, masturbated constantly, and soiled his room; he was later transferred to the State Hospital. JE was an alcoholic who went on periodic sprees, and after drying out for several months, he was discharged.¹³

While the asylum superintendents of the day discussed the role of heredity in mental diseases, and worried about eugenics, their institutions played a more prosaic function in caring for the elderly. Mental institutions housed growing numbers of elderly whose own children were unable or unwilling to care for them. Harrington, for example, reported in 1913 an increasing proportion of elderly patients. He attributed their presence to the fact that in many families everyone capable of working was employed and there was no one at home to care for the older relatives. RP, for example, was admitted to the State Hospital at age eighty-six after exhibiting signs of increasing senility, such as loss of memory, disorientation, and a short attention span. She began to wander away from home and became "unmanageable" so that "some form of restraint has become necessary." RP showed signs of senile dementia, believing that she could converse with "spirits" who advised her. She thought that her body was being emptied of fluids, and she would get up at night to rub water over herself. She also believed that her heart stopped periodically, and in order to get it started again would jump up and down as many as 500 times before becoming exhausted. While at first she sat around in a stupor for hours on end, she gradually began to brighten and appeared cheerful when spoken to. She was discharged as improved after a stay of five months. Others were less lucky. CA was brought to the South Kingston poor farm by her nephew. But she was "said to be noisy and obstinate" and was therefore transferred to the State Hospital. She remained there until her death two years later.¹⁴

Other superintendents at the institution worried about the cause rather than the consequences of this elderly population, calling for research into possible causes of senility. There were frequent references in the annual reports to the growing numbers of older people in the institution. In 1949, for instance, 33 percent of the patients admitted were over sixty-five, while only 12 percent of the state's population was in that age group.¹⁵ Little was actually done for the elderly kept at the hospital. A 1942 *Annual Report* suggested that B vitamins given to elderly female patients met with good results. The treatment was also said to be expensive. There are no other references to this vitamin therapy, nor was there any mention of other treatments provided for this population.¹⁶

Medical science developed no cures for mental illness in the early twentieth century. However, some somatic illnesses that caused symp-

13. The placement of the elderly and the physically ill in mental hospitals, and its meaning for the interpretation of the history of these institutions, is discussed in Gerald N. Grob, "Rediscovering Asylums: The Unhistorical History of the Mental Hospital," in *The Therapeutic Revolution: Essays in the Social History of American Medicine*, ed. Morris J. Vogel and Charles E. Rosenberg (Philadelphia, 1974), 135-157. Harrington reported in 1911 that 10% of the patients in the hospital were syphilitic and 19% were alcoholics. See SHI, AR, 1911, 8. See cases 3632, 5554, and 5410.

14. SHI, AR, 1913, 38; cases 3664 and 4558.

15. Department of Social Welfare, *Annual Report, 1949*, 107 (hereafter cited as DSW, AR), *Providence Journal*, Mar. 14, 1954.

16. DSW, AR, 1942, 44.

Conscientious Objectors at the State Hospital during World War II

On February 17, 1943, the "Conchies" arrived at the Rhode Island State Hospital for Mental Diseases. Conchies was the popular term for conscientious objectors, men whose religion forbade them from serving in the military. During World War II these men went to government work camps and from there many were sent to perform alternative service.

At one point there were 100 conscientious objectors serving as attendants at the Rhode Island State Hospital. The state's director of welfare described them as "a very high type of young man." They received room, board, laundry, medical attention, and a small monthly stipend. Often the wives of these men held salaried positions at the hospitals as cooks, nurses, or attendants.

The conscientious objectors were desperately needed at the hospital. Many of the attendants had left their jobs to serve in the military. At one point only 225 employees remained to do the work normally done by 300.

Conscientious objectors working at the hospital helped to improve conditions for both patients and employees. In addition to filling in for the absent workers, they and many others were responsible for bringing the union into the hospital.¹

1. Department of Social Welfare, *Annual Report, 1945*; 12; *Providence Journal*, Feb. 5, Feb. 17, 1943.

17. SHI, *AR*, 1916, 9; SHMD, *AR*, 1917, 12. Drugs for treating epilepsy were first used in 1921, and a dramatic reduction in the number of seizures was recorded. The average number of seizures per month fell from 183 to 31. SHMD, *AR*, 1921, 19.

18. SHMD, *AR*, 1928, 8, 22.

toms of mental disorder were treated. Epileptics received luminal and later dilantin, drugs that suppressed seizures, while syphilitics found relief through drug and fever treatments.¹⁷

Other medical treatments were given to various patients at the hospital. Hydrotherapy, a treatment that promised to aid disturbed patients, was begun at the hospital in 1927. Dr. Rebekah Wright, a hydrotherapist, was hired and treatments begun in the "tonic bath suite." Initially a variety of treatments were offered. In 1928, for example, a total of 20,170 were given including salt glows, foot baths, needle sprays, and fan douches (see Table II).¹⁸

While the hospital claimed that hydrotherapy cured acutely ill patients, it is obvious that it was used most frequently as a form of restraint, a fact which the hospital tacitly admitted. Over the years the types of treatment offered were limited to wet packs and continuous baths, and increasingly attendants rather than nurses were trained to apply them. A select group of patients were treated. In 1934, for example, 727 received continuous baths and 343 patients were subject to wet sheet packs. When tranquilizers became available in the 1950s to con-

trol the behavior of patients, hydrotherapy was halted.¹⁹ More drastic treatments to control disturbed patients included shock therapy and neurosurgery. Initially insulin shock was used and later metrazol was given; then, in 1942, electro-shock was substituted for the drugs. In later years lobotomies were done on some of the most severely disturbed patients.²⁰

For most of the patients there was no specific course of treatment available. Occupational therapy—generally chores necessary for the institution's upkeep—was punctuated by occasional recreational opportunities. Farm labor, housekeeping chores, and work in the industrial shop, which included building and mending items used at the hospital, remained the sole occupations for the patients. In this way the hospital of the mid-twentieth century was quite similar to what it had been at its opening. In 1938 the *Annual Report* noted that an average of 1,022 patients were involved in daily occupational pursuits. Formal recreational activities included participation in sports, occasional day trips, dances, and music lessons provided by volunteers.²¹

After World War II, developments in medicine and pharmacology radically changed the types of treatments being offered at the hospital. The first important advance was the application of penicillin to syphilis cases. Not only did it quickly cure the disease, but it could be used to halt the infection in its early stages and thus prevent many people from experiencing symptoms that required hospitalization.²²

19. Hydrotherapy as a substitute for mechanical restraint is discussed in Albert Deutsch, *The Mentally Ill in America* (New York, 1949), 446. See also SHMD, AR, 1935, 10.

20. DSW, AR, 1939, 111–112; AR, 1942, 22; AR, 1949, 120.

21. DPW, AR, 1937, 122; AR, 1938, 119.

22. Theodor Roseburg, *Microbes and Morals* (New York, 1971), 214–218; Stephen Bender, *Venereal Disease* (Dubque, Iowa, 1971), 8–9, 23; DSW, AR, 1956, 143.

TABLE II

Hydrotherapy 1927

<i>Treatment</i>	<i>Number of Treatments</i>
TONIC BATH SUITE	
Wet Sheet Packs (Tonic)	27
Salt Glows	1383
Saline Baths	971
Sitz Baths	247
Hot and Cold Fomentations to Spine	665
Swedish Shampoos	726
Tub Showers	820
Electric Light Baths	100
Foot Baths	1479
Needle Sprays	6735
Fan Douches	5106
Rain Douches	1911
Total	20,170
CONTINUOUS BATH DEPARTMENT	
Baths	3405
WET SHEET PACKS	3854

SOURCE: Rhode Island State Hospital for Mental Diseases, *Annual Report*, 1928, p. 22.

23. DSW, AR, 1955, 149.
 24. DSW, AR, 1956, 144.
 25. DSW, AR, 1959, 42.

In 1954 a therapeutic revolution occurred when tranquilizers were introduced at the hospital. Their use resulted in shorter stays and less destructive and disruptive behavior by patients.²³ Psychotropic drugs were not without side-effects, could not be used for all patients, and did not cure mental diseases. Nevertheless, many patients improved to the point where they could leave the hospital after a short stay. There was a reduction in the use of shock therapy, hydrotherapy, and neurosurgery. Many of the locked wards were opened. The effective use of tranquilizers meant that there was a greater demand for occupational therapy, recreational therapy, and psychotherapy in order to prepare patients for non-institutional life.²⁴

The use of tranquilizers resulted in a decrease in the hospital's population. The hospital had experienced annual increases since its opening. Between 1941 and 1954 the average daily population increased by 33.8 persons per year, but after the introduction of tranquilizers it fell. During the period from 1955 to 1960 the average daily population declined by an average of 12.7 persons per year. The patients aided least by the pharmaceutical revolution were those who were the victims of alcoholism and of the diseases of old age. Unlike the so called "drug treatables," these patients were difficult to care for and had little chance of improvement.²⁵

III

Life at the institution always depended upon the economic and social conditions of the nation as well as on developments in medical science. During the Depression problems of high staff turnover and the shortages of trained personnel were temporarily abated. The hospital suddenly found itself with a large and stable staff, including registered nurses willing to work for low salaries. The onset of World War II again depleted the medical staff and the attendant and nursing force. How-

Occupational classes at the State Hospital for Mental Diseases, ca. 1929. Photograph courtesy of Rhode Island Department of Mental Health, Retardation and Hospitals.



ever, at this time conscientious objectors were sent from work camps to fill vacant positions at the hospital. They and their wives, who took on paying positions, alleviated the shortage.²⁶

But staff shortages were not the only problem the hospital had to face. One of the worst problems that recurred throughout the history of the institution was patient abuse by staff members. In 1900 a patient died of what was "believed to be brutality," although the man charged was not convicted. In 1923, two attendants were charged with manslaughter in the death of an eighty-two-year-old patient. In the 1930s and again in 1940 there were outbreaks of food poisoning. The isolation of the hospital, and the class of people it held, meant that public scrutiny of the hospital's operation was impossible. Difficulties were exacerbated by the budget problems of the hospital, which kept personnel in short supply, facilities in poor condition, and social services limited.²⁷

Investigations by newspaper reporters and by official commissions regularly revealed the problems of the institution. In 1960 four members of the House Public Welfare Committee visited the new women's geriatric ward and found filthy conditions. A reporter visiting the hospital in 1961 made the same observation, stating that the geriatric ward for women smelled, and that in some wards patients were sleeping on the floor, sometimes without mattresses. Patients were employed to care for other patients. Some earned five dollars a week; others were "volunteers." The answer to these problems and to many others began with more money. But this was not enough. The needs of the mentally ill, and of the alcoholics and aging people who increasingly made up the population of the institution, could not be met by dollars alone.²⁸

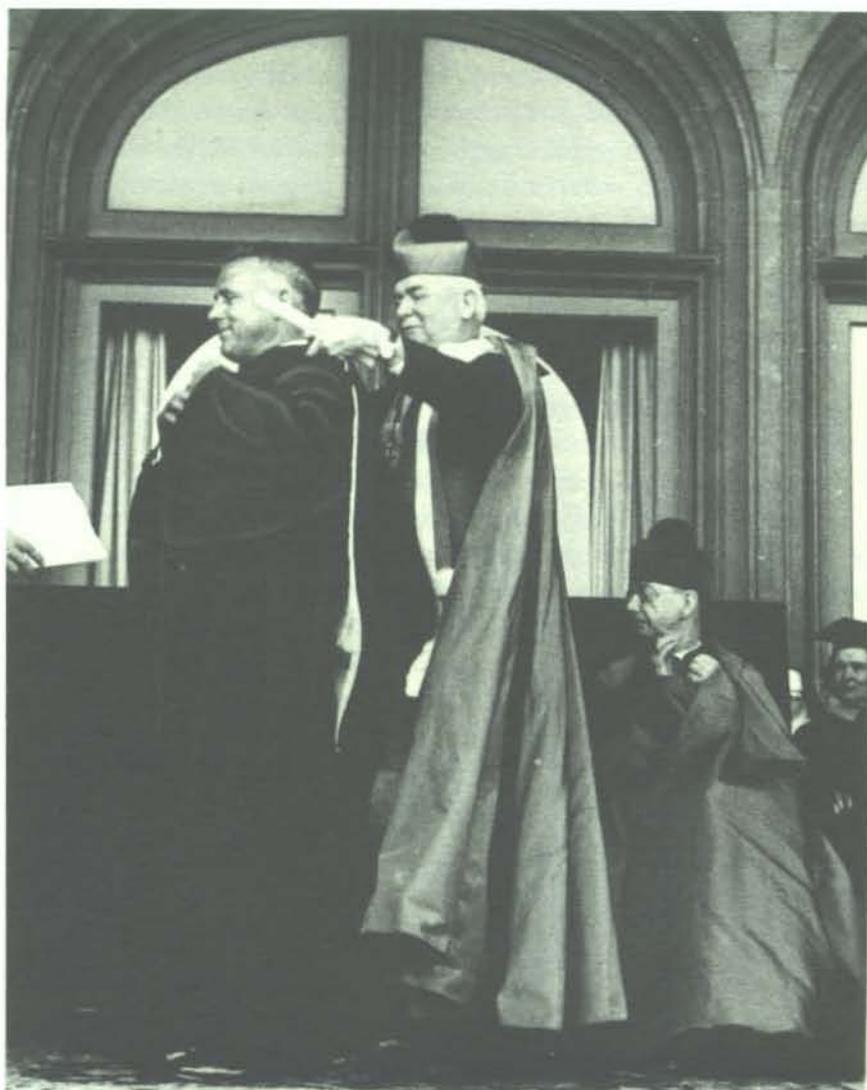
The problem was with the institution itself. Built in 1870 for the incurably insane, it was in its early years a humane alternative to the almshouses and jails that housed many of the state's mentally ill. However, the institution was given the responsibility for providing cheap care rather than humane treatment. This goal meant that patient care would always be seen as a budget item. Though medical science brought relief to some of the sufferers of mental diseases, the problem of the living conditions of the mentally ill was not addressed by these advances. As mental illness was better understood, the threat posed by those who suffered from it was diminished. This allowed for the realization that the institution built to meet the need of the 1870s was not the answer for the problems found a century later.

26. SHMD, AR, 1933, 14-15; DSW, AR, 1945, 12; *Providence Journal*, Feb. 5, Feb. 17, 1943.

27. BSCC, AR, 1900, 17; *Providence Journal*, Feb. 3, 1923, Oct. 2, 1937, Sept. 5, 1938, Feb. 6, 1940; DPW, AR, 1937, 43-45.

28. *Providence Journal*, Jan. 26, 1960, Nov. 9, 1960, Nov. 10, 1960, Nov. 11, 1960.

Honorary doctor of laws degree is conferred on Congressman John E. Fogarty by The Most Reverend Russell J. McVinney, Bishop of Providence, at Salve Regina College commencement in Newport, June 5, 1961. Photograph courtesy of the Providence Journal Company.



"The Full Light of This Dawn": Congressman John Fogarty and the Historical Cycle of Community Mental Health Policy in Rhode Island

by Barbara Bair*

"Most historical writing on lunacy reform perpetuates the illusion that the whole process represented progress toward enlightenment. . . . Yet this is a perspective made possible only by concentrating on the rhetoric of intention to the neglect of the facts."¹

In October of 1963, Public Law 88-164 ("The Mental Retardation Facilities and Community Mental Health Centers Construction Act") was passed by the Congress of the United States. This legislation was a landmark in the history of mental health care because it symbolized the official endorsement of a nationwide policy of deinstitutionalization. As such, it represented a significant turning point away from old policies of institutionalization toward more innovative policies which sought to integrate systems of custodial care with community mental health care facilities. It also represented a high point in the career of John E. Fogarty, congressman from Rhode Island, 1944-1967, who had spent years as a dedicated advocate of federal responsibility and funding for progressive systems of mental health care.

In the early 1960s many supporters of this shift in policy heralded the possible development of state-level community mental health care systems as the beginning of a "third revolution" in the delivery of mental health care. However, the passage of the community mental health appropriations mainly represented a "revolution" of words rather than of action. The primary changes that took place were ideological and rhetorical, not concrete. Sociologist David Mechanic has suggested that such an ironic development is not atypical in the field of mental health policy. His notion that "ideologies develop more rapidly than patterns of care, and while . . . the ideology [may be] coherent, the services [remain] sporadic and fragmentary" holds true in recent Rhode Island history.² For years after the passage of community mental health legislation in the 1960s, the general inertia of established patterns of care in Rhode Island remained substantially unaltered despite incentives for change.

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1. Andrew Scull, "Madness and Segregative Control," *Social Problems*, XXIV (1977), 337-351.

2. The term "third revolution" was used by Nicholas Hobbs, who identified the institutional reform efforts of Philippe Pinel, Dorothea Dix, and others as the "first revolution," and the introduction of Freudian psychology as the second. Nicholas Hobbs, "Mental Health's Third Revolution," *American Journal of Orthopsychiatry*, XXXIV (1964), 822-833. See also David Mechanic, *Mental Health and Social Policy* (Englewood Cliffs, N.J., 1969), 63.

3. The selected papers of Adolf Meyer have been published as *Commonsense Psychiatry*, ed. Alfred Lief (1948). See also Clifford Beers, *A Mind That Found Itself* (1908). For an overview of the role of mental hygiene in community mental health see Stuart Golann and Carl Eisdorfer, "Mental Health and the Community: The Development of Issues," in Golann and Eisdorfer, eds., *Handbook of Community Mental Health* (New York, 1972), 3-17.

4. The Rhode Island Society for Mental Hygiene became the Rhode Island Association for Mental Health in 1957. See G. Richard Weir, "A Brief Review of Mental Health Development in the U.S. and R.I." (unpublished mimeograph, Providence, 1979).

5. For information on the development of foster home care in Rhode Island see Hester Crutcher, *Foster Home Care for Mental Patients* (New York, 1944). For an overview of mental health policy in Rhode Island see David Rochefort, "Three Centuries of Care of the Mentally Disabled in Rhode Island and the Nation, 1650-1950," *Rhode Island History*, XL (1981), 111-132.

6. Francine Sobey, *The Nonprofessional Revolution in Mental Health* (New York, 1970), 11.

The modern origins of community mental health in Rhode Island lie with Adolf Meyer, Clifford Beers, and the development of the "mental hygiene" movement in the first two decades of the twentieth century. Meyer, a neurologist and psychiatrist who was professor of psychiatry at Cornell University (1904-1909) and Johns Hopkins University (1910-1941), adopted the progressive stance in mental health. He believed in the necessity of institutional reform and also in the idea of a spectrum of services, emphasizing preventative education and parole, or after-care, as important additions to the one-step custodial "solution." Meyer also embraced a psychobiological approach to treatment which acknowledged the unity of mind and body as determinants of personality and the causative role of environment in behavior. Clifford Beers, the author of an influential autobiographical critique of institutionalization, was the founder of the first mental hygiene movement in Connecticut. Beers's organization implemented many of Meyer's ideas.³

In Rhode Island proponents of Meyer's and Beers's perspectives followed the example of the Connecticut group and founded the Rhode Island Society for Mental Hygiene. Led by Dr. Charles Chapin, Dr. Arthur Ruggles, Zachariah Chafee, Jr., and others, the Rhode Island organization opened the first mental hygiene clinic in 1916, on Thayer Street in Providence. It also sponsored clinics with volunteer staffs that traveled to various Rhode Island communities during the 1920s and 1930s.⁴ This early variation on the idea of community mental health services was, however, a small operation which provided the type of services given little priority by most public authorities. This lack of emphasis on community services in statewide policy-making is illustrated by the fact that the Rhode Island General Assembly passed legislation authorizing family care in 1914 but did not appropriate funds for the program until twenty-six years later. Clearly, while theories changed in the Progressive Era and deinstitutionalization was discussed as a public issue, the realities of the delivery of care remained virtually the same, with funds and decision-making power still centered in the institutions.⁵

Many of the "progressive" elements of the early community mental health movement could be more accurately called "archaic." As one observer of health care delivery has pointed out, "very few ideas and actions are truly 'new,' 'innovative,' or 'unique,' especially when viewed historically. The 'new' foster care and home care programs for the mentally ill . . . were utilized in Belgium in the 1500's."⁶ The "new" family care policies sponsored by Rhode Island reformers in the 1920s were variations on a well-established tradition. Home care was the norm in America throughout the colonial period and remained a practice well into the nineteenth and twentieth centuries, particularly in nonurban areas and among the lower classes. As one expert on the early development of institutionalization has written, "Americans in the colonial period had followed very different procedures. They relieved the poor at home or with relatives or neighbors; they did not remove them to alms-

houses. . . . The colonists left the insane in the care of their families, supporting them, in case of need, as one of the poor."⁷ This method of caring for the mentally ill in colonial Rhode Island was in accordance with communitarian religious ideologies, with a quasi-medieval interpretation of social structure, and with the economic realities of the times.

Visions of communally-born social burdens were not egalitarian in their origin, rather they were derived from a feudal and socioreligious tradition of paternalism. Nor were they based on ideas of excessive tolerance for differences or dependency. Caring for the ill, the old, the poor, or the handicapped was part of a cycle of need and charity which was considered an inevitable part of the status quo.⁸ Kai Erikson has argued that such deviance played an important role in the preservation of a static order by clearly defining the boundaries of obligation and of "acceptable" (or "normal") behavior.⁹ Home care was simply an outgrowth of the major social structures of the community—the extended family and the church—and of the policy of communal self-policing inherent in Calvinist doctrine.

Home care for the mentally ill also had its precedents in the workings of a barter economy. While Rhode Islanders dealt with limited resources and unevenly distributed skills—relying upon one another to share tools, knowledge, physical abilities and facilities in order to meet common needs—they were also establishing precedents for mutual aid in health care.¹⁰ However, with the increasing urbanization of Rhode Island society and the evolution from mercantilism to laissez-faire capitalism, communitarian assumptions of mutual care and resource scarcity were eroded. By the late eighteenth century, the "enlightened" goals of individualism, independence, and private aggrandizement began to overshadow the earlier framework of interdependency and public weal. As older hierarchical standards were removed and replaced by a tacit economic hierarchy (with its myths of upper mobility and equal opportunity) the "unsuccessful" or "abnormal" members of communities began to be considered targets of blame rather than natural parts of the social system.¹¹ At the same time institutions—almshouses, prisons, reformatories, factories and asylums—began to augment the family and church as prime agents of "reform," or promoters of stability and social control. The backers of such institutions sought to instill the habits of order, regimentation, and uniformity into an increasingly stratified and heterogeneous population.¹²

As the nineteenth century progressed and the Rhode Island socioeconomic landscape was transformed by immigration and industrialization, this desire for homogeneity and control on the part of leading members of society did not wane. In the late 1800s and the beginning of the twentieth century medical professionals were as susceptible to ethnocentric and class-biased opinions as the American mainstream in general. They, however, had the power to translate these social attitudes into medical practice—into theories of mental "health" and "ill-

7. David Rothman, *The Discovery of the Asylum* (Boston, 1971), xiii.

8. See Nicholas Kittrie, *The Right to be Different: Deviance and Enforced Therapy* (Baltimore, 1971), 50–101. See also Rothman, *Discovery of the Asylum*, 3–29.

9. See Kai T. Erikson, *Wayward Puritans: A Study of the Sociology of Deviance* (New York, 1966).

10. For accounts of family-centered community economies see Philip J. Greven, Jr., *Four Generations: Population, Land, and Family in Colonial Andover, Massachusetts* (Ithaca, N.Y., 1972), and James Henretta, "Families and Farms: Mentalité in Pre-Industrial America," *William and Mary Quarterly*, XXXV (1978), 3–32. Excellent treatments of communal norms in health are Rose Lockwood, "Birth, Illness and Death in 18th C. New England," *Journal of Social History*, XII (1978), and Maris Vinoskis, "Angels' Heads and Weeping Willows: Death in Early America," in Michael Gordon, ed., *The American Family in Social-Historical Perspective* (New York, 1978), 546–563.

11. For a classic treatise on "American" values in the late eighteenth century see J. Hector St. John de Crevecoeur, *Letters from an American Farmer* (New York, 1782). For examples of the socioeconomic transformation of urban neighborhoods in the nineteenth century see Sam Bass Warner, Jr., *The Private City: Philadelphia in Three Periods of Its Growth* (Philadelphia, 1968), and Stephen Thernstrom, *Poverty and Progress* (New York, 1977).

12. For critiques of institutions as forces of social control in the early nineteenth century see John Kasson, "The Factory as Republican Community: Lowell, Massachusetts," in *Civilizing the Machine* (New York, 1976), 55–106, and Gary Kulik, "Pawtucket Village and the Strike of 1824: The Origins of Class Conflict in Rhode Island," *Radical History Review*, XVII (1978), 5–37.

13. Dr. Joseph Ladd, "Some Problems Met With at The School for Feeble Minded," *Symposium on Psychiatry*, Oct. 30, 1924, 80.

14. Dr. Henry Jones, "The State of Rhode Island Ready to Have a Law Authorizing the Eugenic Sterilization of the Mental Defectives and Criminals," *Rhode Island Medical Journal* (May 1925), 76-77.

15. E.H. Mullan, "Mental Examination of Immigrants, Administration and Line Inspection at Ellis Island," *U.S. Public Health Reports*, May 18, 1917, 733-739.

ness." Even "progressive" thinkers such as Dr. Ruggles were not free of the Spencerian biases of the day. In his comments at a Symposium on Psychiatry in Rhode Island, Dr. Joseph Ladd told of a case he had brought to the attention of Dr. Ruggles. The patient in question had "very little intellectual defect" but was, in the doctor's opinion, emotionally unstable and "showed grave character defect." Dr. Ladd asked Dr. Ruggles what he would do in such a case and his "reply was that his experience went to show that there was very little result to be expected in treating such patients as came from degenerative stock."¹³

While some mental hygienists were emphasizing education and prevention other Rhode Islanders had different notions of "reform." In 1925 Dr. Henry Jones of Cranston, Rhode Island, advocated that mental defectives in state institutions be sterilized prior to their release. In a speech given before the Rhode Island Medico-Legal Society, Dr. Jones made little distinction between criminality, poverty, mental illness, low intelligence, a non-Anglo-Saxon heritage, and sexuality in his "medical" definition of "defectiveness." He told his audience that several brutal murders that had been committed in the Providence area were, in his opinion, "without doubt brought about by the uncontrollable sex urge of some low grade mental defective." He went on to equate limited mental ability with moral degeneracy and recommended medical treatment as an efficient method for controlling deviant behavior. With an adroit mixture of Social Darwinism, pseudoscientificism, and latent "Victorian" qualms, he argued that "eugenic sterilization" should be perceived not "as a punishment for crime committed, but as a method of medical treatment that will continue to lessen that desire for depraved sexual indulgence that shackles the minds of male and female, and that urges and forces them to commit these murderous assaults on others."¹⁴

Dr. Jones's views were not aberrations, but attitudes shared by many of his peers, who extended these viewpoints not only to criminals and mental patients but to the poor and alien in general. In Dr. Jones's time, medical officers who inspected immigrants at Ellis Island used class-and-culturally-biased criteria to identify "maniacal psychosis." The "signs and symptoms" of mental illness that these inspectors looked for included "peculiarities in dress," and "excitement, impudence, unruliness" or the opposite, "a great amount of calmness, jovial air, or self-confident smile." A lack of physical beauty ("stigmata of degeneration, facial scars, acne") could also be seen as a sign of mental illness, as could the results of language barriers and strange surroundings ("inattention, lack of comprehension"). Simple nervousness, physical modesty, or lack of submission to authority ("refusing to be examined, objecting to have eyelids turned, awkward manner, biting nails") were also part of the litany of signs of mental "illness."¹⁵

The basic issue which lay behind the viewpoints of Dr. Jones and of many of his contemporaries was not one of mental illness or health but of social status and control. There is a connection between medical

professionals' desire to, as one sociologist has put it, "maintain and increase [their] status and position" and the theories and forms of health care prevalent in a society.¹⁶ The initial evolution in mental health care from community service to institutionalization in the early nineteenth century coincides with the rise of professionalism in medicine. Throughout the 1800s, as professionals gained a middle class clientele and control of educational and licensing facilities, older ideas of mental illness as sin (an inevitable part of fallible human life) gave way to ideas of mental disorder as crime (calling for institutional correction) and finally to ideas of mental illness as disease of the brain (calling for professional medical intervention). By Dr. Jones's time, medical doctors had been fighting a century-long battle for professional dominance. Allied with legislators, judges, and scientists who shared a similar socioeconomic standing and world view, physicians in the 1920s were involved in providing the supremacy of "medical" theories and approaches over the ideas and methods used by lay people and nonallopathic sects, particularly over the practices common among rural, nonwhite, and immigrant populations.¹⁷

The historical events of the two decades following the 1920s caused many people in the population at large to re-evaluate the ethnocentric and class-biased definitions of mental illness that had prevailed among professionals and had been generally accepted by the public earlier in the twentieth century. The distress experienced by poverty-stricken members of the middle class in the 1930s or by shell-shocked veterans in the 1940s made the public aware of the vulnerability of the "normal" person to stresses inherent in his or her physical or socioeconomic environment. World War II also gave psychiatrists greater clinical and administrative experience that widened their conceptions of the possibilities inherent in noninstitutional treatment and rehabilitation. After the war this experience was translated into civilian life and the serious consideration of the efficacy of noncustodial community mental health services was reborn. In 1946 a turning point was reached in public policy when Congress passed the Mental Health Act establishing the National Institute of Mental Health. This was the first major acknowledgment of national responsibility for public mental health care.¹⁸

Ironically, the war years also resulted in further socioeconomic polarization in the delivery of mental health care. As Freudian theory and psychodynamic approaches were introduced—methods and theories which were oriented toward neuroses and the treatment of an articulate middle class—mental health care became a more distinctly two-class, or two-tiered, system. A system of private practice and community services existed for those with the ability to pay, while a system of institutionalization existed for those dependent upon state support.¹⁹

The 1940s were also significant years in the history of mental health policy because they marked the beginning of Congressman John E. Fogarty's career as a representative of Rhode Island. Born in Providence



President John F. Kennedy and Congressman John E. Fogarty, ca. 1963. Photograph courtesy of Rhode Island Department of Mental Health, Retardation and Hospitals.

16. Mechanic, *Mental Health*, 54.

17. For critiques of class bias and the exclusionary nature of medical practice see Eliot Friedson, *Profession of Medicine* (New York, 1970), and Susan Cayleff, "The Eradication of Female Midwifery" (unpublished thesis, Sarah Lawrence College, 1978).

18. Albert Deutsch, *The Mentally Ill in America* (New York, 1949), 463.

19. See Alan Levenson, "The Community Mental Health Centers Program," in Golann and Eisdorfer, eds., *Handbook*, 687–698, and A. B. Hollingshead and F. C. Redlich, *Social Class and Mental Illness* (New York, 1958).

20. Congressman Fogarty's papers, including speeches, legislation, memoranda, and correspondence, are preserved in the collections of the Philips Memorial Library, Providence College. All references to the Fogarty Papers will hereafter be cited "JEF" according to the Smith index. See Matthew Smith, *John Edward Fogarty: An Inventory of His Papers* (Providence, 1970).

21. JEF, *Speech to the 11th Annual Mental Hospital Institute*, FS Box 8a, 6 (1959), 4.

22. JEF, "Economics, Ethics, and Mental Illness," *Speech to the American Psychiatric Association*, FS Box 8a, 6 (1959), 12.

in 1913, John Fogarty attended La Salle Academy and Providence College Evening School in the 1930s. He became a bricklayer and was elected president of the Bricklayer's Union in 1939. A year later he was elected to Congress. After serving in the Navy, he was re-elected and appointed to the House Appropriations Committee's Subcommittee for Labor and Federal Security, which became the House Appropriations Committee for Health, Education, and Welfare in 1953. Fogarty served as chairman of that committee from 1949 until his death in January of 1967. During his long career, Fogarty became the leading advocate for public health services for the mentally ill, for government funding for research in the field of mental illness, and for the creation of community mental health programs on the state and local level.²⁰

Congressman Fogarty was a master of rhetoric who had an uncanny ability to elicit straightforward answers from those testifying before his committee. During the 1950s a burgeoning of public funding for mental health began as a direct result of what became known as his "Fogarty Questions." These questions were directed at government officials and professionals responsible for public health policy. They brought to light the dismal picture of federal inaction and neglect in the mental health field.

A champion of the common person, Fogarty attacked the two-class system of care. Lecturing on the importance of community services, he would remind his listeners that:

As a people, we Americans are committed morally and ethically to the proposition that each man and woman is entitled to the opportunity to realize his best capabilities. This includes the opportunity to receive proper medical care, regardless of income, social class, or the nature of the illness.²¹

Concerned with the problem of professional bias, the congressman urged health-care providers to familiarize themselves with the hardships faced by their patients in everyday life. He encouraged "the hospital physician, nurse, social worker, and psychologist" to make "closer contact with the community" and obtain "a clearer understanding of the problems confronting the patient when he leaves the hospital." Recognizing that in health knowledge is power, he also encouraged professionals to communicate with their patients and include the public in decision-making processes—thus beginning a cycle of awareness and activism, which he believed would ultimately lead to public support for broadened federal health programs. He warned that in order to maintain this kind of information sharing, laypeople "may expect from [mental health professionals] greater subordination of gain, position, convenience, and professional and institutional rivalry." Fogarty, in short, advocated application of democratic principles and an appeal to public conscience as the route to mental health reform.²²

While Fogarty was opening governmental closet doors on the national level, states were becoming more acutely aware of the problems within their own institutions. In the 1950s investigative reporters

toured institutions and made the care of the mentally ill "news," increasing public awareness and modifying what one journalist calls the "almost medieval concepts as to the nature of the mental patient."²³ The use of psychotropic drugs, which some critics saw as "chemical straitjackets," was greeted by most professionals as a breakthrough which made community care a viable option.²⁴ Plagued by problems of overcrowding, staff shortages, and money deficiencies, state officials began to look at "community mental health" primarily as a process of deinstitutionalization—a policy that would cut costs for states and institutions. As Fogarty explained to a state gathering of the Association for Mental Health, "revulsion at public neglect" combined with "the high cost of traditional custodial hospital care" had caused people to re-examine "the locked ward, the bolted door and the barred window" as a solution to the social problem of mental distress. Instead of "sole reliance on the mental hospital" and on isolation of the mentally ill from the community, people in the 1950s were beginning to think of mental illness as "a spectrum of problems requiring a spectrum of services."²⁵

Amidst this change in "the tide of public indifference," Congress passed the Mental Health Study Act (1955) and created the Joint Committee on Mental Illness and Health.²⁶ After six years of study, testimony, and observation of health care systems abroad, the committee published its report. Entitled "Action for Mental Health," the report was a definitive policy statement on the need for a comprehensive community mental health plan in the United States. The report also expressed the basic tenets of the idea of community mental health:

The objective of modern treatment of persons with major mental illness is to enable the patient to maintain himself in the community in a normal manner. To do so, it is necessary, (1) to save the patient from the debilitating effects of institutionalization as much as possible, (2) if the patient requires hospitalization, to return him to home and community life as soon as possible, and (3) thereafter to maintain him in the community as long as possible.²⁷

Fogarty elaborated upon the place of the institution in a community mental health program in a speech given to the American Psychiatric Association and to an Emma Pendleton Bradley Conference in Riverside. Stressing the importance of a range of optional services and "transitional arrangements" for reintegration of the ex-patient into family and work situations, Fogarty said:

The hospital must take its place as part of a network of mental health services in the community. The treatment and rehabilitation programs of the hospital need to become more closely integrated with community health and social services, so that the patient can receive continuous psychiatric and social assistance that will change as his needs change—and so that he will be able to maintain his links to the community and to his family throughout the course of his illness.²⁸

23. Mike Gorman, "Society's Attitude Toward the Mentally Ill: The Crucial Factor," in Robert Westlake, ed., *Shaping the Future of Mental Health Care* (Cambridge, Mass., 1976), 34.

24. See Judi Chamberlin, *On Our Own: Patient-Controlled Alternatives to the Mental Health System* (New York, 1978), 13.

25. JEF, *Speech to the Maryland Association of Mental Health*, FS Box 13b, 12 (1964), 1-4.

26. See JEF, *Address to the National Association for Mental Health*, FS Box 10d, 17 (1961).

27. Joint Committee on Mental Illness and Health, *Action on Mental Health* (New York, 1961), xvii.

28. JEF, "Economics, Ethics, and Mental Illness," *Speech to the American Psychiatric Association*, FS Box 8a, 6 (1959), 11.



*Congressman Fogarty with
Easter Seal Child, 1966.
Photograph courtesy of the
Providence Journal Company.*

29. JEF, *Address to the Bridgeton-Pascoag P.T.A.*, FS Box 14b, 9 (1965), 4.

30. Rhode Island Governor's Council on Mental Health, *A Comprehensive Mental Health Program for Rhode Island* (Providence, 1965), 45.

31. Hospitals with outpatient services in 1964 were: Bradley, Butler, Our Lady of Fatima, Pawtucket Memorial, Rhode Island Hospital, Roger Williams, Institute of Mental Health, and St. Joseph's. Community clinics in operation in 1964 included: Cranston Child Guidance, East Providence Community Mental Health Board, Newport County Community Mental Health Clinic, Providence Child Guidance, Warwick Community Clinic, Washington County Community Mental Health Board, Rhode Island Mental Hygiene, and the Veteran's Administration Out-Patient Clinic.

In the two years following the publication of the committee report, Fogarty worked closely with the Kennedy administration to push public health-oriented mental health legislation through Congress. In February 1963, President Kennedy delivered a special message to Congress on mental illness and retardation, endorsing a deinstitutionalization policy. In October of the same year Public Law 88-164, "The Mental Retardation Facilities and Community Mental Health Centers Construction Act," was passed. Amendments appropriating supplementary funds were passed in 1965 (P.L. 89-105), 1967, and 1970. The new community mental health legislation designated hundreds of millions of dollars in grants-in-aid to states, first to develop a statewide plan coordinating services and then to implement the plan through actual construction and staffing of centers.

In Rhode Island, federal legislation had been preceded by passage of the Chafee-Slater Act in 1962. The act provided matching funds from the state to local communities for public education and outpatient services. It also provided for the establishment of Community Mental Health Boards in Warwick, East Providence, Barrington, and Washington and Newport Counties.²⁹ In 1963, Governor John Chafee appointed the Rhode Island Governor's Council on Mental Health to develop a comprehensive plan for the state. Convening in October, the fourteen members from various agencies and community groups heard testimony from mental health officials about the functions of the existing agencies. Between September of 1964 and April of 1965 studies were conducted to examine the laws still on the books governing cases involving mental illness, to estimate the extent of mental illness in the state, and to review the quality of existing services and personnel.³⁰

The results of these investigations showed that 46 percent of all hospital beds in Rhode Island were occupied by mental patients in 1964. Although no exact studies of the rate of mental illness in Rhode Island were conducted, it was estimated that the rate of mental patients per 10,000 of the general population was 402.6, versus 283.7 per 10,000 for the nation as a whole. While admissions to mental institutions had not decreased from 1955 to 1963, the number of releases had increased, resulting in a slow process of deinstitutionalization. A survey was also distributed to mental health professionals. The results of the survey indicated that the greatest perceived need was for outpatient facilities for "persons from low income groups" and that outpatient services already in existence were unfairly distributed and inaccessible. In 1964 there were nine hospitals in Rhode Island providing outpatient services and eight community clinics or community boards.³¹ The studies of personnel showed that there were sixty-eight psychiatrists in the state in 1964, or one psychiatrist per every 13,000 Rhode Islanders. Of those sixty-eight practitioners, 75 percent were in private practice, dealing primarily with neurotic disorders. Most crisis counseling and referral was done by laypeople, clergymen, and general physicians. No compre-

hensive coordination of services existed and the system was characterized by severe gaps and overlaps.

After considering these findings, the governor's council issued its recommendations. It noted that any comprehensive program should provide "equitably for all members of the community regardless of status" and should maximize "the complemental nature of services and programs, regardless of auspice."³² It then recommended that the state expand programs according to the Rhode Island Mental Health Clinic Act of 1962. This meant establishing regional mental health boards and catchment areas; recruiting psychiatric personnel and supporting psychology departments in state schools through scholarship programs; encouraging general hospitals to open acute-care psychiatric units; and establishing day care, rehabilitation, and after-care (foster home care, home care, residential living, education, and vocational opportunity). The authors of the report were optimistic about the possibility of the successful coordination of these services:

Rhode Island has a unique opportunity to tackle its problems in a truly integrated manner. Its very compactness and positive history of public-voluntary undertakings makes for the real possibility of developing a network of services, voluntary and public, that would be comprehensive in scope, complementary in nature, and non-duplicating in kind.³³

Despite this optimism, it would take years—long after the publication of the 1965 report and after the death of John Fogarty—until a coalition of concerned citizens and public agents would finally produce a comprehensive mental health plan for Rhode Island.³⁴

The political sanction placed upon deinstitutionalization policies by government officials was only one manifestation of the public rebellion and role redefinition going on at many levels in American society in the 1960s. Like the Civil Rights movement and organized resistance to the Vietnam War, the exposés of institutional conditions and criticisms of the stigma attached to mental patients were part of a growing re-examination of the discriminatory nature of social realities, especially when contrasted with the supposed American ideals of equal opportunity and equal participation in decision-making. Where the desire for private monetary "success" and a focus on the nuclear family had dominated mainstream thought in the 1950s, the 1960s brought a revival of old ideas of community—a rebirth of the notions of mutual aid, social responsibility, and public welfare.

In the mental health field, the dynamics of deinstitutionalization which characterized the policies of the 1960s developed into the patients' rights movement of the 1970s and early 1980s.³⁵ Rejecting the idea that the medical model (active practitioner/passive patient) was inherently therapeutic, patients' rights advocates called for relationships between practitioners and clients which allowed power to be

32. Governor's Council, *Comprehensive Mental Health Program*, 75.

33. *Ibid.*, 78. See also the *Annual Reports* for the Governor's Council, 1968–1973.

34. G. Richard Weir (Director, Rhode Island Mental Health Association), Interview, Aug. 21, 1981.

35. See Phil Brown, "The Mental Patients Rights Movement and Mental Health Institutional Change," *International Journal of Health Services* [forthcoming].

36. For an illustration of patients' rights advocacy in Rhode Island see Barbara Bair, "The Parents Council for Retarded Children and Social Change in Rhode Island, 1951-1970," *R.I. Hist.*, XL (1981), 145-159.

37. See Chamberlin, *On Our Own*.

38. Emily Dickinson, "Much Madness is Divinest Sense—" (1862), in Thomas Johnson, ed., *Final Harvest: Emily Dickinson's Poems* (Boston, 1961), 101.

39. Sobey, *Nonprofessional Revolution*, 26. See also Richard Budson, *The Psychiatric Halfway House* (Pittsburgh, 1978), and George Fairweather et al., *Community Life for the Mentally Ill* (Chicago, 1969).

40. June Jackson Christmas et al., "New Careers and New Mental Health Service: Fantasy or Future," *American Journal of Psychiatry*, CXXVI (1970), 1480-1486.

more equitably distributed. These revised models preserved the disturbed person's free will and self-determination as much as possible and focused on groups rather than individuals as the basic unit of care, emphasizing horizontal inter-relationships rather than a vertical two-way relationship.³⁶ Members of the patients' rights movement also challenged entrenched powers of social construction and social control. Acting within a social current of protest against racism, poverty, militarism, and, later, sexism, they charged that the power of a medico-legal elite to label the behavior of others either "normal" or "deviant," acceptable or unacceptable, was primarily a moral and sociopolitical matter and not a medical or scientific one.³⁷ By thus insisting upon the difference between mental "illness" and nonconformity or dissension, patients' rights activists were echoing thought expressed in the poetry of Emily Dickinson a century earlier:

Much Madness is divinest Sense—
 To a discerning Eye—
 Much Sense—the starkest Madness—
 'Tis the Majority
 In this, as All, prevail—
 Assent—and you are sane—
 Demur—you're straightway dangerous
 And handled with a Chain—³⁸

The changes in the rhetoric of mental health policy in the 1960s and 1970s called not only for reorientation toward the mentally ill but also toward the roles played by mental health personnel. As in the analysis of the development of community mental health policies, writers have often used the metaphor of "revolt" to describe the need for the reintroduction of lay people into mental health care delivery. The planned introduction of local lay people into community care situations to serve as mental health aides, homemakers, counselors, companions, and foster care providers—what has been termed "the nonprofessional revolution in mental health"—was in part a reaction against the trend toward increased specialization and maldistribution of care.³⁹ The policy was also a recognition that the shift from rural to urban norms and toward more complicated technologies in the workplace had produced a growing number of unskilled and unemployed people, particularly among the young and the aged and among racial minorities. Part of the rhetoric of community mental health policy was to match these people's need for employment with unmet needs for care, thereby creating a synergistic situation altering feelings of marginality and low-status, "conditions that may themselves have been among the determinants of mental disorder."⁴⁰ This process was in accordance with John Fogarty's definition of mental "health," which he called the "freedom" from "poverty" which "breeds despair" that "breeds mental illness," a freedom that he saw as "a prerequisite" for the realization of the "maximum self-expression and self-development of every person."⁴¹

Congressman Fogarty based his career on a faith that national legislative reforms like the deinstitutionalization policies of the 1960s could bring about meaningful change on the local level. An idealist, he believed that privatism—what he called “utter negligence” of responsibility for “the less fortunate among us”—could be overcome by increasing public awareness and by an appeal to “the understanding and humanity of the majority of the American people.” He likened his efforts in the introduction of liberalized mental health legislation to the planting of a “seed,” which would be “nurtured” by the separate states and “from which coordinated mental health services would grow.”⁴² Countering charges that the passage of Federal legislation in the 1960s had usurped states’ rights, he told a leadership conference that federal funding actually “would encourage local responsibility of a degree that has not existed since the state hospital system was founded.” As he informed his fellow Rhode Islanders:

It must be the community itself which assembles the resources available and makes the decision on how those resources can be used to its own best advantage. We Rhode Islanders know this, the idea is not new to us at all. The tradition of effective community action in this State dates back to the Providence Plantations, in a spirit of humanitarianism, free inquiry and the cooperation of many professions, and of private and public agencies whose staffs and volunteers are willing to work together to meet the demands of the society in which they live, as those demands change.⁴³

In the last years of his life, Fogarty toured the state speaking to citizen’s groups, religious groups, mental health professionals, legal professionals, labor unions, educators and government officials. He urged them to rekindle the spirit of cooperation and to initiate reforms while federal funds were still available.⁴⁴ He appealed to conscience, reminding his listeners that the real costs of mental illness were not monetary but social, “acts of violence, days of trouble, and nights of misery,” costs that could be prevented through public determination and would be increased by continued “concern for pennies instead of people.”⁴⁵

Despite his faith, Fogarty’s “seed” of significant change failed to take root and grow in Rhode Island. His efforts to instigate reform fell victim to the same cycle of incentive and inertia that has characterized the history of mental health policy for a century. In the Progressive Era, mental health reformers had advocated ideas which were precursors to the deinstitutionalization policies of the 1960s. These ideas, however, did little to alter the realities of day-to-day care or to change entrenched positions of authority. While community care and rehabilitation became part of official rhetoric, custodialism remained the norm. As historian David Rothman has termed it, “conscience” was not strong enough to overcome “convenience” and the focus of mental health policy remained on institutions.⁴⁶ A similar lapse in action occurred in Rhode Island in the mid-1960s. In late 1965, Fogarty gave an uncharac-

41. JEF, *Speech to VISTA Members, Osawatoma State Hospital*, FS Box 15f, 32 (1966), 5, 11, and JEF, *Address to the Northeast State Governor’s Conference on Mental Health in Providence*, FS Box 5, 7 (1956), 2. See also H. Levin, “Psychologist to the Powerless,” in F. Korten et al., eds., *Psychology and the Problems of Society* (Washington, D.C., 1970), and Laura Hines, “A Nonprofessional Discusses Her Role in Mental Health,” in B. Denner and R. Price, eds., *Community Mental Health* (New York, 1973), 127–135.

42. JEF, “Federal and Citizen Action for Mental Health,” *Speech to the National Association for Mental Health*, FS Box 14c, 26 (1965), 9.

43. JEF, “The Responsibility of the Federal Government in the Fight Against Mental Illness,” *Speech at National Leadership Conference on Action for Mental Health*, FS Box 11a, 11 (1962), 6. See also JEF, “Fight Against Mental Illness: A National and Local Concern,” *Speech to the D.C. [District of Columbia] Association for Mental Health*, FS Box 11a, 12 (1962).

44. See, for example, JEF, *Address to the Conference for Leaders in State Mental Health Planning*, FS Box 14b, 8 (1965), and JEF, “The Rhode Island Jaycees and Mental Health,” *Speech to Gloucester Jr. Chamber of Commerce*, FS Box 14f, 27 (1965).

45. JEF, *Congressional Record* (Feb. 19, 1964), 760, and JEF, “Mental Health in Rhode Island and the Metals Industry,” *Speech to the American Society for Metals, R.I. Chapter*, FS Box 15c, 17 (1966), 14.

46. David Rothman, *Conscience and Convenience: The Asylum and Its Alternatives in Progressive America* (Boston, 1980).

47. JEF, *Speech to Rhode Island Association for Mental Health*, FS Box 14f, 31 (1965), 1-3 (reprinted in the *Congressional Record*, May 26, 1966).

48. JEF, *Remarks at the Maryland Association for Mental Health*, FS Box 13b, 12 (1964), 9.

teristically bitter speech which he later had entered into the *Congressional Record*. In that speech he told his audience that:

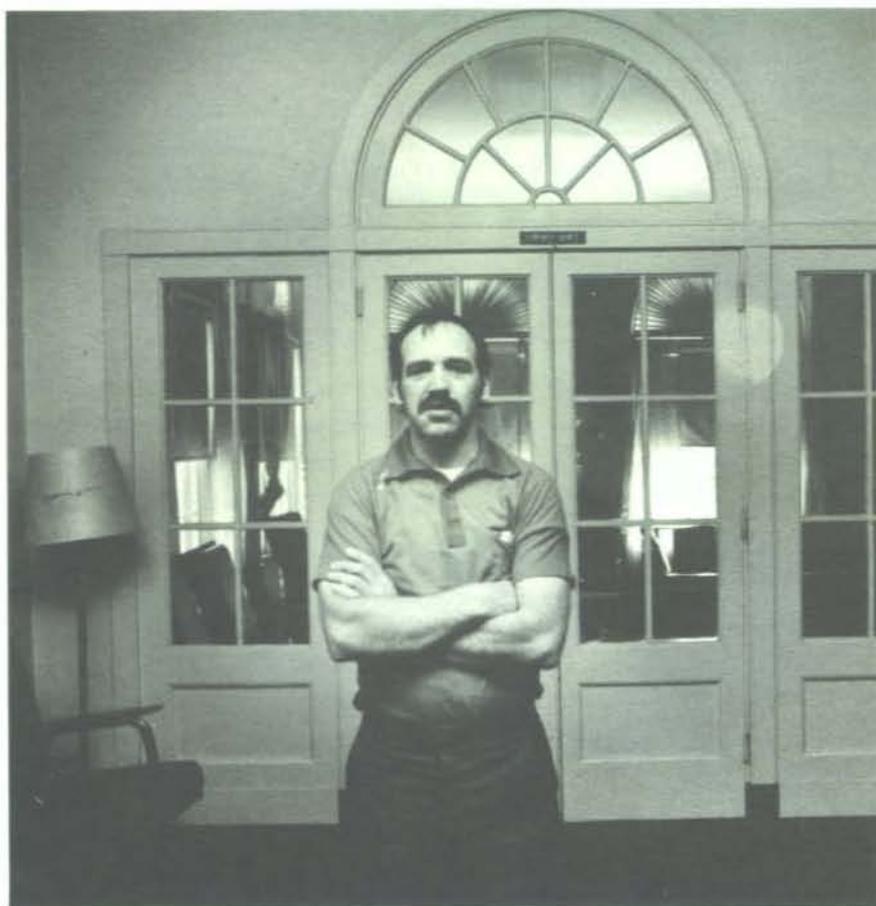
What I have done I did as a citizen of the State of Rhode Island for the betterment of my fellow Rhode Islanders. Thus, I think you can understand my disappointment when I say that my own State stands near the bottom of the list when it comes to taking advantage of these opportunities. . . . A new day has dawned for the mentally ill and mentally retarded in the United States. Unfortunately, the full light of this dawn has yet to reach Rhode Island.⁴⁷

The speech was a subdued expression of Congressman Fogarty's exasperation with the juxtaposition of federal incentives and local inertia—the supremacy of privatism over the sense of public responsibility. The unanswered question of his career was, as he phrased it, the question of the possibility of real reform, of "how to alter old systems while still being, as it were, entrapped within them."⁴⁸

Days of Darkness and Hope
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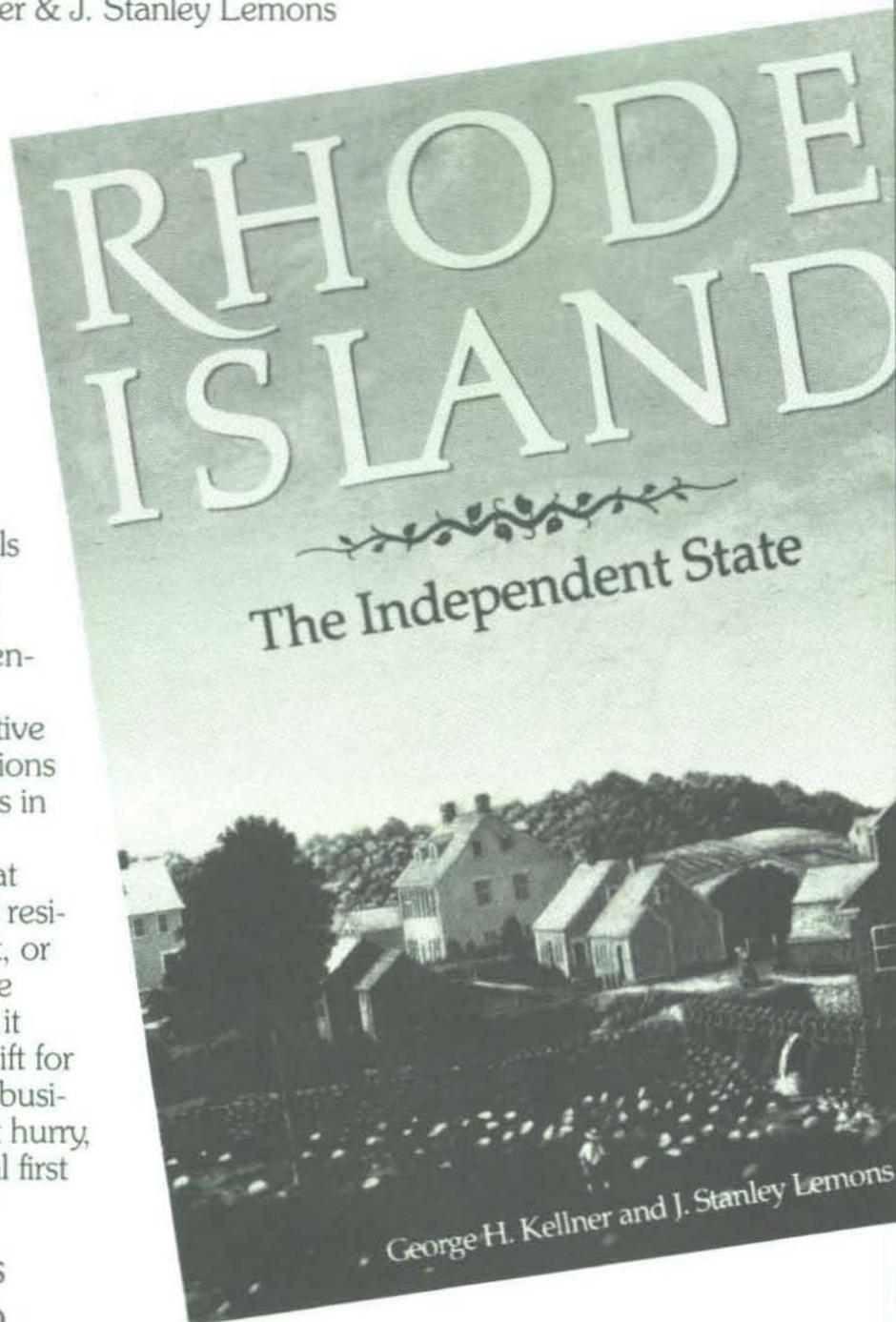


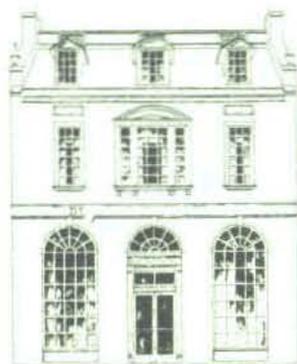
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